Primary Health Care Strengthening Project

Progress Report, Quarter 4
Plus
Executive Summary for Year 1

Submitted to USAID/Caucasus by:
International Medical Corps

In collaboration with:
Abt Associates, Inc., Curatio International Foundation, Johns Hopkins University/Center for Communication Programs

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List of Acronyms

Abt	Abt Associates Inc.
CIF	Curatio International Foundation
DAI	Doctor's Advancement Institute
FP	Family Planning
FM	Family Medicine
GCC	Governmental Coordination Council
GoAZ	Government of Azerbaijan
HCF	Health Care Financing/Policy Development
HF TWG	Health Financing Technical Working Group
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
JHU/CCP	Johns Hopkins University Center for Communication Programs
KAP	Knowledge, Attitudes, Practice
MoF	Ministry of Finance
MoH	Ministry of Health
MoED	Ministry of Economic Development
MoJ	Ministry of Justice
MoLSP	Ministry of Labor and Social Protection
NGO	Non-government Organization
PHC	Primary Health Care
PHC TWG	PHC Technical Working Group
RH	Reproductive Health
TOR	Terms of Reference
USAID	United States Agency for International Development
WB	World Bank
WGPHC	Working group on PHC strengthening
WHO	World Health Organization

I. Executive Summary

1. Program location

The main program is located in Baku, Azerbaijan. The Baku office houses most of the Project staff. It is also strategically located very close to the Ministry of Health. The project also has a satellite office in Seki, one of the three targeted regions, which will be used as base to carry out field activities in Sheki and Gakh.

2. **Problem statement**

Since the collapse of the Soviet-style health system in 1991, public financing of health care in Azerbaijan has dropped significantly. The current estimate of per capita public spending on health is $12 dollars. Rural health care expenditures have dropped even more substantially. Less than 1% of GDP is spent on public sector health care services, as opposed to over 5% of GDP in the late 1980's. Although the GDP per capita is under $940, much of the burden of health care costs increasingly falls upon the family, as a result of the decline in basic services and government funding.

In addition to a frail health system, the health status of Azerbaijani citizens has declined dramatically since independence from the Soviet Union. The leading causes of mortality among adults in Azerbaijan are cardiovascular diseases, cancers, diabetes, and injuries, and these are increasing. The decline in health status among the vast majority of the population is directly related to their lifestyle choices and lack of knowledge pertaining to their health needs. It is extremely important that the populations' awareness of, and attitude toward personal health are altered. At the same time, improved legislation provides an opportunity for the people of Azerbaijan to fully exercise their rights as patients, and to offer adequate basic health care. There is a need to raise the local population's awareness of these rights along with the introduction of effective mechanisms empowering communities on health related issues.

3. Description of beneficiaries

The project beneficiaries for each component are:

Component 1 – Direct beneficiaries include Government of Azerbaijan, in particular the Ministry of Health and Ministry of Finance. Potential beneficiaries may include the entire Azerbaijan population.

Component 2 – Direct beneficiaries include the Ministry of Health, Ministry of Finance, and Health Care Providers. Potential beneficiaries may include the entire Azerbaijan population.

Component 3 – Direct beneficiaries include the users of health services residing in the three targeted districts of Seki, Gakh and Ismayili, as well as the District Health Department staff and targeted facilities and staff.

Component 4 – Direct beneficiaries include the Ministry of Health through strengthening capacity in strategic health communication, with indirect beneficiaries including other ministry members and NGOs. Direct beneficiaries of the national multi-media campaign include users of media residing in Azerbaijan and participants in community-based activities, while indirect beneficiaries include those who learn about the campaign messages from media viewers and campaign participants.

Component 5 – Direct beneficiaries include the Ministry of Health and the health providers and officials in 15 targeted districts: Khizi, Deveichi, Siazan, Salyan, Massali, Neftchila, Agdam, Ter-Ter, Agdash, Belasuvar, Lenkoran, Kasakh, Ganja, Khachmaz, and Agjabedi. Indirect beneficiaries include populations at-risk of HAI residing in these districts.

4. Program goals, objectives and major strategies (IMC)

The goal of the Project is to create a supportive policy environment that helps to *increase the responsiveness and effectiveness* of the Primary Health Care system in Azerbaijan.

This goal is realized through the provision of technical assistance to the MoH and to other governmental and nongovernmental organizations in a collaborative effort to strengthen Azerbaijan's primary health care system and system of health care financing. This technical assistance will greatly assist the MoH in implementing overall health sector reforms and their new World Bank 86.5 million US$ Health Sector Reform Project (HSRP). PHC Project works in close collaboration with the MoH to develop institutional capacity that will enable the ministry 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. This is conducted through the following four project objectives/components:

- Increase public expenditures for health and improve allocation for PHC
- Create a policy and legal framework that defines PHC and the PHC delivery system
- Improve the quality of PHC service
- Promote personal responsibility for health among individuals and families

5. Start and end dates

The program started on September 1, 2005 and will end on August 30, 2007.

6. Level of funding

PHC Strengthening Project	**Contract amount**
IMC	$ 4,987,189.00
Abt	$ 1,200,380
CCP	$ 857,641
CIF	$ 342,904

AI Component	**Approved budget**
IMC	$ 362,500.00
Abt	$ 112,581.56
CCP	$ 100,733.00
CIF	$ 17,787.36

7. Main authors of the document

International Medical Corps, Abt Associates, Curatio International Foundation, and John's Hopkins University/Center for Communication Programs

8. Notable project results/key achievements

The Project has accomplished and/or initiated major activities during the Year 1:

- Advocated for the establishment of governmental interagency Health Reform Coordination Council (CC) and its Technical Working Group (TWG) responsible for heath financing and health service delivery (with the emphasis on PHC strengthening) reform;
- Formed and operated the Project's PHC Technical Working Group (PHC TWG) instrumental in ensuring participatory approach towards elaborating PHC reform initiatives;
- Assisted GoAZ in developing the Health Sector Reform Project (HSRP) that will be financed through the World Bank loan and state budget;
- Developed draft "Program for Health Financing Reform in Azerbaijan for 2006-2011" calling for major increases in public spending on health, concentration of fragmented health funds in "single payer" entity and fundamental reform of health sector financing and provider payment system;
- Initiated development of "PHC Concept Paper" outlining the options for institutional and organization development of PHC system;
- Initiated the development of the retraining curriculum for FM by technical assistance provided by international consultants.
- Assisted the Ministry of Health to develop and adopt a protocol for human avian influenza (HAI) surveillance and to implement the surveillance system in 15 high risk districts. Developed the following technical materials to support HAI surveillance: (1) training of trainers (TOT) curriculum and materials, (2) district level training curriculum and materials, (3) laminated instructions for providers regarding case reporting, (4) protocol for HAI surveillance, (5) finalized surveillance forms (initiated by WHO/MOH), (6) bound compilation of all HAI-related surveillance forms and their instructions, and (7) HAI surveillance monitoring/self-assessment forms for facilities and district SES offices. (see Attachments A and B)
- Trained 16 national level epidemiologists [Trainers/Technical Consultants (TTCs)] to be experts in human avian influenza surveillance and to lead efforts to operationalize HAI surveillance in 15 high-risk districts.
- The 16 TTCs trained 300 district epidemiology staff and health care providers to detect, report, and respond quickly to HAI cases. The TTCs followed up with monitoring visits to all districts after training to identify achievements and challenges related to HAI surveillance and to work with district staff to improve surveillance capacity.

- The TTC teams provided instructions on HAI case reporting to approximately 550 health care providers in the first eleven districts trained. (see Attachment C)
- In conjunction with district level trainings, TTCs conducted HAI workshops for 151 district officials responsible for emergency response. In these workshops, they reviewed and elaborated their roles, responsibilities, and actions in case of an HAI outbreak.
- Development of a communication strategy in conjunction with GoAZ ministries, national and international NGOS and other potential collaborating partners from advertising and research firms.
- The development of the Azerbaijan Health Communication Campaign brief and a request for proposals for the first wave of the media campaign.

9. GoAZ and other donor collaborations, including in-kind contributions

During the Year 1 the Project established close partnership relations with the MoH, MoF and pilot district health authorities. The Project staff maintained policy dialogue through regular contacts with senior staff of MoH and MoF, including Deputy Ministers, heads of various MoH and MoF departments and national coordinators in clinical specialties relevant to PHC. Formal establishment of the Governmental Coordination Council (GCC) and Technical Working Group (TWG) on Modernization of Health Care Services and Introduction of Mandatory Health Insurances may be considered as one of the most successful results of this collaboration, as it establishes formal venue for policy dialogue and decision making on health reform initiatives within the government and between the government and development partners. The GCC and TWG also present significant opportunity for achievement of the Project objectives, particularly for Components 1 & 2. The first major step in seizing this opportunity is an elaboration of the "Proposal on Health Financing Reform Program for Azerbaijan in 2006-2011". This document has been reviewed and approved by the TWG and will be submitted to the Government Coordination Council for approval. If approved through the Cabinet of Ministers decree, the Program will serve as the governmentally endorsed framework document for health financing reform (including strengthening of PHC financing system) in the next five to seven years and thus will represent major milestone achieved by the Project in securing the governmental ownership over the health sector financing reforms.

The Project also enjoyed excellent working relationships, information sharing and mutual support with major donors, including the World Bank and UNICEF. Development of the 86.5 Million US$ HSRP has been another notable achievement of the Project's collaboration with GoAZ and the World Bank. With the approval of USAID, two of the Project's key staff (COP, Dr. Peter Hauslohner and Senior Health Finance Analyst, Dr. Akaki Zoidze) and two consultants (provided to the GoAZ through Project's STTA) closely collaborated with MoH working groups responsible for elaboration of HSRP components and officially participated in the World Bank Appraisal Mission for HSRP Project.

As part of the AI project, the Project provided technical assistance for the creation and installation of a national hotline for avian influenza housed at the Republican Anti-plague station. The Project also facilitated the involvement of the World Bank in providing funds to the Republican Ant-plague station for the creation of an online database for tracking and evaluating hotline calls.

9. Collaborations with other USAID projects

The Project collaborated closely with the following USAID projects: ACQUIRE project, PRAGMA project, UNICEF, EMDI, Counterpart, as well as CHF USAID-funded projects during Year 1.

First, The ACQUIRE project hosted a study tour on reproductive health and family planning in Ankara, Turkey in April, 2006 for members of MoH, Parliament and other stakeholders. The Project sent one of its key staff to this study tour and also participated in a debriefing meeting held one month after the study tour. This activity helped to strengthen the Projects understanding of reproductive health and family planning policy issues as well as the organizational structure of family planning health services and how its integration into primary health care services. Additionally, it strengthened the relationship between the governmental officials and the Project (please see Attachment M for trip report). It is expected that the Project and ACQUIRE will be working very closely on the integration of reproductive health and primary health care.

Second, the 3rd Annual Health Systems Development course for Central Asia, the Caucasus and Moldova took place on May 22 through June 2 in the city of Bishkek, Kyrgyzstan. The city played host to fifty-nine representatives from 10 selected CIS countries attending the innovative and highly regarded course, featuring guest speakers from Harvard University and London Imperial College's International Center for Health Management. Provided by the World Bank Institute, the course focuses on government's role in the primary health care sector and the methods by which to strengthen primary health care (PHC). The interest shown in the course by the Project and its partners (MoH, MoF, Parliament, private sector and NGO representatives) led to a partnership with the U.S. government funded project entitled 'START Participant Training Program' and the selection of nine local specialists from different sectors of Azerbaijan to attend the course.

Third, the Project participated in the AIHA sponsored workshop on 'Healthcare Management' held in May in Tbilisi, Georgia. The main focus of this workshop was on new management tools in healthcare. One of the key project staff working on health financing and management attended this workshop. As well chief doctors from Seki, Gakh, and Ismayili attended this course. The chief doctors learned new management tools and methods, which are drastically different from the current methods inherited from the Soviet Period.

Fourth, as part of the AI activities, the Project consulted with staff at PRAGMA in the development of educational brochures and other education media on AI. PRAGMA was also notified about all the district-wide training session days and times and invited to recruit participants from the agricultural sector to these trainings, as suited.

Fifth, the Project collaborated with UNICEF in the development of a 1-day avian influenza workshop for journalists followed by a second 1-day AI workshop for journalists and public relations officers from GoAz ministries. As well, the Project collaborated with the National Avian Influenza Communication Committee (UNICEF, USAID-Agriculture and World Development, Pragma, FAO, Red Crescent Society, BP, and World Bank) in determining the needs of new IEC materials on avian influenza.

Lastly, the Project has met with ABA CEELI on several occasions to coordinate legal advise and assist with planning of policy reform. More coordination is planned as the PHCS moves into more policy dialog with the MOH, MOF and GOAZ in Year 2.

Increasingly, the Project and EMDI are cooperating in the field of strategic planning for the MOH. the EMDI and PHC projects will produce white papers (Concept papers) for the MoH. These papers will be closely linked and designed together so that EM and PHC are connected as joint parts of health reform. The EMDI project will also create a special package to train PHC providers on emergency medicine and first aid skills. Starting in Year two, the EMDI and PHC project teams will hold regular integrated meetings for planning purposes.

IMC has also provided technical assistance to both CHF and Counterpart. First, IMC provided technical assistance to CHF for the assessment of health points for micro projects developed for Zagatala and Massaly. This assistance helped to identify how to select clinics for renovation based on pre-selected criteria as well as assistance on developing a renovation plan for the selected clinic. As well, IMC has held meetings with CHF to ensure that programs between PHC and Community Development are well coordinated and not duplicative in the common region of Seki. IMC also provided technical assistance to the Counterpart Project by establishing contact between Counterpart and NGO's that work in the field of health to assist in their identification of qualified NGO's.

It should be noted that during preparation of the Year 2 workplan, the Project consulted regularly with the AIHA on the development of the model FM clinic as well as curriculum development for FM. The Project will continue close collaboration with ACQUIRE and AIHA on the implementation of RH and FM activities. The Project will also work closely with the PIPE project in Year 2 to coordinate the health finance policy activities.

II. Management Overview

1. **<u>Environmental Compliance -</u> Report on Environmental Compliance as outlined in Initial Environmental Impact Statement.**
   Not Applicable – activities did not conduct any activities related to environmental compliance for Year 1.

2. **<u>Gender</u> - Outline any critical gender issues and/or dynamics. How has gender equity been addressed?**
   During Year 1, the Project applied all possible efforts towards ensuring gender integration. The Project's survey methodologies and instruments for the Household Utilization and Expenditure survey, Facility/Provider Survey, as well as the KAP Survey were designed in the way to account for gender specific issues related to access, utilization and quality of health care services and on health behavior more generally. For these purpose, the Project is collecting and analyzing baseline survey data disaggregated by sex to eventually help design health policy targeting the vulnerable populations. The Project strived to achieve that principles of gender equity are practiced in the Project's various working groups and that both men and women participate fully and equally at all levels of policymaking and policy implementation. The majority of the PHC Technical Working Group (PHC TWG) are women. Equal participation has also been ensured in Project sponsored Study Tours and workshops (NHA Regional Workshop in Tbilisi and the World Bank Flagship Course in Bishkek).

3. **<u>Anti-Corruption</u> - Outline how anti-corruption has been addressed, and other issues related to anti-corruption.**
   During the Year 1, the Project assisted development of comprehensive health financing reform proposal, implementation of which will represent a major anti-corruption measure in the health sector. Concentration of fragmented public health funds in a single, newly created institution and introduction of performance based provider payment systems based on contractual relationships will ensure more transparency and accountability in public spending on health, while increased government expenditure for health care will decrease widespread informal payments in the sector. The Project also assisted the MoH in introduction of licensing/certification system for medical personnel. Well functioning and fair system of personnel licensing and certification may serve as an effective tool against corruption associated with hiring and appointment of doctors and nurses in public facilities. The Project also ensured prevention of corruption through the transparent development and execution of the Project budget and the equally transparent procedures used for hiring local staff and managing Project activities.

4. **<u>Changes in management</u> (staff, activity, etc.) and effect on performance – if any.**
   The Project underwent changes in the management structure during the past year. The notable changes include:

   a) Assignment of Natalia Valeeva as Deputy Chief of Party; Adam Sirois' position was changed to Country Director.
   b) Assignment of Dr. Carol Underwood (JHU/CCP) to head Component 4 activities in the project. Dr. Underwood will be contributing 60% to the project.
   c) Assignment of Mehrnaz Davoudi as Senior Program Manager
   d) Hiring of multiple national staff:
      1. 2 Project Officers – Baku based
      2. 1 Filed Coordinator – Sheki Based
      3. 3 Administrative/Finance staff – Sheki Based
      4. 4 hired/assigned the following personnel during the program year.

III. Progress Toward Strategic Objective and Intermediate Results (IR)

The following summary is provided for the Quarter 4 program period only.

IR/COMPONENT #1: Increase public expenditures for health and improve allocation for PHC

1.1 Develop Capacity of the MoH, MoF and MoED.

1.1.1 Encourage formation of a technical working group on health financing (HFWG). The Project continued to work closely with the Technical Working Group (TWG) of the Governmental Coordination Council (CC) headed by the Minister of Health (MoH), which effectively substituted the Health Financing Technical Working Group (HF TWG) that has been proposed in the Project Application and Work Plan for the Year 1. The technical working group is responsible for preparation of technical proposals on health care financing and primary health care reform for the Council and ultimately for the Cabinet of Ministers.

1.1.2 Conduct HFWG meetings at least quarterly and provide technical assistance. Two formal meetings of the TWG on Health Financing and Primary Health Care Reform were held in July and August, 2006, facilitated by the Project. The purpose of both meetings was the review of the "Proposal on Health Financing Reform Program for Azerbaijan in 2006-2011" developed with the Project's technical assistance. Comments and suggestions have been provided by the working group members that have been incorporated in the final draft of the document. As a result of this review, TWG decided to formally submit the Program Proposal to the CC. (see Attachment D for the full version of the proposal)

1.1.3 Conduct training of national experts on health care financing. No activity has been undertaken during the accounting period.

1.1.4 Organize and conduct study tours for national stakeholders. The Project continued the preparation of the Estonia study tour program, logistical arrangements (invitation letters for participants, visas, etc.) and background materials on Estonian health reforms and health financing system. The study tour took place on September 25 – 30 (see Attachment E for full Trip Report of the study tour).

1.1.5 Provide technical assistance and mentoring to the HFWG. The Project assisted TWG in the review of the 'Proposals for Health Financing Reform Program of Azerbaijan 2006-2011.' The Projects prepared presentation and held discussions with TWG on various aspects of health financing reform included in the Program Proposal; namely Basic Benefit Package (BBP), Social Health Insurance (SHI), concentration of funds in single payer institution, performance based provider payment methods, etc. Practical application of these concepts in context of Azerbaijan has also been discussed.

1.2 Begin to Develop PHC Financing and Management Interventions.

1.2.1 Assist the HFWG in the evaluation of regional experience. The Project presented health financing reform cases from the countries in the region (Georgia, Armenia, Estonia, Russia, Kyrgyz Republic) during the TWG meetings to assist the TWG group members in selection of the reform model which will be most relevant for Azerbaijan.

1.2.2 Develop a variety of reimbursement options to be piloted. Reimbursement options has been elaborated in the "Proposal for Health Financing Reform Program in Azerbaijan for 2006-2011" reviewed and approved by the TWG for submission to the CC.

IR/COMPONENT #2: Create a policy and legal framework that defines PHC and the PHC delivery system

2.1 Develop Capacity of MOH and Promote Policy Dialogue

2.1.1 Conduct consultations with MoH and other major stakeholders in PHC reform in both the GoAZ and the NGO community. Periodic consultations with MoH, the PHC TWG, and other stakeholders from the Governmental Coordination Council (GCC) on various aspects of PHC reform has been held during the reporting period. Additionally, the Project provided technical and financial support for the preparation of the joint PHC Strengthening Project and WB/MOH Health Reform Project launch in Sheki, which will be held during first week of October, 2006.

2.1.2 Establish working group on technical aspects of PHC strengthening. The MOH has so far not supported efforts to establish official working groups on PHC or health finance. The informal PHC advisory group (PHC TWG), which the Project convened several times in Year 1, includes several persons from or associated with the MOH (e.g. national coordinators, medical state university representatives, and main national experts on medicine) and will be maintained in Year 2. The Government Coordination Council (GCC) and its working group are the official government structures that have been tasked with reviewing the draft program for health financing reform. According to the Cabinet of Ministers decree # 139a, this structure will be used to elaborate/review specific technical proposals and programs required to implement the national primary health care reform. The Project's informal PHC TWG continued to function during the reporting period and provided contribution to the elaboration of PHC Concept Paper that will be submitted to the working group of the (GCC). (see Attachment F for PHC TWG meetings)

2.1.3 WGPHC reviews PHC models, options, and implementation strategies. The Project staff had a meeting with PIU/MOH and discussed the main aspects that has to be reflected in the Policy Discussion Paper on PHC Reform. The list of key points for the Policy Paper had been identified and PHC staff reviewed various PHC models and options and incorporated the findings into of the first draft of the document, titled 'Policy Discussion Paper on PHC Reform'. The project will work with PIU/MOH and PHC TWG to finalize the Policy Paper during Quarter 1/Year 2. The PHC TWG will review the models/options available, and ones that most appropriate for the local context will be chosen for further consideration by GCC.

2.1.4. Train PHC TWG members (national experts) in health policy analysis techniques. Following the Bishkek Flagship Course on Health Reform, the group of MOH national experts who attended the event has developed a presentation on various aspects of the health reform in Kyrgyzstan with special emphasis on heath policy. The group will make the presentation for the PIU/MOH and the PHC TWG members in Quarter 1/Year 2. (The copy of the presentation is available upon request).

2.1.5. Conduct review and update of national legal and policy framework for PHC. A draft outline of the PHC Concept Paper has been developed. This concept paper addresses the legal and policy framework for PHC. It also included extensive revision of RH national legislation and policy issues since RH is an important integral part of any PHC policy. The RH related issues has been considered and incorporated into the draft outline. As part of this effort, the Project also drafted the Decree on General Practice in collaboration with DAI, ACQUIRE project and AIHA. The draft-decree will be submitted to the MOH for review and further approval (see Attachment G) This document includes RH services as a part of general practitioner/family doctor scope of work with education/training requirements which need to be completed in order to provide quality services at PHC level.

2.2. Improve Policy Content

2.2.1 Prepare general policy discussion paper on PHC reform. Preparation of "General Policy Discussion Paper on PHC Reform" and "PHC Development and Strategy Paper," was envisioned during this quarter. However, during the reporting period the MoH formally requested the Project to assist in the preparation of the "PHC Concept Paper", including a somewhat different set of questions to be answered, the Project decided to substitute this for the Strategy Report envisioned in the Year 1 work plan. Among the issues to be covered in the Concept Paper: basic service model options; options for training providers, in particular, GPs (family doctors); and options for payment of providers. The draft of the Concept Paper has been prepared after further review by the PHC TWG will be submitted to MoH in mid November.

2.2.2 Design and conduct household-based health services utilization and expenditure survey. The Project finalized training of the interviewers and field supervisors from the local company "SIAR". IMC funded the survey in Sheki and Agdash, and the HSRP WB/MOH provided funding for the survey in Gakh, Ismayilli, and Absheron and for 2 control districts (Guba and Yasamal). The field tests of the final instruments were also finalized during the first two weeks of July and the Baseline Survey was launched in Sheki on July 12th. By the end of reporting period field work for five out of seven pilot districts was finalized with continuous involvement, supervision, quality check and follow up

training provided by the Project. The analysis and results of the survey are expected to be finalized by the end of Quarter 1/Year 2. (see Attachment H for the survey instruments)

2.2.3 Design concept of PHC development and strategic plan. This activity was not finalized during the reporting period (see above). The design concept and strategic plan will be elaborated based on the "PHC Concept Paper", expected to be finalized during the Year 2.

IR/COMPONENT #3: Improve the quality of PHC service

3.1 Establish Pilot Demonstration Sites

3.1.1. Pilot demonstration districts will be selected. In close collaboration with the MoH, the following five pilot districts for the HSRP were identified during Quarter 3: Gakh, Sheki, Agdash, Ismayilli, and Absheron. The pilot projects for Component 3 include Seki, Gakh and Ismayili.

3.2 Design and Implement PHC Provider Capability Survey

3.2.1 Develop PHC Provider Capability and Quality Survey. The survey design was finalized during the Quarter 3, and interviewers/field supervisors have been trained.

3.2.2 Conduct PHC Provider Capability and Quality Survey. The Project finalized training of the interviewers and field supervisors from the local company "SIAR". IMC funded the survey in Sheki and Agdash, and the HSRP WB/MOH provided funding for the survey in Gakh, Ismayilli, and Absheron and for 2 control districts (Guba and Yasamal). The field tests of the final instruments were also finalized during the first two weeks of July and the Baseline Survey was launched in Sheki on July 12th. By the end of reporting period field work for five out of seven pilot districts was finalized with continuous involvement, supervision, quality check and follow up training provided by the Project. The analysis and results of the survey are expected to be finalized by the end of the Quarter 1/Year 2. (see Attachment I for survey instruments)

3.3 Assist PHC Reform Planning Process in One or More Pilot Districts

3.3.1 Review and discussion of results of baseline. Survey analysis is expected to be complete during Quarter 1/Year 2 of the project with the first draft of the baseline results to be ready during Quarter 2/Year 2. The Project is expecting to present on the preliminary results of surveys for the Seki district at the launch of the WB HSRP in Seki.

3.3.2 Assist district leaders to understand the goals and benefits of a strong PHC system. Introductory meetings with executive committees and district health authorities on PHC Project and its linkages with MOH/WB Health Sector Reform Project have been conducted in Isamyilli, Absheron, Sheki, Agdash, and Gakh. In Sheki, the PHC Project office has been established which has enabled close collaboration between the Project and district level authorities.

3.3.3 Develop new models of a district health care network, and service delivery. No activities were planned and have been undertaken in the reporting period.

3.3.4 Develop new financing, management, and information systems No activities were planned and have been undertaken in the reporting period.

3.3.5 Develop specific training plans and/or programs. No activities were planned and have been undertaken in the reporting period.

3.4 Assist MOH and Doctor's Advancement Institute in Development GP/FM RE-Training Curriculum and Program

3.4.1 Review existing FM curriculum. Existing FM curriculum was reviewed by project staff and two international consultants in Quarter 3. A set of recommendation for FM was prepared and presented to MoH. Please see Attachment J.

3.4.2 Review other approved in-service and post- graduate training modules related to PHC. The Project staff reviewed existing training module on Family Planning, as well as PHC modular trainings and submitted them to DAI for review and further approval. The Project is expecting approval during Quarter 1/Year 2.

3.4.3 Develop recommendations to Doctor's Advancement Institute (DAI) and MOH for a curriculum and re-training program. Recommendations were developed during Quarter 3 and submitted to the Family Medicine department of the DAI for their feed back and comments. In Quarter 4 the project

will continue to work with DAI and finalize the topical outline for the re-training program. Once the outline is finalized, it should be evaluated for similarities and differences to the existing re-training program. The final draft of the document will be presented to WGPHC for their comments and feed back. Please see Attachment J.

3.4.3 Develop recommendations to Doctor's Advancement Institute (DAI) and MOH on phased implementation of new GP re-training program. Recommendations were developed by the Project consultants in Quarter 3. Please see Attachment J.

3.5 Assist development of Licensing and Certification standards and procedures

In July, the Project consultant Dr. Otar Vasadze worked with the representatives of the MOH to review existing legislative and normative base for certification of medical personnel. The following meaningful products were developed: the Program for Implementation of Medical Personnel Certification, the Draft Presidential Decree on licensing of medical activities and certification of health personnel, and the Draft of Legal Charter of the licensing and certification unit of the Ministry of Health. These documents could be found in Attachment K. The products were presented to WGPHC, MOH officials, and INGOs.

3.6 Assist provision of IMCI training of PHC providers in pilot districts

The Project has coordinated preparation to the WHO workshop on IMCI between the MOH and AHAP partners. The presentation on IMCI Program implementation has been developed in close collaboration with the National Coordinator on IMC and AHAP. In addition, executive summary of the IMC involvement in IMCI has been prepared at the request of MOH. IMCI training is expected to be implemented in Quarter2-3/Year 2.

IR/COMPONENT #4: Promote personal responsibility for health among individuals and families

4.1 Promote Establishment/Strengthening of a Health Communication Unit

4.1.1 Assess existing health promotion capacity of MoH and other agencies. See workshop described below, 4.1.5

4.1.2 Develop a capacity-building plan and strategy for MoH. No activities were planned and have been undertaken in the reporting period.

4.1.3 Develop TOR for the Health Communications Unit. No activities were planned and have been undertaken in the reporting period.

4.1.4 Identify human resources that could be involved, directly or indirectly, in supporting this unit. For the two-day Communication Strategy workshop in September, CCP recruited health promotion/health advisor staff with the expectation that key members would be identified to form a working group in the development and implementation of the national media campaign. This furthers the project's goals of building/strengthening capacity in strategic health communication and the establishment of the Health Communication Unit. See 4.1.5

4.1.5. Provide technical assistance and on-the job training to selected staff of the MoH and potential collaborating agencies. CCP conducted a 2-day health communication strategy workshop, September 7-8, for health promotion/health advisor staff in three ministries, parliament members, national and international NGOs, and representatives from an advertising agency and a TV health show. The workshop brought together key collaborating partners to build consensus on Azerbaijan health priorities in order to develop key elements in a health communication media campaign. Participants identified measurable communication objectives for the next year and determined health messages areas, media for dissemination, and primary target audiences. Outputs include a brief on the objectives and strategy for the project's health communication media campaign as well as a request for proposals to advertising agencies for first wave of the media campaign. Selecting from the group of participants and in collaboration with the MoH, the project will form a working group with key members from the MoH.

4.2 Prepare for Communications in Support of Health Reform in Pilot Districts

4.2.1 Develop baseline household-based KAP survey. From August to September CCP further defined the KAP baseline survey instrument and sample frame and developed a timeline in coordination with the PHC project's Household Expenditure (HE) survey. The survey protocol and instrument was finalized after consultation the MoH and two ministry staff were selected to provide supervision at the onset of the survey. Selection of a research firm was determined with careful coordination with the project's HE survey. Preparations for training of survey interviewers and supervisors began in September; fieldwork is expected to commence October 10, 2006. See Attachment L for survey instrument.

4.2.2 Implement baseline household KAP survey**.** The KAP survey is contracted to begin on October 6, 2006. CCP has contracted ERA to conduct the survey in five intervention districts and two control districts. The KAP survey will be conducted at the same households included in the HH Utilization and Expenditure Survey. This will allowed for cross analysis between KAP, utilization and expenditures within the same households.

4.2.3 Review community mobilization curricula and methodologies used previously in Azerbaijan. The project has begun strategizing on various community mobilization models with the idea to develop health competence through empowerment of women in the family and community. Arab Women Speak Out (AWSO) is a successful advocacy project that is being considered as a model for development in Azerbaijan linking women's economic and social development with community and family health including reproductive health.

4.3 Develop and Implement Healthy Lifestyles Mass Media Campaign

4.3.1 Conduct media agency assessment. This activity was conducted and completed in February 2006.

4.3.2 Conduct formative research for message development of Year 1 mass media campaign.
Analysis of the formative research results were completed and introduced at the Communication Strategy Workshop conducted by CCP on September 7-8, 2006. The findings of the formative research assisted in guiding the communication strategy and have informed the research instrument for the baseline KAP survey.

4.3.3. Implement Media Campaign. At the conclusion of the project's Communication Strategy workshop conducted on September 7-8, 2006, CCP developed a health communication campaign strategy brief. The brief describes the goals of the health communication campaign, as developed in the workshop, and specifically defines the objectives, audiences, channels, and impact evaluation indicators of the first wave of the media campaign. A request for proposals for an advertising firm has been written and will be issued the beginning of October.

CCP continued discussions with the producers of the ITV health show, "Saglam Ol." The project has facilitated a collaboration with the show's producers, CCP and the ACQUIRE project to consider providing technical assistance on health content and creative show formats.

4.4 Advocate/Assist Development of MoH "Branding" in Support of Health Reform

4.4.1 Advocate utility of "branding" strategy with MoH key staff. No activities were planned and have been undertaken in the reporting period.

4.4.2 Assist development of potential logos and slogans. CCP facilitated a discussion at the communication strategy workshop held September 7-8 on the use of a slogan to be used on all communication materials, a slogan that will tie together all materials and be introduced to the population to create interest and become a marker of credible information on good health.

IV. Avian Influenza Project

Component 1: Strengthen HAI Surveillance

Achievements

- The 4-day training of trainers (TOT) course for human avian influenza (HAI) surveillance was completed July 4, 2006, and a team of 16 national Trainers/Technical Consultants (TTCs) from the Republic Center of Epidemiology and Hygiene was certified.
- During July 2006, two-person teams from the national team of TTCs conducted avian influenza training in 11 districts identified by the MOH as at elevated risk for HAI outbreaks: Khizi, Deveichi, Salyan, Massali, Neftchila, Agdam, Ter-Ter, Agdash, Belasuvar, Siyazan and Lenkoran. In total 210 medical professionals from the district Centers of Hygiene and Epidemiology and the Central District Hospitals were trained on the HAI surveillance system. In addition, 101 district officials responsible for emergency response participated in an HAI workshop reviewing and elaborating their roles, responsibilities, and actions in case of a new HAI outbreak.
- During August 2006, TTC teams visited the 11 districts during their routine monthly "Med Sovet" meetings of representatives from all facilities in the districts. During the meetings, the TTCs explained the HAI epidemiologic situation in Azerbaijan, introduced the HAI surveillance system and protocol, reviewed the case report forms, and provided instructions on how to fill out these forms. During these meetings, the TTC teams provided instructions in HAI surveillance to approximately 550 providers.
- A short document outlining specific HAI surveillance instructions for health care providers was drafted and approved by the MOH. The project printed 500 laminated sets of these instructions for providers - one for each PHC facility in the first eleven districts. (please see Attachment C)
- The MOH requested to extend training activities to four additional districts (Kazakh, Ganja, Khachmaz, and Agjabedi). These four districts are on the seasonal bird's migration pathway and are therefore considered at increased risk for HAI. The project reacted positively and trained an additional 90 medical professionals in these four districts during September 25-29, 2006. In addition, 50 district officials responsible for emergency response participated in an HAI workshop reviewing and elaborating their roles, responsibilities, and actions in case of a new HAI outbreak.
- 10,000 copies of the HAI case reporting forms (first page only) were produced and distributed in all PHC facilities in the first 11 districts trained.
- All together, during July-September 2006, 300 health workers and 151 district officials were trained on AI in a 15 districts.

1.2 Next Steps

- During October 2006, the TTCs (in teams of two) will visit all 15 districts to monitor and evaluate the effectiveness of the enhanced HAI surveillance system at both the district and facility levels.
- A second monitoring and evaluation visit will be made to all 15 districts during November 2006.
- In the beginning of November the project will print and distribute 200 laminated sets of the instructions for providers and 4000 copies of the HAI case reporting forms (first page only) for the providers in four additional districts. The MOH will produce and disseminate additional forms as needed in the future.
- During late November 2006, a qualitative assessment will be carried out to see how the surveillance system is working at all levels. Focus group discussions and in depth interviews will be conducted to document strengths and weaknesses of the current system. Based on the results of this assessment, the system will be fine tuned as needed.
- A final project workshop will be held in December 2006 with the MOH and other partners and stakeholders. The project will produce a final report, including recommendations to the MOH based on monitoring and evaluation and qualitative assessment results.
- Should an outbreak occur during October - December 2006, the TTCs will visit affected districts to support district teams as required to ensure that surveillance and response are functioning effectively.

Component 2: Strengthen AI Related Communications

2.1 Achievements

- CCP provided technical assistance to the MoH (w/discussions with the MoAg) to house an AI hotline in the MoH. A presentation of hotline objectives, phone system options, recommendations and next steps was given by Dr. Carol Underwood and the CCP hotline consultant at the first meeting with Viktor Gasimov, Head of Inspection of sanitary-epidemiological surveillance at the Ministry of Health, Faiq Mammedzadeh, Deputy Director, Republican Anti-plague Station; Ziyyaddin Kazimov, Director, Center for Hygiene and Epidemiology; a representative from the Republican Veterinary Services Branch sent by Ismail Hasanov, Chief Officer; and Azer Melikov, AI specialist from the Project. The CCP consultant provided drafts of: Q&A for hotline attendants; training manual for hotline staff; hotline manual (which includes job descriptions, telephone infrastructure options, sample call sheet, budget consideration, policies and procedures, evaluation systems, and media promotion); and a sample call sheet. During the course of two hotline workshops, the material was further refined. Workshop attendees included representatives from MoH, MoAg, USAID, UNICEF and the Project. In addition, CCP emphasized the need for tracking (statistical reporting and assessment of the hotline) and facilitated funding for the MoH from the World Bank for an online tracking database.

  Mr. Gasimov took the lead in the establishment of the AI hotline and in discussions with the Ministry of Communications, Mr. Gasimov selected a PBX system to be externally hosted (for better maintenance), a toll-free 3-digit hotline phone number and determined that his department would staff and supervise the hotline. The phone system will have a queue of three hotline attendants for incoming calls, as well as an opt-out option for callers to leave a message.

- The Project with technical assistance from CCP worked with the National Avian Influenza Communication Committee (UNICEF, USAID-Agriculture and World Development, Pragma, FAO, Red Crescent Society, BP, and World Bank) in assessing the needs of new IEC materials on avian flu and determined the focus of new AI material to be on backyard poultry farmers and their families and PHC providers. CCP has contracted with an advertising agency to produce four TV public service announcements (PSAs), four radio PSAs, one poster, and one brochure. Two PSAs inform the general population about the virus and provide information on preventive measures and two PSAs inform backyard poultry farmers and their families. The MOH approved the first two spots, which will be pretested among the general public early in October. A poster for non-physician health care workers and a brochure for all health care workers are currently under review by the MOH.
- In collaboration with MoH, UNICEF and the services of Internews, CCP conducted a workshop on AI communication for journalists on September 16, 2006. The workshop raised journalists' awareness of and reporting on Avian Influenza with a focus on the transmission of AI and the importance of responsible reporting during an outbreak or suspected cases of AI or HAI. Regional as well as Baku-based journalists attended the training; the participants represented private broadcasters and newspapers from Sumgait, Mingachevir, Zagatala, Guba, Ganja and Lankaran.

2.2 Next steps

- The communication materials are currently (September-October) being reviewed by the MoH and will be pretested before final production.
- CCP will provide the MoH with technical assistance as needed in the installation of the phone system and the tracking database. At the next AI/HAI outbreak, the CCP hotline consultant will provide approximately 7 to 10 days of additional technical assistance in fine-tuning materials, tracking, and phone system needs.
- A second AI workshop for journalists and public relations officers of the ministries is scheduled for October 17, 2006.

V. Upcoming Events and Travel with Dates

Name of Event/Travel	Date	Number Traveling
1. Workshop on development of New Republican Health Insurance Fund. **Component 2** (Baku)	December	3
2. Workshop to introduce HSRP and PHC Project. **Component 2** (Seki)	October	None
3. Organizational and Training Workshops for District Level Commission/Working Groups. **Component 2** (Baku)	December	None
4. Clinical guideline development and re-training curriculum development consultancy **Component 3** (Baku)	October	One week visit
5. Workshop on AI project recommendations and project wrap up **Component 5** (Baku)	December	2
6. Avian Influenza workshop for ministries public relations officers **Component 5** (Baku)	October	None
7. Air avian influenza TV and radio spots **Component 5** (Baku)	October/November	None

VI. PMP Table

Note: The PMP table is based on submitted PMP table for the Year 2 Workplan. This table is under review by USAID and will be modified accordingly pending their recommendations.

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
Component/IR #1: Increase public expenditures for health generally and for PHC in particular									
1.1 Increase capacity of MoH and MoF officials and stakeholders on improving the national health finance systems.	1.1.1 Number of Coordination Council Working Group (CCWG) meetings on health finance reform issues	The CCWG will meet at least quarterly	Meeting Minutes (Quarterly)	-CCWG Formed -One meeting conducted	-4 CCWG meetings on health financing	**CCWG formed and two meeting were conducted on June 7th and June 16th, 2006**	**NA**	**CCWG formed and two meeting were conducted on June 7th and June 16th, 2006**	**Please see Attachment P for meeting minutes**
	1.1.2 Number of study tours for MOH and MoF officials	The project will organize at least one study tour for senior MOH and MoF officials to an NIS country which can demonstrate a model health finance system	Summary reports (Quarterly)	NA	- 1 study tour to Estonia for MoH and MoF officials	**NA**	**- 1 study tour to Estonia for MoH and MoF officials**	**- 1 study tour to Estonia for MoH and MoF officials**	**Please see Attachment E for trip report.**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
	1.1.3 Number of events (national or international conferences, trainings, seminars, etc) attended by MOH and MoF officials on policy issues	The project will organize conferences, trainings and seminars (national and international) for MOH and MoF officials to build their capacity for health finance policy	Summary reports (Quarterly)	- One program launch event - World Bank Institute Regional Flagship Course on Health Reforms held in Bishkek	- Seminar on Regional Health Reforms in Baku - University level course on 'Health Economics' developed	**- Program Launch held in February; -WB Course held in May 2006; nine participants attended.**	**NA**	**- Program Launch held in February; - WB Course held in May 2006; nine participants attended.**	**See Attachments N for Program Launch Summary; Attachment Q provides brief overview for WB Flagship course and detailed information about PHC program staff meeting with key health stakeholders in Bishkek**
1.2 Increase public expenditure on healthcare	1.2.1 Total Healthcare Budget	Public expenditures on healthcare, expressed in USD at average exchange rate per capita expenditures	MoH, MoF, and MoED Budgets (Annually)	Baseline ($20/Capita)	$25/Capita	NA	NA	NA	NA
Component/IR #2: Create a Policy and Legal Framework that Strengthens PHC and the PHC Delivery System									

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
2.1 Increase capacity of MoH officials and stakeholders on national PHC system.	2.1.1 Number of PHC TWG meetings	The PHC TWG will meet regularly (bi-monthly)	Meeting Minutes (Bi-Monthly)	- PHC TWG formed - Four TWG conducted	- 6 PHC TWG meetings	**PHC TWG formed (an informal WG consisting of 10 members); - Four TWG held**	**NA**	**PHC TWG formed (an informal WG consisting of 10 members); - Four TWG held**	**Please see Attachment F for meeting minutes**
	2.1.2 Number of CCWG meetings on PHC reform issues	The CCWG will meet to review proposals prepared by PHC TWG	Meeting Minutes	- CCWG is formed	-4 CCWG meetings on PHC Reform	**CCWG formed**	NA	**CCWG formed**	

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
	2.1.3 Number of events (national or international conferences, trainings, seminars, etc) attended by MOH officials on health policy issues	The project will organize conferences (national and international) for MOH and MoF officials to build their capacity for development of PHC services at the national level	Summary Reports (Quarterly)	- One program launch event - 'Health Care Management Workshop' in Tbilisi	3 Seminars and Workshops on PHC service models, General Practice Development	**-Program launch held in February 2006; - 'Health Care Management Workshop' held in Tbilisi in May 2006 - Participation of PHC staff to ACQUIRE Sponsored Study Tour on RH and FP in Turkey**	**NA**	**-Program launch held in February 2006; - 'Health Care Management Workshop' held in Tbilisi in May 2006**	**Please see attachment M for trip report on Turkey study tour; please refer to Attachment N for Program Launch Summary Report; please see Attachment O for Tbilisi workshop Summary Report;**
2.2 Policy at the national level that provides a framework for improved PHC services	2.2.1 Average rating of achievement of policies and laws supporting needed health reforms are developed and operationalized.	Rating of the extent that policies and laws supporting needed health reforms are developed and operationalized.	Expert Review Panel (Annually)	Baseline Determined	-2 Concept Papers Developed: a) PHC Concept Paper and b) Health Financing Reform for 2006-2011 -Ministerial Decree on General Practice Development	**At baseline, no national PHC policy existed – average rating score of '0' based on USAID PMP indicator scale. 1st draft**	**1st draft paper on PHC Concept Paper developed; 2nd draft paper on Health Financing reform for 2006-2011 – awaiting**	**Due to Project input, the policies have been developed but not approved – average rating score of '1' (policy is drafted) is based on USAID PMP**	**NA**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
					-GP Curriculum and training program adopted	**paper on Health Financing reform for 2006-2011 developed**	**approval by CCWG**	**indicator 3.2.1.1**	
Component/IR #3: Improve the Quality and Accessibility of PHC services									
3.1 Increased range of quality services available to clients at project-supported sites	3.1.1Number of health care facilities in pilot sites with GP Family Practice model	The project will support the creation of 6 GP Family Practices in three districts	- Training records - Bi-monthly meeting and progress notes	NA	-6 GP Family Practice centers established	**NA**	**NA**	**NA**	**NA**
	3.1.2 Percent of children under 5 years with common diarrhea treated with ORS	Antibiotics are not a recommended treatment for common diarrhea; providers will increase usage of ORS for treating common diarrhea	Patient Record Audit (Annually)	Baseline TBD	Year 2 Target TBD (expected to increase 5-10%)	**Approximate baseline is 10%, based on UNICEF Azerbaijan Multi-Indicator Cluster Survey for 2000**	**NA**	**Approximate baseline is 10%, based on UNICEF Azerbaijan Multi-Indicator Cluster Survey for 2000**	**Actual baseline in targeted districts will be determined based on results of the HH Utilization and Expenditure Survey as well as Facility Based Surveys, expected during Quarter 1/Year 2**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
	3.1.3 Percent of providers in targeted facilities with increased knowledge of IMCI and FP	Knowledge will be measured through pre and post tests and follow-up quantitative and qualitative monitoring	-Pre/Post Tests -Follow-up monitoring	NA	-At least 80% of providers will demonstrate overall knowledge about IMCI and FP	**NA**	**NA**	**NA**	**NA**
	3.1.4 Percent of community residents who have been screened for breast cancer.	Screenings include manual examinations during patient visits.	Monthly patient records	NA	Baseline TBD	**NA**	**NA**	**NA**	**NA**
3.2 Improve the management capacity at district level in targeted districts	3.2.1. Improve health information system (HIS)	Establishment of HIS at the district level.	Monthly health statistic reports	NA	- HIS developed in three districts	**NA**	**NA**	**NA**	**NA**
	3.2.1 Improved management of pharmaceutical stock	Protocol on managing and stocking pharmaceuticals in 6 targeted facilities	Quarterly drug report Quarterly external monitoring report	NA	-'Pharmaceutical Management Protocol' developed	**NA**	**NA**	**NA**	**NA**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
3.3 Improve the capacity of MoH to initiate and implement a GP retraining program plan	3.3.1 Develop and update training modules.	The project will assist the MoH to develop one new training module on RH as well as update existing models included in the project curriculum.	Training Modules developed/ updated/approved Progress Briefs	NA	-One new module developed - At least two existing modules updated	**NA**	**NA**	**NA**	**NA**
	3.3.2. Assist the MoH in development of retraining program plan	The project will assist the MoH in planning for the GP retraining program	'Retraining' Program Plan Progress Briefs	NA	- Final Draft of the "Azerbaijan GP Retraining Program Plan'	**NA**	**NA**	**NA**	**NA**
3.4 Improve satisfaction with health of services in pilot sites	3.4.1 Percent of community residents satisfied with health services in their pilot sites	A composite indicator using variables to determine satisfaction.	Household Health and Expenditure Survey KAP survey Patent exit interviews	NA	Baseline TBD	**NA**	**NA**	**NA**	**NA**
Component/IR #4: Promote personal responsibility for health among individuals and families									

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
4.1 Increase knowledge of health services and healthy lifestyles	4.1.1 Percent of respondents with correct knowledge of healthy lifestyles in pilot sites	Healthy lifestyles index will be formulated	KAP Survey (Annually)	Baseline Determined	Year 2 Target TBD	**Baseline not available**	**NA**	**Baseline not available**	**The KAP survey will commence on October 06 and baseline results will be available by Q2/Year 2**
	4.1.2 Average number of warning signs during pregnancy correctly identified by women of reproductive age in pilot sites.	A composite index of knowledge about warning signs will be defined.	KAP Survey (Annually)	Baseline Determined	Year 2 Target TBD	**Baseline not available**	**NA**	**Baseline not available**	**The KAP survey will commence on October 06 and baseline results will be available by Q2/Year 2**
	4.1.3 Percent of respondents with knowledge of ORS	A composite of indicators will be used to measure knowledge of ORS.	KAP Survey (Annually)	Baseline Determined	Year 2 Target TBD	**Baseline not available**	**NA**	**Baseline not available**	**The KAP survey will commence on October 06 and baseline results will be available by Q2/Year 2**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
	4.1.4 Percent of respondents who know how to prevent hypertension, diabetes mellitus (Type II)	Separate indicators will be used to measure knowledge of preventive methods for hypertension and diabetes mellitus.	KAP Survey (Annually)	Baseline Determined	Year 2 Target TBD	**Baseline not available**	**NA**	**Baseline not available**	**The KAP survey will commence on October 06 and baseline results will be available by Q2/Year 2**
	4.1.5 Percent of respondents who disapprove of smoking in the presence of children, pregnant women	Attitudes about smoking and second hand smoke will be measured by separate indicators.	KAP Survey (Annually)	Baseline Determined	Year 2 Target TBD	**Baseline not available**	**NA**	**Baseline not available**	**The KAP survey will commence on October 06 and baseline results will be available by Q2/Year 2**
	4.1.6 Number of public service announcements promoting personal responsibility for health	PSAs designed and broadcast in mass media	PSAs Quarterly project reports	NA	2 PSAs developed and aired	**NA**	**NA**	**NA**	**NA**
5.1 Increase MoH capacity in surveillance of and response to HAI	5.1.1 Number of 'Master Trainers' developed	Master Trainers will be responsible for the training of district level health personnel	Training of Trainers (TOT) report	- At least 15 Master Trainers trained and developed	NA	**NA**	**16 National Master Trainers on AI trained.**	**16 National Master Trainers on AI trained.**	**Please see Attachment R for TOT report.**
	5.1.2 Number of district level personnel	Personnel include epidemiologists, infectious disease	Training reports Meeting minutes	- At least 200 personnel trained in 11	- At least 90 personnel trained in four districts	**NA**	**300 providers in 15 "high risk" districts**	**300 providers in 15 "high risk" districts**	**Please see attachment R for training**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
	trained by Master Trainers	specialists, and clinicians		districts			**were trained along with 151 district officials responsible for emergency response.**	**were trained along with 151 district officials responsible for emergency response.**	**report and Attachment S for meeting minutes.**
	5.1.3 Number of training and surveillance protocols developed	The project assisted the MoH in reviewing, revising existing protocols, and developing new protocols for training and surveillance.	Training packages and protocols	Training Package: - Master Trainers, - Health Providers, - District Emergency Response Teams Protocol on Completion of Reporting/ Surveillance Forms	- Final recommendation on 'Improving HAI Surveillance System in Azerbaijan'	**One training package developed; one surveillance protocol including instructions developed**	**NA**	**One training package developed; one surveillance protocol including instructions developed**	**Please see Attachments A and B for Training packages and protocols**
5.2 Increase MoH capacity in AI communicatio n	5.2.1 Improve media capacity to communicate information about AI to general public	'Media' included general radio and television media, newspaper journalists, as well as government	Workshop for journalists and government spokespeople	- One workshop on overall AI issues (transmission, treatment, etc.)	- One workshop on preventive messages	**NA**	**- One workshop on overall AI issues (transmission, treatment, etc.)**	**- One workshop on overall AI issues (transmission, treatment, etc.)**	**Please see Attachment T for workshop report**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
		spokespeople							
	5.2.2 Number of TV/Radio spots and posters on AI	TV/Radio spots target back-yard farmers as well as the general public; posters/brochures will target medical providers	TV/Radio media spots Posters/brochures	- Four TV/radio spots, posters developed	- Four TV/radio spots aired - 20,000 Posters/brochures (each) printed and distributed	**- Two media spots have been produced**	**- Poster and brochure are finalized** **- Two media spots are under development and undergoing pre-testing**	**-Finalized poster, brochure, and two media spots**	**-Two media spots needed further pre-testing and review by MoH and other stakeholders – expected completion date is early Q1/Year 2** **-Developed media spots and brochures/posters can be available for viewing upon request.**
	5.2.3 Improve instant communication with the general public	Ongoing messages and information will be available to the general public through a AI Hotline	AI Hotline	- Hotline script developed	- Hotline operational	**NA**	**Hotline script developed**	**Hotline script developed**	**Please see Attachment V for Hotline Script; please note that the Project is expecting minor modifications to the script together with**

Sub-Results	Indicator	Definition	Data Source & Frequency of Data Collection	Targets		Q1-3	Q4	Cumulative Year 1	Explanations/ Comments
				Year 1	Year 2				
									MoH

VII. Success Stories

1. Azerbaijan ministries join the health financing study tour to Estonia

In September 2006, the PHC Project team in collaboration with the World Health Organization (WHO), and the WB escorted a study tour team from Azerbaijan to the Republic of Estonia in order to examine Estonia's system of health financing and its general practitioner-based system of primary health care. The delegation was composed of the Minister of Health, the Deputy Minister of Finance and the Director of HSRP.

The HSRP Director said he is very thankful to the PHC Project, which was able to persuade high level government officials to visit Estonia. "It's a great success that the PHC Project invited both the Minister of Health and the Deputy Minister of Finance to Estonia. The Ministers visit is a serious step in health financing reforms"- said Dr. Mehdiyev.

The primary goal of the visit was to familiarize senior health and finance officials from Azerbaijan with Estonia's experience in transforming its health system following independence from the former Soviet Union, with particular emphasis on health financing and primary care reform. Estonia is considered as being one of the more successful post-Soviet countries in terms of its health sector reform. During the past decade it has been able to transform its health sector into western standards. "If we want to achieve better integration of our health system into western standards, we should first observe how this process is conducted in the countries that were a part of a Soviet style system"-declared Dr. Mehdiyev.

The HSRP Director said it was extremely interesting and helpful to observe the transition of the health care system in Estonia from a Soviet style system to a Western system:

> "These meeting were very useful and we discussed a very wide range of topics, principally: organization and operations of the insurance fund; contracting procedures used with different providers; methods of setting prices for services; the organization, financing, and provision of essential pharmaceuticals; and the training of General Practitioners, more commonly called 'family doctors.' It was our first visit to Estonia and it was very exciting to see the country's achievement with our own eyes. We saw that the health financing system works in Estonia. They really have very modern equipments and we become the eyewitnesses of treatment. As the reforms are being conducted several years in Estonia, we will later review some experience components of Estonia and present it to responsible agencies in Azerbaijan."

The HSRP Director is hopeful that study tour will result in increased level of advocacy for health care financing reforms and introduction of health insurance in Azerbaijan.. "The PHC Project team highlighted the enormous importance of a national health insurance. Health insurance on the national level would provide all groups of populations with qualified healthcare services", stated Dr. Mehdiyev. He stated that the MoH highly valued the tremendous work done by PHC Project to assist the GovAZ in health sector reform

2. Government, NGO and civil sectors come together to promote health in Azerbaijan

In Azerbaijan, nearly half of all causes of mortality are linked to social and behavioral factors such as smoking, alcohol use, sedentary lifestyle, and accidents. As chronic disease rates continue to escalate and the social diversity in Azerbaijan continues to grow, public health programs must employ the most effective strategies for enhancing health behaviors, beliefs, and outcomes among the population.

In support of the PHC Projects' health communications component, a two day Communication Strategy Workshop was held in September to explain how a national strategy can measurably contribute to improving the nation's health, and to identify and develop the essential elements of an effective strategy.

"It's great that the government, NGO community and private sector representatives came together to identify health sector priorities and develop a strategy to address them. Thanks to PHC Project team for making it possible," said Zulfiyya Aliyeva, head of the local NGO "Local Development and Democracy Public Union", on the completion of the workshop. Zulfiyya took part in the workshop along with 23 other

participants representing high level government agencies, mass media, and the private and NGO sectors. “The PHC Project was the first to introduce term of ’health communication’ in Azerbaijan. Before this workshop, I could not imagine that many of deaths and serious diseases could be prevented through effective health communication,” said Zulfiyya.

An individual's health can be affected by the socio-political environment, the health service delivery system, community networks, spouses and other family members, and individual behavior. Zulfiyya believes in the importance of the government’s role in behavior change and heath communication. “It is very positive fact that the government officials attended this workshop. It demonstrates their strong willingness to work together with community members in order to call them to take an active part in the process of primary health care improvement. It also demonstrates the importance of AI in our everyday life,” said Zulfiyya.

Zulfiyya strongly believes that the experience she got through the PHC Project’s workshop would be very helpful in future efforts aimed at improving primary health care services at the community level. “This workshop was call for action. Now Government, NGO and private sectors are aware about health priories and importance of health communication. We will be working together to ensure better health and better future for each Azerbaijani,” concluded Zulfiyya.

3. Mass media empowered to prevent avian flu

Since its emergence in Southeast Asia in 2003, avian influenza (AI) has swept across Asia, Europe, and Africa. Azerbaijan, one of the most oil-rich countries in the world, was also hit by this pandemic when it was faced with an avian influenza outbreak in March of 2006. Despite the fact that the GovAZ and international agencies provided a quick response to fight AI, the ratio of human fatalities caused by AI was one of the highest in the world.

The role of the mass media in AI prevention is undeniable. Good reporting is essential to educate the public about the risk of outbreaks among domestic and wild birds and how the public can protect themselves in the event of an AI outbreak. In Azerbaijan, media reporters and journalists are not always provided with comprehensive information about AI and can very often exaggerate the facts which may lead to a panic among the population.

Facilitated with the goal to enable local media to provide essential information in a timely and appropriate manner, the PHC Project held a training workshop in September for 26 regional and Baku-based journalists together with the development agency Internews and the United Nations Children's Fund (UNICEF). Since there’s a growing concern that the second outbreak of avian flu will take place during the fall season, empowering mass media to help the government in disease prevention became one of important objectives of the PHC Project. ”I really feel strongly that reporters covering avian flu must provide unbiased reporting that presents facts clearly, concisely, and without comment. We are responsible before the population,” said Lala Mursalova of the Baku-based ECHO daily upon completion of training.

The training focused on raising professional level of journalists in reporting on avian flu during periods of AI outbreaks in the country within the country. As such, the key step of the training was provision of broadcast and print media outlets with knowledge of how to behave in extreme cases, increase the awareness of the avian flu and to introduce effective ways of delivering relevant messages about AI in the media. Along with other participants Lala Mursalova expressed her satisfaction with the training: “I was lucky to get direct information and tips about AI and its media coverage as required. The knowledge I grasped was tremendously useful for me personally to further applying the gained skills in my workplace”.

Another trained reporter expressed the importance of professionally presenting fact-based AI messages to readers so that the public is well informed and not frightened or panicked: “While covering avian influenza some media reporters use their position to tell people what to think than in fairly reporting the news. Today’s training is a call for journalists to be unbiased and true” added the journalist.

[End of Report]

Case report form for influenza A/H5 infection

Rayon_____ **Health Facility / Clinic**_____

Physician_____ **Date of notification: ___/___/200_**

Important: As soon as case is **PROBABLE**, send to: Telephone: 4932977 OR 4937437 Facsimile: 4987529	
If the patient is referred from another health facility / clinic	Name of referral center:_____ Referral Date : ___/___/200_ Was isolated? Yes ☐ No ☐ Isolation Date: ___/___/200_
General patient information	Hospital Record Number_____ Identification card number: _____ Date of admission: ___/___/200_ Isolation room N°_____ UNIQUE IDENTIFIER AZE/_ _/_ _ /_ _ _ (AZE/##Rayon/YY/Serial Number)

Patient Name : _____ Date of birth: / /200_ Age: ___years___months)

Regular address	Address in past 14 days	
Rayon:_____	Rayon:_____	Sex: M☐ F☐
City/Village:_____	City/Village:_____	
Quartier:_____	Quartier:_____	Citizenship:_____
House:_____	House:_____	Occupation:_____

Question 1: Does the patient present with?

	YES	NO
Fever ≥38°C:	◯	☐

Question 2: And any of the following symptoms?

Shortness of breath	◯	☐
Cough	◯	☐
Sore throat	◯	☐

Date of Onset of illness:	___/___/200_

Question 3: Has the patient had any of the following exposures? (in the 14 days prior to onset of symptoms):

	YES	NO	Last Exposure Date
Contact with suspected human case of influenza A/H5?	◯	☐	___/___/200_
Contact with sick birds, including chickens, or birds that have died of an illness, or their droppings?	◯	☐	___/___/200_
Eaten undercooked bird meat or eggs ?	◯	☐	___/___/200_
Close contact with wild birds (e.g. handling, slaughtering, hunting) or with areas heavily contaminated by their droppings?	◯	☐	___/___/200_
Having worked in laboratory where there is processing of samples from person or animals that are suspected of having highly pathogenic avian influenza (HPAI) infection?	◯	☐	___/___/200_

If ◯'s are ticked in Q1 and Q2, consider as POSSIBLE case → ASK Q3.

If ◯'s are ticked in Q1, Q2 AND Q3 , consider as PROBABLE case → IMMEDIATELY CALL DISTRICT SES AND DISTRICT CHIEF DOCTOR TO NOTIFY ABOUT CASE. Pages 2 and 3 of this form will be completed at district hospital.

If ◯'s are ticked in Q1 and Q2, but ☐ are ticked in Q3, consider as NOT A CASE → SEND FORM TO DISTRICT SES WEEKLY

EXPOSURE DETAILS

Travel History

Place of travel in past 14 days _____

Exposures in the 14 days before onset

Close contact with a case (within 1m)

YES ☐ NO ☐

Case first name:_____ Type of contact:_____

Case last name:_____ Relationship with case:_____

Case address	Date
City/Village:_____	Last contact: ___/___/200_
Quartier:_____	Case onset date: ___/___/200_
House:_____	Case death date: ___/___/200_

Close contact with domestic birds

YES ☐ NO ☐

Bird Type	YES	NO	Healthy	Sick/Dead	Notes
Chicken/Turkey:	☐	☐	☐	☐	
Pigeons:	☐	☐	☐	☐	
Ducks/Goose:	☐	☐	☐	☐	
Pet birds:	☐	☐	☐	☐	
Other:	☐	☐			
Droppings:	☐	☐	Specify:_____		

Circumstances of contact	YES	NO	Nature of contact	YES	NO
Family farm/backyard	☐	☐	Handled	☐	☐
Poultry factory	☐	☐	Slaughtered	☐	☐
Live market	☐	☐	Butchered or prepared	☐	☐
Culling	☐	☐	De-feathering	☐	☐
Food processing (butcher, cook)	☐	☐	Cleaned bird cages, living areas	☐	☐
Veterinarian	☐	☐	Share the same room	☐	☐
Other: _____	☐	☐			

Close contact with wild birds

YES ☐ NO ☐

Species	Nature of Contact	YES	NO
_____	Handled	☐	☐
_____	Slaughtered	☐	☐
_____	Butchered or prepared	☐	☐
_____	Defeathering	☐	☐
	Contact with droppings	☐	☐

Eaten uncooked bird meat or eggs

YES ☐ NO ☐

Bird meat ☐ Date: ___/___/200_

Eggs ☐ Date: ___/___/200_

Worked in a laboratory processing samples suspected of containing A/H5 virus

YES ☐ NO ☐

Hospital: _____ Last day of work: ___/___/200_

Laboratory: _____ Last day of work: ___/___/200_

MEDICAL HISTORY

Past medical history:	Any chronic disease? _____ On-going Pregnancy? _____ Other?_____

Symptom experienced from onset to consultation or admission	Symptoms	YES	NO	Date of Onset
	Fever	☐	☐	___/___/200_
	Sore throat	☐	☐	___/___/200_
	Cough	☐	☐	___/___/200_
	Shortness of breath	☐	☐	___/___/200_
	Diarrhoea	☐	☐	___/___/200_
	Conjunctivitis	☐	☐	___/___/200_
	Body pain	☐	☐	___/___/200_
	Coma	☐	☐	___/___/200_
	Other symptoms (_____)			___/___/200_

Radiology	Chest X-Ray Result: _____	Date of X-ray: ___/___/200_

Blood testing

Erythrocytes	Platelets	Leukocytes	Neutrophils/ Lymphocytes	Hemoglobin	Sedimentation Rate

Glucose	Creatinine	Aminottransferase

Drug treatment in the past week before consultation/admission and following consultation

Drug	Indication	Daily dose	Date of start	duration
Oseltamivir phosphate (Tamiflu®, FluFly®)	_____	_____	___/___/200_	_____
	_____	_____	___/___/200_	_____
	_____	_____	___/___/200_	_____

HOSPITAL ADMISSION TRACKING

N°	Hospital Name/Location	Admission Date	Isolation			Discharge	
			Single room?	Cohorted?	Date	Date	Mode*
1		__/__/200_	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	__/__/200_	__/__/200_	
2		__/__/200_	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	__/__/200_	__/__/200_	

*D= Death, C= Cured, E= Escape, R= Referred

Signature of Chief Medical Doctor of Rayon and date_____

Animal Workers Monitoring Form, Azerbaijan

(Monitoring until 14 days after last exposure to potential infected animals / food)

RECORDER _____WORKING PLACE _____ RAYON_____

WEEK _____ FROM _____/ _____/ _____ TO _____/ _____/ _____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Last contact	Using PPE (YES/NO)	Fever ≥ 38°C on daily check? (YES / NO)							In case of illness during the observation period	
									D1	D2	D3	D4	D5	D6	D7	Referral date	Place
1							__/__/___									__/__/___	
2							__/__/___									__/__/___	
3							__/__/___									__/__/___	
4							__/__/___									__/__/___	
5							__/__/___									__/__/___	
6							__/__/___									__/__/___	
7							__/__/___									__/__/___	
8							__/__/___									__/__/___	
9							__/__/___									__/__/___	
10							__/__/___									__/__/___	
11							__/__/___									__/__/___	
12							__/__/___									__/__/___	
13							__/__/___									__/__/___	
14							__/__/___									__/__/___	
15							__/__/___									__/__/___	
16							__/__/___									__/__/___	
17							__/__/___									__/__/___	
18							__/__/___									__/__/___	
19							__/__/___									__/__/___	
20							__/__/___									__/__/___	

RECORDER _____**WORKING PLACE** _____ **RAYON**_____

WEEK _____ **FROM** _____/_____/_____ **TO** _____/_____/_____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Last contact	Using PPE (YES/NO)	Fever ≥ 38°C on daily check? (YES / NO)							In case of illness during the observation period	
									D8	D9	D10	D11	D12	D13	D14	Referral date	Place
1							__/__/___									__/__/___	
2							__/__/___									__/__/___	
3							__/__/___									__/__/___	
4							__/__/___									__/__/___	
5							__/__/___									__/__/___	
6							__/__/___									__/__/___	
7							__/__/___									__/__/___	
8							__/__/___									__/__/___	
9							__/__/___									__/__/___	
10							__/__/___									__/__/___	
11							__/__/___									__/__/___	
12							__/__/___									__/__/___	
13							__/__/___									__/__/___	
14							__/__/___									__/__/___	
15							__/__/___									__/__/___	
16							__/__/___									__/__/___	
17							__/__/___									__/__/___	
18							__/__/___									__/__/___	
19							__/__/___									__/__/___	
20							__/__/___									__/__/___	

Shipment form for human specimens for Avian Influenza

Quş Qripinə yoxlanmaq üçün insandan götürülən nümunələrin nəqliyyat blankı

Please fill out ONE form for EACH Specimen / Xahiş olunur HƏR nümunə üçün BİR blank doldurun

Name of Sending center/ Göndərən Mərkəzin Ad:_____

Date of sending Göndərmə Tarixi : / /200

Name of requester/ Tələb Edən Şəxsin Adı _____

Telephone_Nr/ Telefon Nömrəsi:_____

E-Mail/ E-poçt:_____

Patient information/ Pasiyent haqqında məlumat

UNIQUE IDENTIFIER AZE/_ _/_ _ /_ _ _ (AZE/##Rayon/YY/Serial Number) ID card number:_____

FƏRDİ KOD AZE/_ _/_ _ /_ _ _ (AZE / ##Rayon / İL / Sıra Nömrəsi) Şəxsiyyət Vəsiqəsi: _____

Patient Name Pasiyentin Adı	Date of birth/ Doğum Tarixi: …../……/…..
Address Ünvan	Age/ years/ il Yaşı: months/ ay
Rayon/ Rayon City/Village/ Şəhər / Kənd	Sex/ Cinsi: M/ K ☐ F/ Q ☐

Health status at date of Specimen:
Nümunə götürülən tarixdə səhhətinin vəziyyəti — Good / Yaxşı ☐ Poor / Zəif ☐ Critical / Ağır ☐ Dead / Keçinib ☐

Date of onset of Symptoms/ Simptomların ortaya çıxma tarixi : …../……/ 200….

If alive, Symptoms:
Əgər sağdırsa, simptomlar — Fever (≥38°C)/ Qızdırma (≥ 38°C) ☐ shortness of breath/ Tənqnəfəslik ☐ Cough/ Öskürək ☐ sore throat/ Boğaz ağrısı ☐

If dead, date of death/ Əgər keçinibsə, ölümün tarixi : …../……/ 200….

Reason for lab request/
Nümunəni laboratoriyaya göndərməyin səbəbi — Symptomatic AND/ Simptomları var VƏ
Contact to probable case/ Şübhəli şəxslə təmasda olub ☐ Contact to sick/wild birds/ Xəstə ilə / çöl quşu ilə təmasda olub ☐ Laboratory worker/ Laboratoriya işçisidir ☐

Specimen information/ Nümunə haqqında məlumat

Date when Specimen was taken/ Nümunənin götürülmə tarixi : …… / ……. /200…

Type of Specimen/
Nümunənin növü — Swab / Yaxma ☐ Tissue / Toxuma ☐ Blood / Qan ☐ other / Digər ☐ Which/ Nə ……..

Location of Specimen/
Nümunə götürüldüyü lokalizassiya — Nasal / Burun ☐ Naso-pharyngeal / Burun – udlaq ☐ Throat/Tracheal / Boğaz / Nəfəs borusu ☐ Lung / Ağ ciyər ☐

Close Contacts Monitoring Form for patients suspected of influenza A/H5 infection in Azerbaijan

(Monitoring until 14 days after last exposure to patient)

INTERVIEWER _____

PATIENT'S NAME_____ **ID CARD NUMBER** _____

DATE OF ONSET IN PATIENT__ / ___ / ___ **DATE OF NOTIFICATION**___ / ___ / ____ **UNIQUE IDENTIFIER AZE** / _ _ / _ _ / _ _ _

N°	First Name	Family Name	Address	Sex	Age	Relation-ship with case*	Last contact	First date of monitoring (D 1)	Fever (≥38°C) on day 1-14 after last exposure? (YES / NO, Initial of Interviewer)							If the contact falls ill during the observation period	
									D 1	D 2	D 3	D 4	D 5	D 6	D 7	Referral date	Place
1							__/__/___	__/__/___								__/__/___	
2							__/__/___	__/__/___								__/__/___	
3							__/__/___	__/__/___								__/__/___	
4							__/__/___	__/__/___								__/__/___	
5							__/__/___	__/__/___								__/__/___	
6							__/__/___	__/__/___								__/__/___	
7							__/__/___	__/__/___								__/__/___	
8							__/__/___	__/__/___								__/__/___	
9							__/__/___	__/__/___								__/__/___	
10							__/__/___	__/__/___								__/__/___	
11							__/__/___	__/__/___								__/__/___	
12							__/__/___	__/__/___								__/__/___	

*Houshold member (H), Friend (F), Working mate (W), Other(O) then specify

PATIENT'S NAME_____ **ID CARD NUMBER** _____

N°	First Name	Family Name	Address	Sex	Age	Relation-ship with case*	Last contact	First date of monitoring (D 1)	Fever (≥38°C) on day 1-14 after last exposure? (YES / NO, Initial of Interviewer)							If the contact falls ill during the observation period	
									D 8	D 9	D 10	D 11	D 12	D 13	D 14	Referral date	Place
1							__/__/___	__/__/___								__/__/___	
2							__/__/___	__/__/___								__/__/___	
3							__/__/___	__/__/___								__/__/___	
4							__/__/___	__/__/___								__/__/___	
5							__/__/___	__/__/___								__/__/___	
6							__/__/___	__/__/___								__/__/___	
7							__/__/___	__/__/___								__/__/___	
8							__/__/___	__/__/___								__/__/___	
9							__/__/___	__/__/___								__/__/___	
10							__/__/___	__/__/___								__/__/___	
11							__/__/___	__/__/___								__/__/___	
12							__/__/___	__/__/___								__/__/___	

*Houshold member (H), Friend (F), Working mate (W), Other(O) then specify

Contact Tracing Form for patients suspected of influenza A/H5 infection, Azerbaijan

ID CARD NUMBER _____

PATIENT'S NAME…….. UNIQUE IDENTIFIER: AZE/_ _/_ _ /_ _ _

Persons in close contact* with the patient during the 7 days prior to onset			Relationship to the case	Status of the contact		
				Ill	Symptoms	Date
1	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
2	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
3	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
4	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
5	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
6	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____
7	First / Family Name	…….	Household member ■		Fever ■	___/___/____
	Sex	M ■ F ■	Close friend ■	Yes ■	Cough ■	___/___/____
	Age	…….Years/ ……Month	School/work mate ■		Sore throat ■	___/___/____
	Date of last contact	___/___/___	Other, specify ■	No ■	Dyspnea ■	___/___/____
	Address	…….	…….		Diarrhea ■	___/___/____

* Touching, staying in a speaking distance, caring for the patient

Influenza Laboratory Request Form for patients suspected of influenza A/H5 infection, Azerbaijan

Hospital of admission ……..

Patient's identification	
Hospital Record Number of Patient _ __ __ __ __ __ _	**UNIQUE IDENTIFIER** **Identification card number: _____** **AZE/_ _/_ _ /_ _ _(AZE/ ##Rayon/YY/Serial Number)**

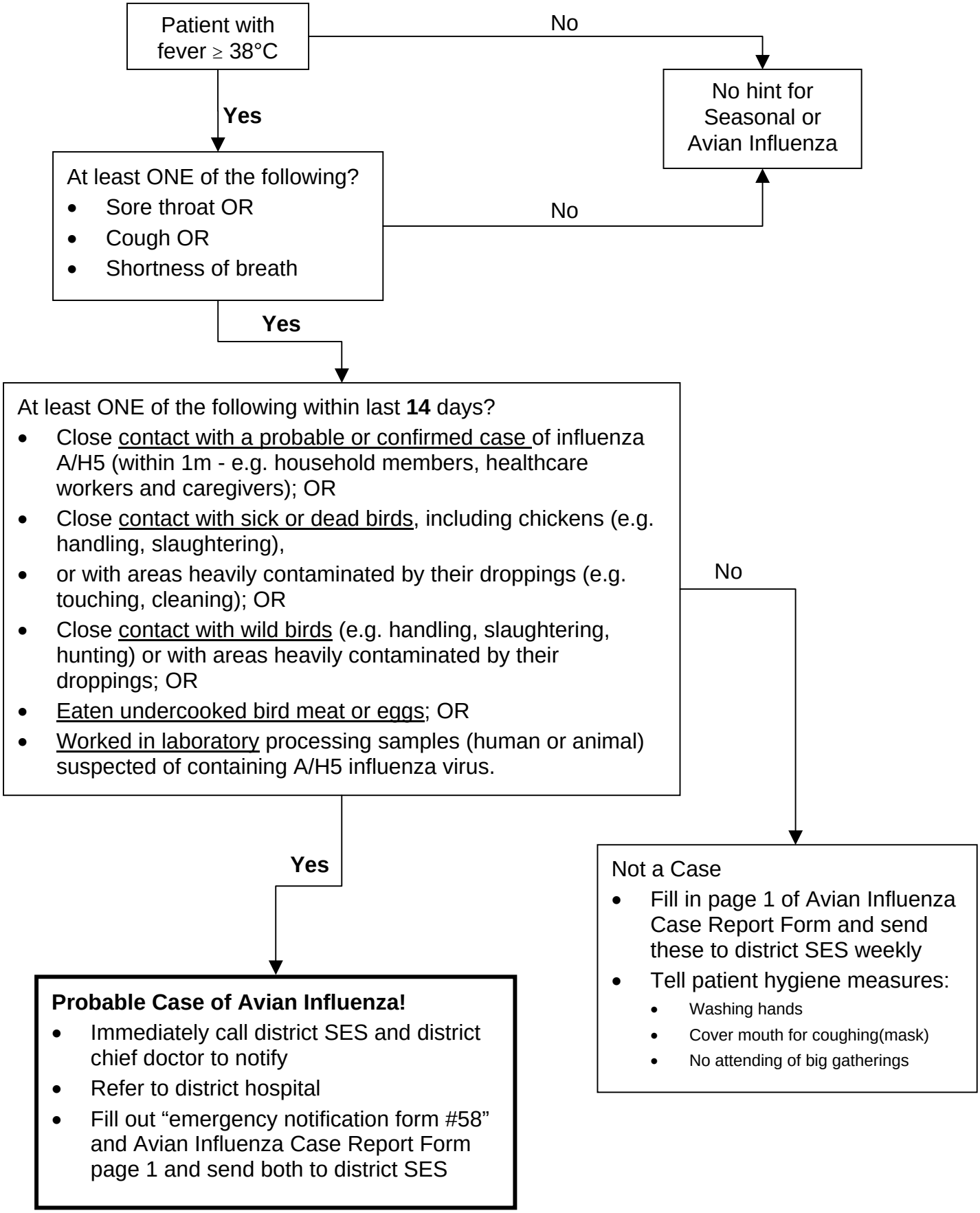
Demographic information

First and family name ……..…..... Gender Male [ ] Female [ ] Age (date of birth) .....years.....months (___/___/____)

Address ……..……

Respiratory specimens

Type of specimen (Swab/blood/tissue)	Location of sampling (Naso-pharyngeal /throat/other)	Life-sample/ postmortem	Sample Number	Date of collection	Condition at receipt at Lab (Good/Bad)	Type of Test done	Results	Date of sending To Ref Lab	Results
				__/__/___				__/__/___	
				__/__/___				__/__/___	
				__/__/___				__/__/__	
				__/__/___				__/__/__	
				__/__/___				__/__/__	
				__/__/___				__/__/__	
				__/__/___				__/__/__	
				__/__/___				__/__/__	



Decision process to detect Seasonal and Avian Influenza

Health Care Workers Monitoring Form, Azerbaijan

(Monitoring until 14 days after last exposure to H5 suspect patient)

RECORDER _____HEALTH STRUCTURE _____ RAYON_____

WEEK _____ FROM _____/ _____/ _____ TO _____/ _____/ _____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Date of Last contact	Fever≥38°C on daily check? (YES / NO)							In case of illness during observation period	
								1	2	3	4	5	6	7	Referral date	Place
1							__/__/___								__/__/___	
2							__/__/___								__/__/___	
3							__/__/___								__/__/___	
4							__/__/___								__/__/___	
5							__/__/___								__/__/___	
6							__/__/___								__/__/___	
7							__/__/___								__/__/___	
8							__/__/___								__/__/___	
9							__/__/___								__/__/___	
10							__/__/___								__/__/___	
11							__/__/___								__/__/___	
12							__/__/___								__/__/___	
13							__/__/___								__/__/___	
14							__/__/___								__/__/___	
15							__/__/___								__/__/___	

IF THE EXPOSURE CAN BE RELATED TO AN H5 PROBABLE PATIENT,

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

RECORDER _____HEALTH STRUCTURE _____ RAYON_____

WEEK _____ FROM _____/ _____/ _____ TO _____/ _____/ _____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Date of Last contact	Fever≥38°C on daily check? (YES / NO)							In case of illness during observation period	
								8	9	10	11	12	13	14	Referral date	Place
1							__/__/___								__/__/___	
2							__/__/___								__/__/___	
3							__/__/___								__/__/___	
4							__/__/___								__/__/___	
5							__/__/___								__/__/___	
6							__/__/___								__/__/___	
7							__/__/___								__/__/___	
8							__/__/___								__/__/___	
9							__/__/___								__/__/___	
10							__/__/___								__/__/___	
11							__/__/___								__/__/___	
12							__/__/___								__/__/___	
13							__/__/___								__/__/___	
14							__/__/___								__/__/___	
15							__/__/___								__/__/___	

IF THE EXPOSURE CAN BE RELATED TO AN H5 PROBABLE PATIENT,

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

Health Care Workers Monitoring Form, Azerbaijan

(Monitoring until 14 days after last exposure to H5 suspect patient)

RECORDER _____HEALTH STRUCTURE _____ RAYON_____

WEEK _____ FROM _____/ _____/ _____ TO _____/ _____/ _____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Date of Last contact	Fever≥38°C on daily check? (YES / NO)							In case of illness during observation period	
								1	2	3	4	5	6	7	Referral date	Place
1							__/__/___								__/__/___	
2							__/__/___								__/__/___	
3							__/__/___								__/__/___	
4							__/__/___								__/__/___	
5							__/__/___								__/__/___	
6							__/__/___								__/__/___	
7							__/__/___								__/__/___	
8							__/__/___								__/__/___	
9							__/__/___								__/__/___	
10							__/__/___								__/__/___	
11							__/__/___								__/__/___	
12							__/__/___								__/__/___	
13							__/__/___								__/__/___	
14							__/__/___								__/__/___	
15							__/__/___								__/__/___	

IF THE EXPOSURE CAN BE RELATED TO AN H5 PROBABLE PATIENT,

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

RECORDER _____HEALTH STRUCTURE _____ RAYON_____

WEEK _____ FROM _____/ _____/ _____ TO _____/ _____/ _____

N°	First Name	Family Name	Age	Sex	Occupation	Address	Date of Last contact	Fever≥38°C on daily check? (YES / NO)							In case of illness during observation period	
								8	9	10	11	12	13	14	Referral date	Place
1							__/__/___								__/__/___	
2							__/__/___								__/__/___	
3							__/__/___								__/__/___	
4							__/__/___								__/__/___	
5							__/__/___								__/__/___	
6							__/__/___								__/__/___	
7							__/__/___								__/__/___	
8							__/__/___								__/__/___	
9							__/__/___								__/__/___	
10							__/__/___								__/__/___	
11							__/__/___								__/__/___	
12							__/__/___								__/__/___	
13							__/__/___								__/__/___	
14							__/__/___								__/__/___	
15							__/__/___								__/__/___	

IF THE EXPOSURE CAN BE RELATED TO AN H5 PROBABLE PATIENT,

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

STAFF N° FROM ABOVE LIST _____ PATIENT: UNIQUE IDENTIFIER _____

Protocol for human avian influenza surveillance in Azerbaijan

1. Patient presents at facility

2. Medical worker identifies whether patient has fever (≥ 38°C)

   If NO: probably not seasonal or avian influenza; no special reporting/action required.

If YES:

3. Send patient to physician for further examination. Physician assesses whether patient has sore throat or cough or shortness of breath.

   If NO: probably not seasonal or avian influenza; no special reporting/action required.

If YES (to at least 1 respiratory symptom):

4. This is a possible case. Physician takes a copy of the **CASE REPORT FORM FOR INFLUENZA A/H5 INFECTION** and fills in the first page. Fill in the patient's passport (identification card) number. **Do not fill in the unique identifier.**

5. Physician pays special attention to question 3. For question 3, physician asks patient whether he or she has had any of the following in the last **14** days before onset of symptoms:
   a. Close contact with sick or dead birds, OR
   b. Close contact with any probable/confirmed cases of human AI, OR
   c. Close contact with areas contaminated by bird/poultry droppings, OR
   d. Eaten raw/undercooked bird meat or eggs, OR
   e. Worked in laboratory where samples (human or animal) suspected of containing A/H5 influenza virus are processsed.
6. Physician makes decision about whether patient meets the probable human avian influenza case definition:
   a. If 's are ticked in question 1 and at least one is ticked in question 2, but only 's are ticked in question 3, then this is considered not a case.
      i. Physician fills in the first page of case report form and sends to district SES on weekly basis as per standard procedure. Advise patient of hygiene measures (hand washing, covering mouth when coughing, avoid large gatherings). District SES will compile weekly reports from all district facilities and report over the phone to the Republican SES and Republican Anti-Plague Station.

b. If ’s are ticked in Q1, Q2 and Q3, then this is a **PROBABLE CASE** of human avian influenza. Clinician immediately contacts district chief doctor (i.e. district hospital chief doctor) and district SES via telephone to notify them that further investigation is required.
    i. Chief doctor arranges transport for patient to distict hospital using ambulance. [Ambulance driver wears basic personal protective equipment (PPE) (respiratory mask); ambulance is disinfected after the patient arrives at the hospital]. At district hospital, infection control procedures are carried out and patient is isolated.
    ii. Clinician fills in hospital referral paperwork
    iii. Clinician sends Emergency Notification Form #058 together with case report form (first page only) to district SES.

7. District SES director decides which epidemiologist(s) is responsible for this case investigation.
8. District epidemiologist immediately visits case at district hospital. District epidemiologist and hospital clinician work together to confirm that this is a probable case and to fill in pages 2 and 3 of the **Case Report Form.** District epidemiologist is in charge of ensuring the form is filled out correctly and is complete and faxes form immediately to the Republican SES while keeping the original at the district SES.
9. District chief doctor, in coordination with head of district SES, immediately notifies (telephone call AND sending urgent notification form) the following authorities about the probable case:
    a. District Executive Administration
    b. District Emergency Anti-Epidemic Committee
    c. District Veterinary Services
    d. Republican SES
    e. Republican Anti-Plague Station
    f. Ministry of Health
10. District hospital clinician/leadership decide if patient should be referred to Baku (2 hospitals were designated during February/March 2006 outbreak – Children’s Hospital #7 and Institute of Lung Diseases). Criteria for referral to Baku include: a) unfavorable clinical condition, and b) lack of appropriate equipment/treatment capacity at the district hospital. If patient is referred to Baku, then laboratory samples will be taken there.
11. If patient is not transferred to Baku, then the clinician at district hospital takes laboratory samples from the patient as soon as the patient is admitted to the hospital. Clinicians should take two types of samples immediately when the patient is admitted: throat swab and blood (3-5 ml of whole blood). The district epidemiologist ensures that this has been done properly and that the following 2 forms are filled out: **Lab request form** and **lab shipment form.**
    a. District chief doctor arranges for samples to be sent to Baku (Republican Anti-Plague Station for PCR analysis) using appropriate packing and transportation satisfying biosafety regulations.

b. The **lab request form** is filled out by the clinician and epidemiologist at the district hospital to record all laboratory samples taken from the patient and their results. Upon discharge of the patient, this form should be filed with the case report form at the district SES.
c. A **lab shipment form** is filled out by clinician at district hospital for each sample and sent with each sample to the Republican Anti-Plague Station laboratory.
d. Republican Anti-Plague Station notifies district SES and district hospital as soon as laboratory test results are available and provides details of all test results so that they can be recorded on the **lab request form**.

12. District hospital and district SES prepare special plan of action jointly to facilitate:
    a. Arranging mobilization of health worker brigades to do active case finding (house-to-house) in community where patient lives/works.
    b. Contact monitoring for 14 days (since the last contact with the patient) - contacts include family, friends, coworkers or students at same school, and any other daily contacts. Contacts are traced and monitored using the **contact tracing form and contact monitoring form.**
    c. Monitoring of high risk groups including: all health workers that had close contact with the patient, the ambulance driver, and animal workers involved in culling or other activities with poultry/wild birds occurring in the district. This monitoring is done using the **health care worker monitoring form** and **animal worker monitoring form.**
13. District hospital and district SES institute control and prevention measures
    a. Provide technical guidance to the Executive Administration and the District Emergency Anti-Epidemic Commission to impose/enforce quarantine
    b. Work with Veterinary Services, Hunting Services & other sectors on social mobilization and awareness activities
    c. Oversee distribution and rational use of PPE among health care facilities and personnel
    d. Train all PHC providers (including FAP personnel) on the HAI surveillance and response procedures in their targeted area.

INSTRUCTIONS FOR HEALTHCARE WORKERS

How to fill out the first part of case report form for influenza A/H5 infection

Basic action directions at primary health care facilities:
Patient presents at facility
Clinician identifies whether patient has fever (≥ 38°C)
If NO: probably not seasonal or avian influenza; no special reporting/action required
If YES: Clinician assesses whether patient has sore throat or cough or shortness of breath, or any other suspicious influenza-like illness symptoms.
If NO: probably not seasonal or avian influenza; no special reporting/action required
If YES (at least one respiratory indication):
This is a **possible case**. The doctor (feldsher) fills out **the first page of "Case report form for influenza A/H5 infection",** calls the chief doctor of the central hospital and notifies about the need to hospitalize the patient.

The chief doctor organizes the transport for the patient to be taken to the district hospital (the driver of the ambulance has to be supplied with PPE- personal protective equipment (respirator, mask)). The ambulance has to be disinfected after delivering the patient. Infection control measures have to be taken at the hospital and the patient has to be isolated.

1. At the top of the form name of the rayon; name of the health facility; name, last name and father's name of the doctor as well as notification date and time should be recorded.

Case report form for influenza A/H5 infection

Rayon_____ **Health Facility/Clinic**_____

Physician_____ **Date of notification:** ___/___/200_

2. The next section reflects the patient's passport information.

Important: As soon as case is **PROBABLE**, send to: Telephone: Facsimile:		
General patient information	Hospital Record Number_____ ID:_____ Date of admission: ___/___/200_ Isolation room N°__ UNIQUE IDENTIFIER AZE/_ _/_ _ /_ _ _ (AZE/##Rayon/YY/Serial Number)	
Patient Name : _____	Date of birth: / /200_ Age:___years___months)	
Regular address	Address in past 14 days	Sex: M ☐ F ☐
Rayon:_____ City/Village:_____ Quartier:_____ House:_____	Rayon:_____ City/Village:_____ Quartier:_____ House:_____	Citizenship:_____ Occupation:_____

This section is designed to get general information on the patient. Hospital record number, date and time of admission and isolation room number (if patient is isolated) have to be recorded **upon admission in a hospital only**. ID number of the patient is shown. Unique Identifier is not filled at this time.

Next section asks for patient's name, surname, father's name, date of birth and age. Regular address of the patient is recorded (in other word, rayon, city or village, quarter and house that is shown in the patient's passport). If none of this information is available, record "Unknown". It asks patient about the place he/she has lived at during the past 14 days. It is important if the patient has lived in an address different from the regular address. If the patient has lived at multiple addresses during the past 14 days, then a different sheet is filled for the rayon, city/village, quarter and house. This

information being on another sheet has to be indicated on the "Case report form for influenza A/H5 infection". Sex, citizenship and occupation of the patient have to be recorded.

The next part allows differentiating a "possible" avian influenza case from others.

Question 1: Does the patient present with?

	YES	NO
Fever ≥38°C:	◯	☐

Question 2: And any of the following symptoms?

Shortness of breath	◯	☐
Cough	◯	☐
Sore throat	◯	☐

Date of Onset of illness:	___/___/200_

Question 1: It is determined whether the patient has the temperature of 38°C or higher. If the temperature is equal or higher than indicated, YES box is checked. If not, NO box is checked.

Question 2: It is determined whether the patient has any of the following symptoms or not: shortness of breath, cough, or sore throat. For every symptom YES or NO boxes are checked.

If the answer to Question 1 is YES and it is checked YES for one of the symptoms for the Question 2, then this is a POSSIBLE CASE.

Onset of symptoms (illness) for the possible case is recorded (day, month, year).

If this is not a possible case, then there is no need to continue filling up the form or taking any special actions.

If this is a possible case, it is necessary to continue with Question 3. Ask the patient whether he\she has had any of the following exposures in the 14 days prior to onset of symptoms or not:

Question 3: Has the patient had any of the following exposures? (in the 14 days prior to onset of symptoms)**:**

	YES	NO	Last Exposure Date
Contact with suspected human case of influenza A/H5?	◯	☐	___/___/200_
Contact with sick birds, including chickens, or birds that have died of an illness, or their droppings?	◯	☐	___/___/200_
Eaten undercooked bird meat or eggs ?	◯	☐	___/___/200_
Close contact with wild birds (e.g. handling, slaughtering, hunting) or with areas heavily contaminated by their droppings?	◯	☐	___/___/200_
Having worked in laboratory where there is processing of samples from person or animals that are suspected of having highly pathogenic avian influenza (HPAI) infection?	◯	☐	___/___/200_

For each type of exposure mark YES or NO, appropriately. If the answer is YES, record the last exposure date. (Information, as much as possible, should be collected concerning the last exposure day)

If YES in Question 1, Question 2 and Question 3 are marked at least once,

then this is a **PROBABLE CASE** of human avian influenza. DISTRICT SES AND CENTRAL DISTRICT HOSPITAL ARE NOTIFIED IMMEDIATELY. The 2nd and 3rd pages of this form (Case report form for influenza A/H5 infection) are filled at the hospital.

Upon answering 1st, 2nd questions a case is determined to be NOT POSSIBLE case, then filling of the form is stopped. The 1st page of the "Case report form for influenza A/H5 infection" is sent to SES on weekly basis.

The INSTRUCTIONS have been prepared by Ministry of Health of Azerbaijan and Primary Health Care Strengthening Project financed by USAID

Health Financing Program for Azerbaijan – 2006-2011

Program Rational

Low level of health sector financing from state sources. Even with twofold increase of the health budget up to app. 160 Million USD (less than 2% of GDP) in 2006 compared to the 2002-2003, the per capita state health expenditure is only 20 USD[1]. The average figure in OECD countries is 2,000USD and CIS is app. 30USD (in Baltic countries Russia, and Kazakhstan health expenditures are significantly higher). As a result state expenditures are not enough to cover the total cost of production of health services and this burden is shifted to the patients and population. This leads to high out of pocket (OOP) and informal (unregistered) payments estimated at app. 94 USD per capita in 2003. Respectively State expenditures on health represents only 25%-30% of estimated total health expenditures in Azerbaijan (see figure 1).

Fragmented management of available health revenues (financial flows). The MoH controls only 25% of the state health budget. More than 75% of state health budget is managed by the local governments (district authorities). Annual health budgets are elaborated based on inadequate normatives and actual expenditures from previous year (historical line time budgeting) which does not take into account the real cost of health care and geographical specificities demographic, epidemiological, socioeconomic factors. Decisions on health investments and expenditures are adopted by different governmental structures (MoF and MoED). This situation constrains the role of MoH as a key governmental Ministry for elaboration and implementation of the national health policy and leads to the duplication and resource waste.

Absence of insurance (risk-pooling) against high health care costs. The insurance (both state and private) is one of the main mechanisms used in most of the developed and transition countries to cope with high cost of production of health services. The health insurance allows redistribution of financial risks from sick to healthy and from poor to rich, allowing access to essential health services when needed. In Azerbaijan the Mandatory State Health Insurance system has not been yet implemented, despite the law passed in 1999. Only insignificant (0.2%) of relatively wealthy share of the Azerbaijan population is covered by the Voluntary Health Insurance.

Poor quality of many of the country's hospitals, polyclinics, and other health care facilities. Since Azerbaijan achieved independence, there has been very little investment in health care infrastructure, especially outside of Baku. The consequence of this has been a profound deterioration in buildings and equipment, which discourages both health care personnel and patients, and which is a prime reason why patients who can afford to do so come here to Baku for care. But the flow of patients to Baku overloads facilities here, while reinforcing the deterioration of facilities and physicians' skills elsewhere.

Ineffective methods for financing health facilities and health personnel (health providers). Input based, rigid line item budgeting for health institutions fosters inefficiency. With existing

[1] It should be noted that this is planned expenditure, while actual expenditure in 2005 was 12USD per capita

system of financing administration of the health facilities do *not have any motivation* to decrease the cost and increase quality of health services provided in their institutions: The facilities treating less or no patients and providing low quality care or no care at all, - are better off, than those facilities treating more patients and providing better care, as level of financing to outpatient and inpatient health facilities will be the same in case if they treat thousands of patients or no patients at all. Current system of financing does not allow for increased motivation of medical personnel, - the administration of even well performing state facilities are limited in the ability to reallocate funds from other budget line items and increase salaries for best personnel, in the situation when the salaries for medical personnel are highly inadequate and represent less then 40% of national average salary.

In Summary:

Low level of government health expenditures, high OOPs and absence of insurance, aggravated with low ability of population to pay for health services (according to official figures up to 46% of the population is poor), fragmented management of available health resources, ineffective methods of financing of health institutions and health personnel contribute to deteriorating health infrastructure, increased cost of services, financial barriers to access, low quality in country's health care sector, worsening financial protection of population from cost of health services and low access to quality essential health services, particularly for poor[2]. This situation in turn leads to worsening health outcomes: morbidity and mortality of Azerbaijan population.
Health Financing Reform Program of Azerbaijan is a framework set by the Government of Azerbaijan for to address current problems in health financing system over 5 year period.

Overall Program Goal:

To ensure access to quality essential health care services for the population of Azebraijan

Specific goals:

- promoting access to care and protecting against financial risk;
- promoting solidarity by distributing the burden of funding the system relative to individual capacity to contribute and by distributing health care services and resources in accordance with individual need;
- promoting efficiency through explicit incentives and streamlined administrative arrangements; and
- being transparent and understandable.

Objectives:

- Increase the public spending on health care
- Improve risk pooling in the health sector
- Improve the planning, budgeting and allocation system for health sector
- Introduce financial incentives for health care institutions to provide quality health care services for the population

[2] According to the Household Budget Survey regularly conducted by the SSC, one in three households declared that they could not use health services because of their inability to pay (2002).

Objective 1. Increase Public Spending on Health Care

Government of Azerbaijan (GoA) declares that increased government spending on the health sector is an absolutely necessary precondition for achievement of MDGs through significant change in access to essential health services for the population. Considering the current and future economic outlook for Azerbaijan, GoA sets **5 year (2006-2011) target of 100 USD per capita or app. 800 million USD, - five fold increase from current level -** for the government health expenditures from all sources (including SHI when introduced). By the year 2015, this figure is intended to reach 200 USD per capita (considering the 7% inflation rate) or up to 2 billion USD as proposed by the State Program for Poverty Reduction and Economic Development (SPPRED). This level of spending on health care should permit as much as 70%-80% of essential health services to be provided to all of the population free of charge and increase the net monthly salaries for physicians to more than 1,000 USD and for nurses to more than 500 USD. Fiscal analysis shows that this sum of 2 Billion USD will represent app. 3 percent of GDP and up to 10 total public budget expenditures (see Annex 1), which is in line with what most of the Eastern European governments spend on health care. GoA intends to achieve these targets through increased health allocations from general budget and introduction the State Mandatory Health Insurance (Social Health Insurance - SHI). Along with SPPRED, the respective three-year and annual health expenditure targets will be reflected in country's Medium Term Expenditure Framework (MTEF) and annual budgets.

Investments in Infrastructure

Major investments are needed in physical infrastructure. Expert evaluation show that approximately 1,2 Billion USD is required to bring needed hospitals, polyclinics, and other health facilities up to acceptable standards of quality. GoA intends to design special long term Health Sector Investment Program (HSIP) that will proceed in parallel with the rationalization of existing health facility networks and fundamental improvements in the functioning of the health infrastructure. The HSIP will encompass health infrastructure rationalization plans on regional and national level and will set annual targets for public investments (including those through State Oil Fund of Azerbaijan - SOFAR) for upgrading health facilities nationwide.

Objective 3. Improve risk pooling in the health sector

Major increases in public expenditures on health—higher budget allocations, greater capital investment—are essential requirements if the accessibility and quality of public health care services are to improve. *But they are not sufficient*. Increased expenditures must be utilized far more effectively than public funds are used presently. In order to achieve a major increase in the effectiveness of public expenditures on health, the GoA strives for fundamental reform of the entire health care system. Reform of the health financing system on national level and introduction of SHI are one of the major directions of the health care reform. .

Introduction of Social Health Insurance[3] - SHI

[3] Social Insurance or pooling means that an insurance scheme is created whereby people who are wealthy and in good health will help pay for the health care needed by the poor and the sick. People in a society share (or pool) their risks of bad health and the consequent high costs of health care services. Of course, people may change from low-risk to high-

Introduction of SHI and establishment of National Health Insurance Fund (NHIF) is one of the most viable means for addressing current problems in health financing system of Azerbaijan. SHI will become the additional revenues source for the health sector and will also address the problem of fragmented health funds through pooling of all governmental health resources in this entity: The NHIF is proposed to be a single financier or purchaser of health services financed by the government, i.e. all health allocations from the state budget intended to finance the health services (including those currently allocated to district self governing bodies) will be eventually concentrated in this fund. The introduction of a single pooling agency will enhance planning in the health sector. NHIF also be given the authority to do selective contracting (i.e., contract with only some providers, whether public or private) and thus increase technical efficiency and promote the gradual downsizing of the number of healthcare facilities. The probability of selective contracting usually increases with the introduction of a new pooling agency (separate from the MOH), since it leads to the separation of the purchasing and delivery functions in healthcare and allows MoH to more concentrate on policy making and regulatory functions for health sector. In summary, the introduction of the SHI system and creation of NHIF will help to:

- Create new source of health care financing and bring additional resources to the system
- Eliminate current fragmentation of public resources on health care and concentrate them in single pooling agency for better policy planning and greater efficiency of health care funds.
- Separate the regulatory, purchasing and delivery functions within the health system for improved governance and policy making
- Introduce greater transparency in the system

The basic features of legal and institutional framework for SHI and NHIF is presented in the annex II.

Following activities phased in time are intended for the establishment of fully functional SHI system in Azerbaijan:

Year 1

- Elaboration and adoption of changes in the “Law on Mandatory Health Insurance”
- Legal and institutional establishment and staffing of NHIF with central and small regional branches
- Delegation to NHIF the function of financing of central institutions (republican institutions, central hospitals, SES, etc.) currently included in the MoH budget;
- Commissioning of costing studies to identify “real” cost of health services
- Elaboration of new financing and contracting mechanism for these institutions allowing the move from current normative based line item budgeting to the financing schemes tied with actual volume of services that this institutions provide to the population.
- Development of internal organizational structure and policies
- Human resources development for central office of NHIF

Year 2-3

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risk as they pass through life – and can therefore change from being a subsidiser of care for others into being a recipient of subsidy from other people.

- Full or partial delegation of the financing function for health institutions currently financed by the local district administrations in selected pilot regions (selected for the new World Bank Health Project - Agdash, Apsheron, Gakh, Ismaili and Sheki).[4]
- Adoption of new financing (payment) and contracting mechanisms for health institutions under the financing responsibility of NHIF;
- Definition and delineation of Essential Package of Services (benefit package - EPS) to be financed through the SHI and General Budget that will support clear formulation of state responsibilities in health care
- Piloting of EPS in pilot districts
- Human resources development for regional branches of NHIF

Year 4-5

- Adoption of new EPS
- Adoption of new financing (payment) and contracting mechanisms for all health institutions under the financing responsibility of NHIF
- Final revision of legal, regulatory and institutional framework of NHIF
- Institutional and human resources development for contracted health institutions

Time lines and responsible state agencies for implementation of these activities in presented in the Chapter ??. Program Implementation Plan

Objective 3. Improve the planning, budgeting and allocation system for health sector

Changes in current budget management mechanism for health is an essential precondition of introduction of the SHI system and at the same time major step in improving the overall health financing system. Introduction of single treasury system and "hardening" of rigid line item budgeting mechanism through the 2002 Law on Budgeting System of Azerbaijan (amended in May 2003) has been progressive step towards enforcement of fiscal discipline. Public funds have undergone substantial structural changes. Following important measures have been undertaken in this regard: a treasury system has been established, transparency and accountability in the public funds have been brought to the forefront, municipalities have been established and their financing sources identified. Changes in the legal framework also allowed introducing the Medium Tem Expenditure Framework (MTEF) as a tool for improved public expenditure management and concrete link between budget and SPPRED. Further implementation of MTEF envisages the improved budget preparation and execution for main public sectors by the line ministries responsible for respective sectors, including the health sector and MoH. Current budgeting system for health sector based on historical "rigid" line item budgeting for the time being represents major impeding factor for introduction of efficiency in this sector. The GoA intends gradual transition from this practice towards more autonomy of the MoH for health sector budget preparation within "hard expenditure ceilings" defined by the MoF for the sector. So called "performance based budgeting" will be introduced, which basically means the allocation of health budget according to the "targeted programs", e.g. Public Health, PHC, hospital care, TB, maternal and child care, etc. Each program

[4] Financing of capital expenditure and part of recurrent costs (rehabilitation, utilities) may be retained by the local administrations

will contain major aims, objectives, activities and outputs for respective program. Required expenditures for the program will be tied to these concrete objectives, activities and outputs and also be broken down by economic classification. This approach allows to tie the funds spend by the government to concrete goals and objectives for each state program, or effectively and transparently tie expanded funds with desired results and make it transparent and clear for what and how the money spent on health care is used. This change is also important for launching the process of optimal EPB definition and financing arrangements and finally for the introduction of functional SHI system.

Presented below is possible break down of the health budget according to targeted programs and possible distribution of financing roles between the MoH and NHIF when fully fledged SHI system and NHIF and main purchaser of health services will be established:

State Health Programs	MoH	NHIF
Public Health (population-based surveillance, epidemiological control, prevention ofcommunicable and non-communicable diseases)	+	
PHC services		+
PHC consultation		+
Immunization		+
TB		+
STI		+
Outpatient diagnosis and treatment at the PHC level		+
Emergency ambulance		+
General Hospital Care		+
Special Programs		+
Program for Poor (Soically Vulnerable Population)		+
Pharmaceuticals for Chronic Patients		+
Psychiatric		+
Oncology		+
TB		+
STI		+
Capital Investments and Rehabilitation of Health Facitlities	+	

Preparation of sectoral MTEFs and annual budgets in such manner will require linking the population health needs with available resources, accurate costing of health needs and health services and significantly improved planning, monitoring and evaluation systems within the health sector.

Linking the financing to health care need on national and regional levels

Public resources are best allocated when the budget is linked to the healthcare needs of the population. The Program intends to introduce the principle for allocation of health funding on a per capita basis, with adjustments made for patient characteristics, including demographic, epidemiologic, socioeconomic and other relevant factors. Further refinements will include adjustments for the cost of delivering care to remote areas. The Program aims at developing a population-based resource allocation formula nationwide and piloting it in the five selected districts.

Defining the Essential Package of Services Financed by the State

At present, a most of the services produced in public medical facilities are provided free of charge, while co-payments apply to others. However, high level out-of-pocket payments found through household surveys suggest that the real cost of services is higher than the amount of public funds

allocated for their financing. The gap between real costs and reimbursement rates is currently covered by individual patients on a fee-for-service basis.
In addition to increasing of public spending on health care, the issue of high OOP, equity and access to essential healthcare will be addressed through revision and costing of a essential package of services. The provision of existing services will be reassessed in terms of affordability, various scenarios of population coverage, the size and content o f the service package and the service mix. One option is to define an essential package that would be provided to the entire population free of charge and financed by general tax revenues. This package would include all primary and preventive care, plus public health interventions and some secondary and tertiary care. An expanded version of the package could include additional curative services that would require a financial contribution from the population, yet offered free of charge to the poorest. Again, the potential cost of expanded coverage will be realistically assessed to ensure that it is affordable. Wider consultation will be held with various stakeholders and general society to adopt a strategic decision whether the government should gradually assume full responsibility for financing all health services or limit its scope o f responsibility to a basic service package, thus allowing for expansion of the health insurance market. Regardless of this decision, there will be a clear delineation between services covered by the government and those covered by health insurance. Ideally, the latter should not cover the same mix of services, but supplement the government package.

The principal aims of a benefits package are therefore to:

- Provide a universal package of essential health services, ensuring coverage for the poor;
- Reflect the epidemiological profile and national health priorities;
- Maximise health benefits relative to per capita expenditure, through services which are as far as possible equitable, effectively administered, cost effective and contribute to improved health outcomes;
- Meet the health 'needs' of the population.

Elaboration and practical application of the EPS involves deliberation on and adoption of two main sets of policy decisions:

(1) Defining the benefits and population covered with limited public funds for health.

This policy decision has both a political and a technical component. The political component is to choose among three options for distributing the current limited health budget across services and populations (see below). The technical component is to develop the specific content of the package of services to be covered within the envelope of available resources and the appropriate targeting mechanism to identify the beneficiary population.

(2) Identifying the expansion path for covered services and population as government funding increases in future years.

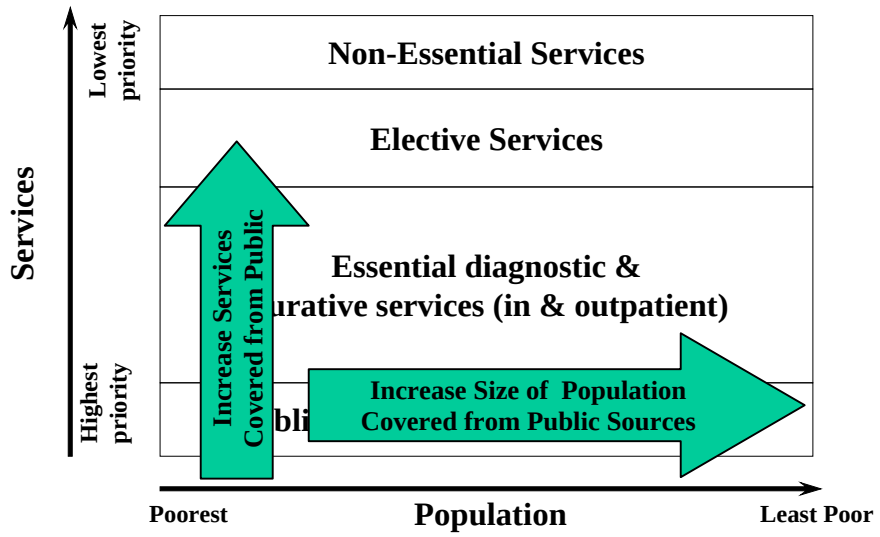
This policy decision also has a political and a technical component. The political component is the decision about how increased government funding for health increases will be distributed between increasing coverage of services and increasing the population covered. The technical component is to calculate the costs of expanding coverage of services and population to support budget formation, and to present the budgetary implications of alternative scenarios of expanding coverage.

There are several policy options for consideration for GoA:

Policy Options: Distributing Government Health Funds Across Priority Services and Populations

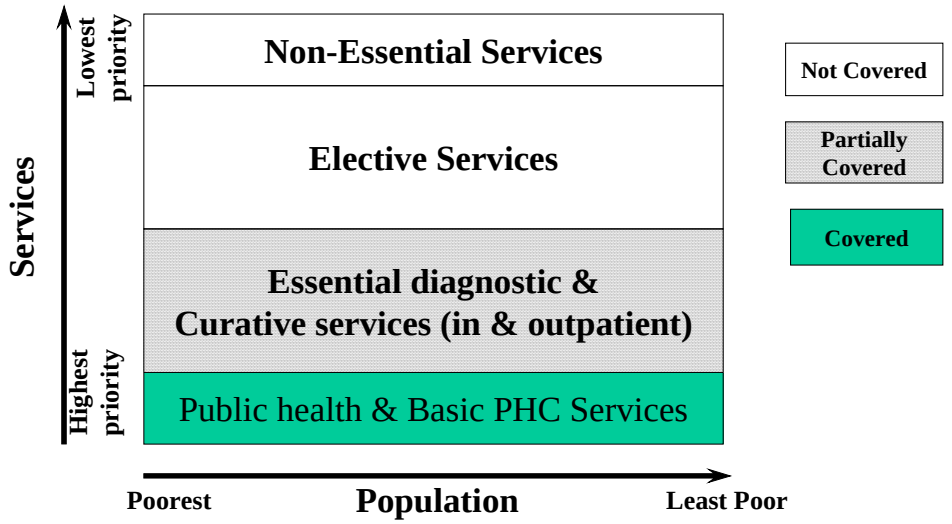
Once the government commits to responsibility for policy and regulation of the entire set of essential health care services, it is possible to develop effective policies that appropriately integrate public and private sources (fee for service, voluntary health insurance) of financing, and ensures that as the availability of public funding for health increases, the range of services financed and the population covered will increase in an appropriate way that furthers the Government's health policy priorities (see Figure 2). The health services can be ranked from highest priority to lowest priority, and the population from most vulnerable to least vulnerable (according to socioeconomic or other criteria), which identifies the expansion path for government funding according to these priorities.

Figure 1. Expansion of Government Funding for Health Care



The main decision needs to be made about how the government intends to prioritize limited public funding for health. Other policy areas can then be developed to support and complement the implementation of that decision. Figure 2 shows the current formal distribution of government funding for health across services and population groups. A limited package of basic primary health care (PHC) is provided to the entire population. Essential diagnostic and curative services (both outpatient and inpatient) are only partially covered in reality for most of the population, with some lack of clarity in exactly which population groups are entitled to how much coverage for which services.

Figure 2. Current Coverage of Services and Population with Government Health Funding



If the Government of Azerbaijan decides to establish the mandate to include the entire set of essential health services under the health financing policy umbrella and identify the expansion path for increasing government funding for health care along priority services and priority populations, the following options for allocating current government budget funds across services and populations are the following:

Option 1: **Everyone gets the same**
[*The entire population is entitled to the same limited set of services*]

Under Option 1, government budget funds are used to cover the entire population with the same set of services. Given the current health resource envelop, this would result in a very limited package of services being covered for everyone (Figure 3). The expansion path for coverage with government funds under this option would be to gradually increase the services covered for the entire population (Figure 4).

Figure 3. Coverage of Services and Population with Government Health Funding Under Option 1

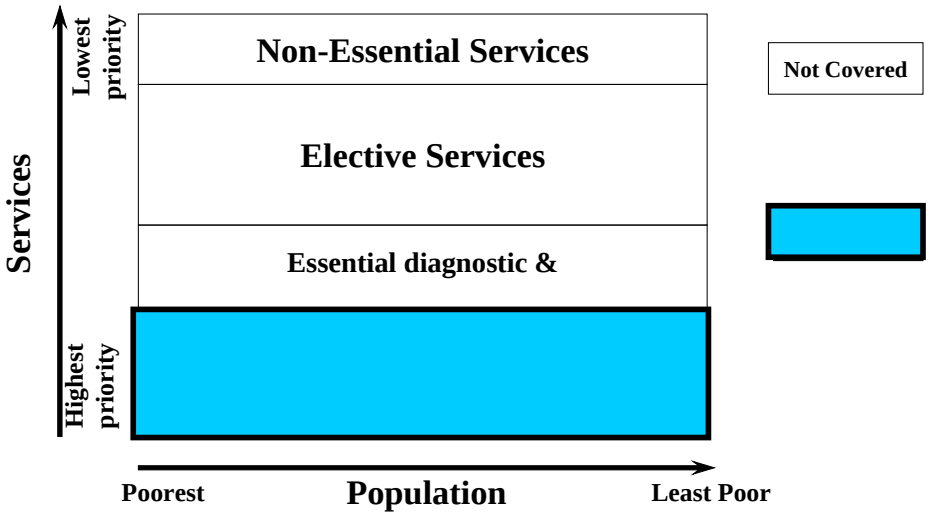
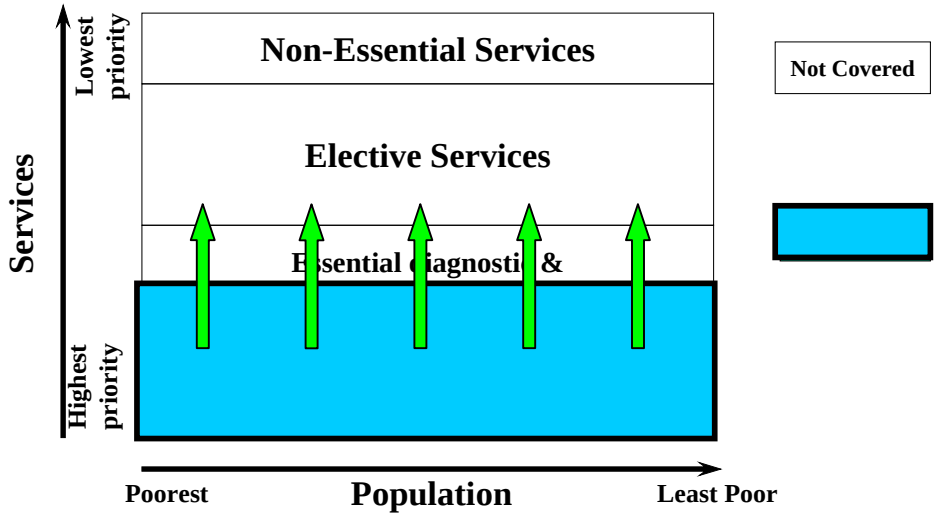


Figure 4. Expansion of Coverage of Services and Population with Government Health Funding Under Option 1



Option 2: **Only the poor are covered**
[*Only the poorest population is entitled to government-funded services*]

Under Option 2, government funds are targeted only to the poorest population group, so a more comprehensive package of services can be covered (Figure 5). Most of the population, however, would be left to finance health care completely out-of-pocket. This option creates the risk of households who are currently on the margin of poverty, or even significantly above the poverty line, falling into poverty when faced with catastrophic health expenditures. The expansion path for coverage with government funds under option 2 would be to expand coverage to include more of the population with a comprehensive set of services (Figure 6).

Figure 5. Coverage of Services and Population with Government Health Funding Under Option 2

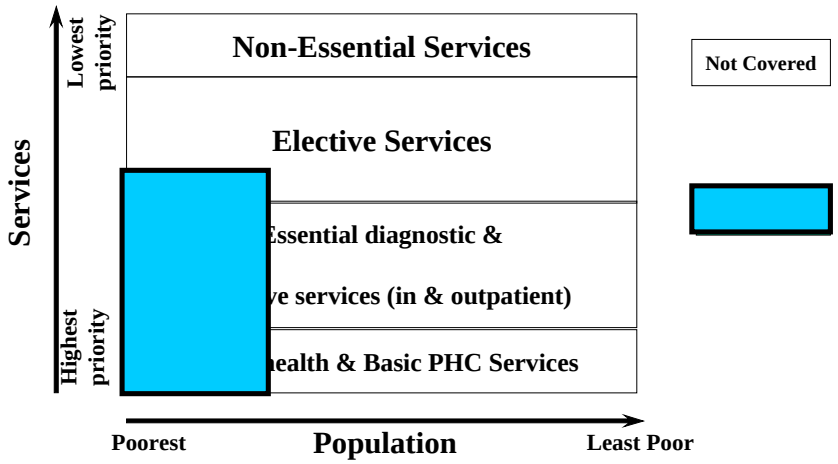
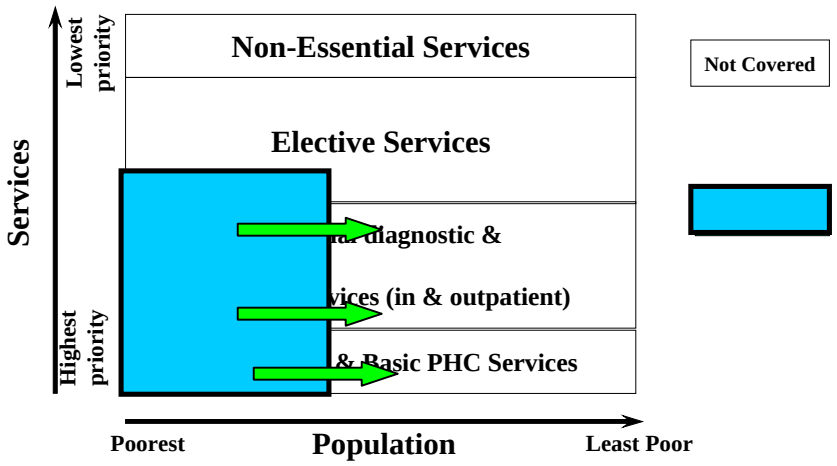


Figure 6. Expansion of Coverage of Services and Population with Government Health Funding Under Option 2



Option 2 is theoretically possible, and should therefore be included in the universe of options to be considered. In practice, however, this option is neither realistic nor desirable. The basic set of public health services include public goods, such as disease surveillance and community-based disease prevention, and "quasi-public goods," such as immunization and diagnosis and treatment of infectious diseases, that are not adequately provided, or not provided at all in the case of pure public goods, if left to the market and entirely out-of-pocket payments.

Option 3: **Combination of Universal Coverage and Targeting to the Poor**
[*The entire population is entitled to a limited set of basic services, and the poor are entitled to an expanded set of services*]

Under Option 3, the government funds a limited set of basic services for the entire population, and also funds an additional set of services for the poorest population (Figure 7). The expansion path for coverage with government funds under option 2 would be to expand coverage to cover a combination of both more of the population and a more comprehensive set of services (Figure 8).

Figure 7. Coverage of Services and Population with Government Health Funding Under Option 3

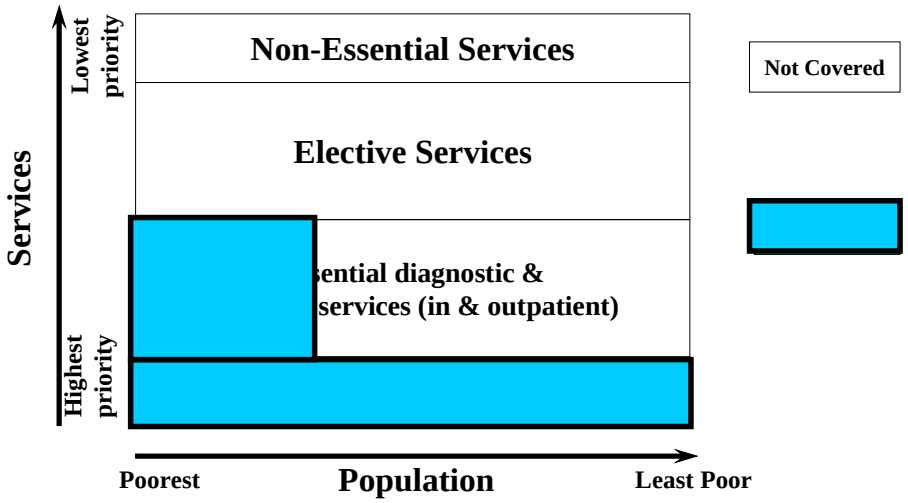
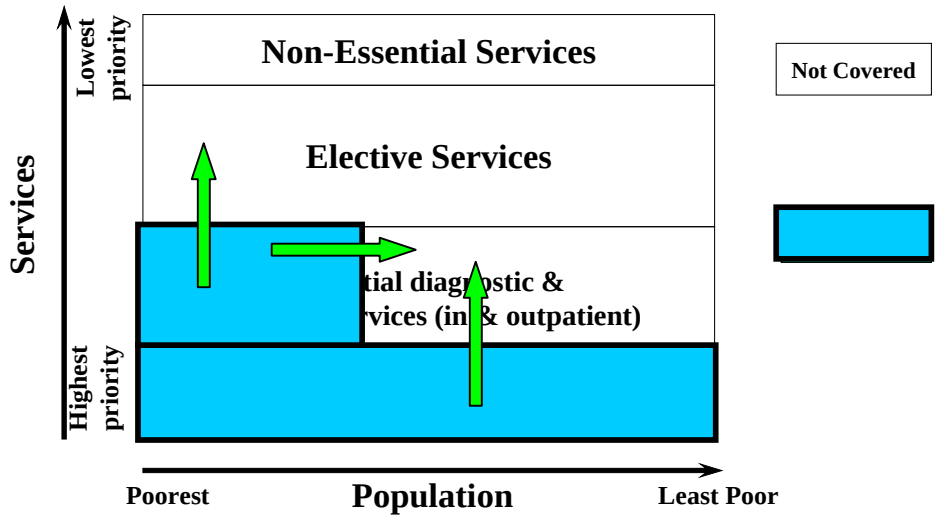


Figure 8. Expansion of Coverage of Services and Population with Government Health Funding Under Option 3



Decision on which policy option to pursue will be even more critical for defining the path of the health financing reforms for the next 5 years until appropriate level of public expenditures on health is achieved.

Objective 4. Introduce financial incentives for health care institutions to provide quality health care services for the population

The Program plans to introduce new prospective provider payment mechanisms for primary and secondary facilities in the five pilot districts in order to improve technical efficiency, cost containment and quality. Ambulatory facilities could receive payments on a per capita basis, with flexibility for generating savings that could then be reallocated for pharmaceuticals and equipment purchases. Prospective payments could also be used for hospitals and connect payments to activities. Starting with a simple system where payments will be based on measurable units of hospital outputs, more sophisticated mechanisms can be introduced where services associated with a particular treatment will be grouped in bundles and a monetary value will be assigned to them. The hospital, knowing the monetary value per bundle, could make a profit by carefully administering inputs and hospital stay. Diagnostic Related Group (DRG) is among the most well known prospective payment mechanisms. International experience also shows that prospective payment mechanisms in a fiscally tight environment can be applied within a global budget, which is used to cap hospital expenditures with case-based payments (see annex IV).

PHC

In order to introduce improvements in technical efficiency, cost-containment and quality of care, performance-related payments to primary health care providers need to be put in place. Primary-care facilities (polyclinics, DACs, FAPs) could receive payment on a per capita basis, with the flexibility to generate savings that could be reallocated for pharmaceuticals and equipment. The per capita payments to PHC providers will be performance related. *Performance withholds*[5] and *bonuses*[6] of up to 10% of budgeted funds for the providers will be used to create financial incentives for better performance and outcomes.Such an approach could improve levels of equipment and supplies, as well as enhance national training programs for physicians and nurses. These changes would need to be combined with a more systematic approach towards monitoring user charges and wages in the state healthcare system.

Hospitals

Performance-related payments should also be introduced for hospitals. Gains in efficiency could be made by replacing current budgeting with payment mechanisms that reward hospitals for higher throughput while motivating a decrease in cost per case. Based on the experience o f other countries, performance-based payments are best applied within a global budget. Lowering the average length of stay and staffing levels could lower the cost per case and result in overall cost savings, particularly if combined within a global budget (Annex IV).

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[5] Portions of the health provider compensation that are held back by the purchasing public agency and released only upon the evidence of success in attaining agreed upon performance goals.

[6] Additional payment, predetermined in the contract with health provider, that are paid to the provider upon successful attainment of specific performance indicators.

Conclusions and Next Steps

According to the Program, the main health financing policy directions for Azerbaijan over the next five years will focus on the priority of providing a larger share of the population with access to essential health care services through: (1) increased budget allocations to the health sector; (2) allocation of government funding prioritized by services and population groups covered; and (3) the development, support and regulation of risk-pooling mechanisms for private health expenditures and (4) Improved provider payment mechanisms. These health financing priorities were identified in health sector strategy documents prior to the *rose revolution*, and they continue to be the most urgent health financing issues to be addressed by the new administration.

The immediate policy decision that must be made is how to prioritize current limited public funding for health based on the three options for elaboration and implementation of EPS. When this decision is made, the following next steps are suggested:

1) Initiate policy discussions on the overall funding allocations for health to be reflected in the MTEF.

2) Arrive at a consensus on the policy and regulatory role of the state in overall health financing, as discussed above. Decisions should be made on issues such as integrated health financing policy for public health expenditures as a transition to an integrated or unified national risk pool using public funds, integrated policy for purchasing and provider payment, and health sector optimization.

3) Conduct an analysis of the overall resource requirements to provide essential health care services to the population, financing all inputs at adequate levels (including salary increases for health professionals) under the current service delivery structure and alternative structures.

4) Conduct a cost analysis and simulation of alternative definitions of the package of health services to be financed from government funds and different definitions of the populations to receive varying levels of coverage. These estimates can be used as a basis for defining government commitments for health care in 2007, and through the MTEF process as a basis to expand health sector budget allocations in future years. These estimates will also provide guidance for intra-sectoral allocation of the government health budget, including relative allocations for public health, primary health care, and hospital care, as well as allocations across population groups.

5) Elaborate during 2006-2007 a consolidated health sector strategy that reflects health financing policy decisions related to:

    a) Overall legal and regulatory framework for health financing

    b) Legal and regulatory framework for risk-pooling for private expenditures (public and/or private insurance market)

    c) Institutional structure of the health sector

d) Revenue collection and flow of funds

e) Benefits and coverage
   i) Definition of essential set of health care services
   ii) Allocation of government health sector funds to priority services and populations

f) Institutional development of public and/or private insurance market

g) Purchasing (contracting and provider payment)

h) Structure of the service delivery system

Timelines for these activities and responsible governmental agencies for carrying out these steps are presented below in Program Implementation Plan

Program Implementation Plan

ACTIVITIES	*STAKEHOLDERS*	*DATES*
TASK 1. Improving of mobilization of public finances for health care		
1.1 Increased allocations for health care from the consolidated state budget		
1.1.1. Adoption of the SPPRED with relevant public expenditure targets on health care through 2015	**Cabinet of Ministers, Ministry of Economic Development (MoED)**	**2006**
1.1.2. Adoption of Medium Term Expenditure Framework (MTEF) with three year targets on health care allocations	**Ministry of Finance (MoF), MoH**	**2006-2007**
1.1.3. Adoption of annual budgets with health expenditure targets according to the SPPRED and MTEF	**Ministry of Finance, MoH, Parliament**	**2007-2015**
1.2 Introduction of earmarked health insurance contribution		
1.2.1 Development of legislative environment/documents	**MoH, Cabinet of Ministers**	**2006**
1.2.2 Development of draft laws, presentation and negotiations of the amendments in Parliament	**MoH, MoF and MoJ, Parliamentary Committee on Health Affairs**	**2007**
1.2.3 Approval of draft laws and amendments in Parliament	**Parliament**	**2007**
1.3 Establishment of National Health Insurance Fund (NHIF)		
1.3.1 Development of legislative documents (Charter and Organizational Structure)	**MoH, MoF,**	**2006**

1.3.2 Adoption of Cabinet of Ministers' Decree	**Cabinet of Ministers**	**2006**
1.6 Definition of Package of Essential Service (PES) Financed by the State, including the benefit package financed through SHI 1.6.1 Development of proposals for PES 1.6.2 Pilot testing of PES 1.6.3 Approval of PES by the Cabinet of Ministers for nationwide implementation	**MoH, MoF** **MoH, MoF, Local Health Administrations** **Cabinet of Ministers**	**2006** **2007-2009** **2008-2009**
1.7 Shifting to targeted program based budgeting system in health sector 1.7.1 Development of health sector programs 1.7.2 Elaboration of health sector budget proposal based on targeted programs 1.7.3 Approval/adoption of the State Budget Law by Parliament	**MoH, NHIF** **MoH, MoF, Cabinet of Ministers** **Parliament**	**2007** **2008** **2008**
Task 2. Improving management capacity of public finances		
2.1 Health economists and managers capacity development 2.1.1 Training of administrative personnel Mastering in health economics and management 2.2.3 Training of health care management specialists	**MoH, World Bank** **Baku State Medical University, Postgraduate Medical Institute**	**2002-2007**
Task 3. Improving public purchasing of health services		
3.1 Elaborating new payment systems for outpatient and inpatient care	**MoH, MoF**	**2006-2007**
3.2 Testing new payment systems in pilot districts	**NHIF, MoH, MoF, Local Administrations**	**2007-2008**
3.3 Nationwide implementation of new provider payment systems	**MoH, MoF, NHIF, Local Administrations**	**2008-2010**
3.3 Quality assurance and patient's satisfaction (ranking of health care providers, accreditation of facilities,)	**MoH, NHIF**	**2003-2007**

3.4 Improvement of public awareness by more emphasis on PR (EPS and health care institutions contracted by state accreditation)	**MoH**	**2002-2007**
3.5 Masterplan for the provision of health care, resulting in a licensing system based on needs	**MoH**	**2007-2009**
3.6 Selection criteria for contracting by purchases	**MoH, NHIF**	**2007-2008**
3.7 Regulate the tariffs of extra package services	**MoH**	**2007-2008**
3.8 Regulation of pharmaceutical market	**MoH**	**2007-2009**
3.9 Prioritization of cost-effective programs	**MoH, MoF**	**2007**
3.10 Balancing man-power planning, man-power management and man-power education	**MoH, Ministry of Education**	**2002-2010**
Task 4 Improving risk pooling for effective spending on health		
4.1 Concentration of funds allocated for health care on central level	**MoH, MoF, Parliament**	**2006**
4.1.1 Reallocating most of the MoH funds for health care institutions to the NHIF n the draft State Budget Law	**MoH, MoF, Parliament**	**2007-2008**
4.1.2 Reallocating (or increasing) health care expenditures on local level to the NHIF in pilot districts, employing new regional allocation formula linked to regional specificities	**MoH, MoF, Cabinet of Ministers Parliament**	**2009-2010**
4.1.3 Reallocating (increasing) of (all) health care funds on central level through NHIF and MoH		
4.2 Improvement of public awareness of patients rights, coverage of health insurance packages, payment systems, co-payments etc.	**MoH, Private Insurance Companies**	**2002-2007**
4.3. Introduction of tax incentives for people purchasing private health insurances	**MoH, MoF, Parliament**	**2008-09**

Annex I . Fiscal Analysis[7]

In 2005, public spending on health in Azerbaijan was US$121.9 million[8] (0.97 percent of total and 1.66 percent of non-oil GDP and 4 percent of the Government's consolidated budget) (Table 1). According to the 2004 household survey private spending on health was equal to 1.6 percent of total and 2.3 percent, non-oil GDP.[9] Assuming that in 2005 private spending on health remained unchanged in terms of GDP, total spending on health in 2005 was 2.56 percent of total GDP (3.96 percent of non-oil GDP). In per capita terms, public spending in 2005 was around US$14.5 while private spending was US$23.5 (total per capita spending on health was equal to US$38).

Table 1. Total health expenditures, 2005

	Health expenditures		
	% of GDP	% of non-oil GDP	Per capita US$
Public spending	0.97	1.66	14.5
Private spending	1.59	2.29	23.5
Total	2.56	3.95	38.0

Source: MOF for public spending and 2004 National Household Survey for private spending.

In order to estimate the total cost of health care services in Azerbaijan in 2015, the analysis uses as starting point an estimate of the health sector wage bill and assumes that the gross labor cost is 60 percent of the overall health care cost. It also makes the following assumptions[10]:

- Population: 9.2 million[11]
- Number of physicians: 33 per 10,000; total 30,500[12]
- Number of nurses and midwives: 75 per 10,000; total 69,317
- Support to medical staff ratio 1:1: 99,817
- Average monthly wage in 2015: US$718[13]
- Total number of formal sector employees: 1.85 million[14]
- Gross to net wage ratio 1.4:1.0
- Physicians' average net monthly salary (1.4 times the average salary): US$1005

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[7] The fiscal analysis is prepared by the World Bank Team for the Project Appraisal Document (PAD) for Health Sector Reform Project. Certain figures are modified for the current document.

[8] Exchange rate for 2005: 1US$=0.9 AZM.

[9] According to a 2002 health expenditure household survey, the estimated total health expenditures were between 3.3 percent and 4.1 percent of the GDP, with a public-to-private ratio varying between 20/80 and 25/75. It is worth noting that the 2002 estimate might be more reliable than the 2004 estimate (public-to-private ratio: 40/60) as it was based on a special health expenditure survey as opposed to a general household survey. Nevertheless, the analysis uses the 2004 estimate because it is the most recent one.

[10] All figures are nominal.

[11] Source for 2005 population: MOH; average population growth rate 1 percent after 2005: this is the average growth rate of the population for the period 1998-2004, State Statistical Committee of Azerbaijan, Statistical Yearbook of Azerbaijan, 2004, www.azstat.org.

[12] In 2003, Azerbaijan had 36.1 physicians per 10,000 population (as compared to 33.1 physicians per 10,000 in the European Region) and 84.2 nurses and midwifes per 10,000 population (as compared to 72 nurses and midwifes per 10,000 in the European Region), WHO/Health for all database.

[13] The average nominal wage increase is assumed to be 15 percent after 2005.

[14] The net job growth is assumed to be 30 percent until 2010, 2.5 percent afterwards.

- Nurses' average net monthly salary (50 percent of physician's salary): US$502
- Support staff salary is estimated at US$200
- Nominal GDP in 2015: US$56.8 billion (non-oil GDP: US$34.9 billion) – see Tables 9.3 and 9.4

Based on the above, the gross labor cost for the health sector in 2015 will be equal to US$1.4 billion and the total cost for health care services US$2.39 billion (4.21 percent of total and 6.85 percent of non-oil GDP) (Table 2).

From total health expenditures of US$2.39 billion, the Government is expected to finance the EPS.[15] Under the assumption that the unit cost of the EPS is US$100 today (US$184 in 2015 with an inflation rate of 7 percent), the total cost for the provision of the EPS in 2015 will be equal to US$1.7 billion (2.89 percent of total and 4.87 percent of non-oil GDP). Compared to the Government's consolidated budget (US$17.7 billion – SPPRED projections), public spending on health in 2015 will represent approximately 9.6 percent of total government spending. It is worth noting that (i) EPS resources are also expected to cover salaries for health personnel and (ii) the total cost for the provision of the EPS is below 3.6 percent of GDP (US$2.04 billion) that the Government envisages to spend under the SPPRED (Table 9.4). The ratio of public to private spending has changed from 40/60 in 2005 to 70/30 in 2015. The latter ratio is one commonly found in countries that offer universal risk protection against out-of-pocket health expenditures.

Table 2. Fiscal impact analysis – Total health expenditures, 2015

	Health expenditures		
	% of GDP	% of non-oil GDP	% of Consolidated Budget
Public spending	2.89	4.87	9.6
Private spending	1.32	1.98	-
Total	4.21	6.85	-

As far as the financing of total health expenditures is concerned, various combinations are possible. Here the option of mandatory health insurance contributions is explored together with direct budget transfers. Taking into account an estimated net wage bill for Azerbaijan equal to US$15.9 billion, mandatory health insurance contributions equal to 4 percent of the wage bill and with 100 percent compliance would provide US$636 million. In order to each US$1.7 billion, the Government budget would have to provide US$1,074 million (5.5 percent of the Government's consolidated budget) and the population share would cover the rest US$690 million (Table 3). Alternatively, if mandatory health insurance contributions were equal to 8 percent of the wage bill, they would provide US$1.2 billion, leaving the Government budget to finance US$428 million (2.4 percent of the Government's consolidated budget) and the population US$742 million.[16]

Table 3. Financing scenarios, 2015 (million US$)

	Scenario A (4% mandatory contributions	**Scenario B (8% mandatory contributions**

[15] For simplicity reasons we assume that no other health items will be financed from the Government given that the BBP is expected to be the main expenditure item.

[16] Total spending for health increases marginally under the scenario of health insurance contributions of 8 percent because the assumption of gross to net wage ratio changes from 1.4:1.0 to 1.43:1.0.

	+ 5.3% of CB)	**+ 2.4% of CB)**
Health insurance contributions	795	1,272
Government's budget	905	428
Private spending	690	742
Total	2,390	2,442

Sensitivity analysis has also been carried out assuming higher salaries for health workers and support staff. In particular, it is assumed that by 2015, physician salaries will be 2 times the average salary (US$1,436), nurse and midwife salaries will be 50 percent of physicians' salary (US$718) and salaries for support personnel will be equal to US$287. Higher salaries result in the gross labor cost for the health sector in 2015 being equal to US$2.05 billion and the total cost for health care services equal to US$3.42 billion (6.02 percent of total and 9.81 percent of non-oil GDP). Under a financing scenario of health insurance contributions equal to 4 percent and an additional budget transfer equal to 5.5 percent of the Government's consolidated budget, the extra funds to cover increased salaries would come from higher out-of-pocket payments equal to US$1.72 billion. The ratio of public to private spending under this scenario would be 50/50.

Annex II. Legal and Institutional Framework for SHI and NHIF[17]

Parties to Health Insurance

The social health insurance system is characterized by the delineation of roles and responsibilities of three parties:

- **Health care providers:** health care establishments, physicians, dentists, specialists – working in either public sector or private sector;
- **Health care purchasers** - National Health Insurance Fund – funded through contributions or the tax system;
- **Consumers** - the insured people.

The introduction of social health insurance will have the following consequences for the above mentioned participants:

- For health care providers – effective competition will increase the incentive for the provision of a better quality of services and cost containment. The relationship with the purchaser (NHIF) will be on the based on a contract that defines rights and obligations for both parties.
- For the NHIF, as a new player - it is very important that it is accepted by all stakeholders in its principle role as the funder of a guaranteed package of health care services.
- For the insured person, social health insurance will allay the basic risk of uncertainty in being able to afford expensive health services.

Principles of Social Health Insurance

The key principles of social health insurance relate to equity and solidarity and are discussed below.

Mandatory participation - This is the most significant principle of the social security systems and usually implies the mandatory collection of contributions from all economically active people and/or their employers.

Accessibility to basic package of health care services - Within the guaranteed package all insured people have equal rights of access to health care services.

Solidarity - The principle of solidarity assumes the possibility for re-allocation of contribution resources from the healthy to the ill, from the rich to the poor and from employed to unemployed people.

Shared responsibility for health - Depending on the system of government, the principle of shared responsibility for health is supported by the participation of all levels of government and their agencies.

Freedom of choice of health care provider - The health insurance regulatory framework should provide the freedom of choice of a healthcare provider.

[17] This section of the document draws largerly from "Health Financing Study" prepared in by *G&G Consulting + HIC + ANKON* in 2005 under the World Bank Azerbaijan Health Sector Learning and Innovation Loan.

Purchaser / Provider split - Health insurance funds are not involved in the provision of health care.

Status and Institutional Interrelations of NHIF

Relations with the Government. The NHIF should be operationally autonomous specializing in performing legal and financial functions for the implementation of the State health financing policies. The NHIF will not be a ministerial dependency, but a legal person linked to the Government via the Ministry. Thus, it will work closely with the MoH, with the Ministry of Finance/Treasury, Parliament and other public and private stakeholders.

Relations with the MoH. The MoH plays an essential role as the highest-level entity representing the interests and responsibility of the State regarding health. The Ministry formulates the national health policies, has the overall responsibility for public health, and has numerous functions with respect to improving the health status of the population, designs the general State strategy towards health, determines health needs, and exercises broad regulatory functions regarding the health sector. Thus, the NHIF needs to work in close collaboration with the Ministry to properly implement the national health care financing strategies. An adequate form to ensure autonomy and the proper relations with the Ministry is by having the Minister (or his/her representative) as Chairman of the NHIF governing body (a Board of Directors or a Supervisory Body), and through continuous reporting and consultation mechanisms.

Relations with the Ministry of Finance/Treasury. The Ministry of Finance controls the actual allocation of State financial resources. For the NHIF to play an effective and credible role as purchaser, it needs to secure that the State resources will be available, and that they will not be just a promise with no consequences if unfulfilled. Therefore, the NHIF needs to closely work with the MOF/Treasury so that the budgetary commitments are fully honored and the financial resources are made available to the NHIF to honor its contract obligations with providers and third-party intermediaries. This is a critical matter if contracting is to properly work as the vehicle for mobilizing financial resources in exchange for health care good and services. It cannot be acceptable, as it is today, that contracts signed by NHIF contain a *Force Majeure* clause exempting the NHIF of responsibility in case of incomplete disbursement of State funds that precludes the NHIF from honoring its contracts.

The NHIF, a semi independent entity under the control of the MoH should be established as principal agency responsible for the implementation of the SHI and a single purchaser of health services for the population. The MoH is proposed to chair the governing board of the NHIF. MoF, MoED, Ministry of tax Revenues and possibly representatives of professional associations (medical association), major employers and trade unions will be represented on the Board to ensure participation and transparency.

The key elements that require regulation in the establishment of NHIF functions are:

- the legal framework;
- benefits package and eligibility;
- prices paid to providers and manner of payment;
- budget;
- Quality of care.

These issues are discussed below.

Creation of Legal Framework for SHI

- Parliament approves changes, or adopts new Law on Mandatory Health Insurance (or Social Health Insurance)
- MoH develops policy and the Cabinet of Ministers approves legislation to establish NHIF and its functions, governance framework including the establishment of the NHIF Governing Board.
- MoH/MoF elaborates method of supervising NHIF activities.

Regulation of benefits package and eligibility

- NHIF Governing Board - approves the contents of the benefits package, eligibility and co-payment protocols that accord with the available resources
- Cabinet of Ministers – approves the benefits package and eligibility after consideration of the socio-political implications.

Regulating Prices and reimbursement methods

- Governing Board of the NHIF – approves a framework for provider payment, categorization of services and their prices.

Allocating NHIF Budget

- NHIF Governing Board approves the budget based on the outcomes of decisions with respect to benefits package, eligibility, co-payments and prices/
- Cabinet of Ministers sends NHIF budget to Parliament;
- Parliament approves NHIF budget.

Regulation of quality of care

- MoH promulgates policies related to good medical practice, appropriate care, provider licensing and accreditation.
- MoH develop evidence based practice guidelines and education programs.
- NHIF Governing Board includes quality of care issues among the conditions in the provider contract.

Monitoring NHIF Operations

In order to protect the interest of insured people, the Azerbaijan National Health Insurance Fund (NHIF) should be subject to regulation and supervision. This supervision should be provided by either the MOF or MOH. There should also be a supervisory role for the National Audit Office.

Supervisory functions should include:

- Ensuring that NHIF activities comply with the legal framework;
- Monitoring and analysis of NHIF activity for the preparation of annual reports and accounts;
- Audit of the NHIF's budget.

NHIF organisation

The NHIF will be established as a centralized structure with a head office in Baku and branch office network throughout the regions (one branch serving several rayons), with the staff consisting from 25 people at initial phase – year 1 and 2 (central office and small regional office for pilot regions). Gradually the staff of NHIF will be increased up to the 120-140 nationwide.

Main tasks of the NHIF central office:

- implementation of mandatory health insurance;
- managing the system of provider contracting;
- managing equity of access to the basic benefits package;
- managing the finances for the national social health system, including budgeting and reporting;
- development and management of provider payment models;
- management of the health information system;
- management of the regional branch network and reporting on branch performance.

Main tasks of regional branch offices

- advising NHIF central office on local conditions, with respect to health priority areas, socio-economic conditions and provider network;
- contracting with providers in the region and the administration of the contracts;
- monitoring the collection of contributions from the insured and their employers in the region;
- managing data inputs into the NHIF health information system;
- performance reporting to the central administration.

Budgeting and Performance

The basic national budget formula will be population-based and take into account population demographics, social need and prospective utilisation. The formula would consist of the following variables:

- population size;
- age structure;
- gender structure;
- health profile;
- health priorities.

The initial budget development process would involve the following steps:

- Estimation of the revenue available to NHIF from member contributions and government payments;
- Actuarial analysis of health service utilisation rates within the draft benefit package design;
- Costing of the benefits package according to the estimated service use and development of expenditure estimates for NHIF;
- Comparison of revenue and expenditure estimates and adjustment of variable elements such as benefits package entitlement or co-payment.

Although the branch offices would not directly manage the regional budgets, they would need to take steps to ensure that the funds allocated to their regions are spent as effectively as possible. The

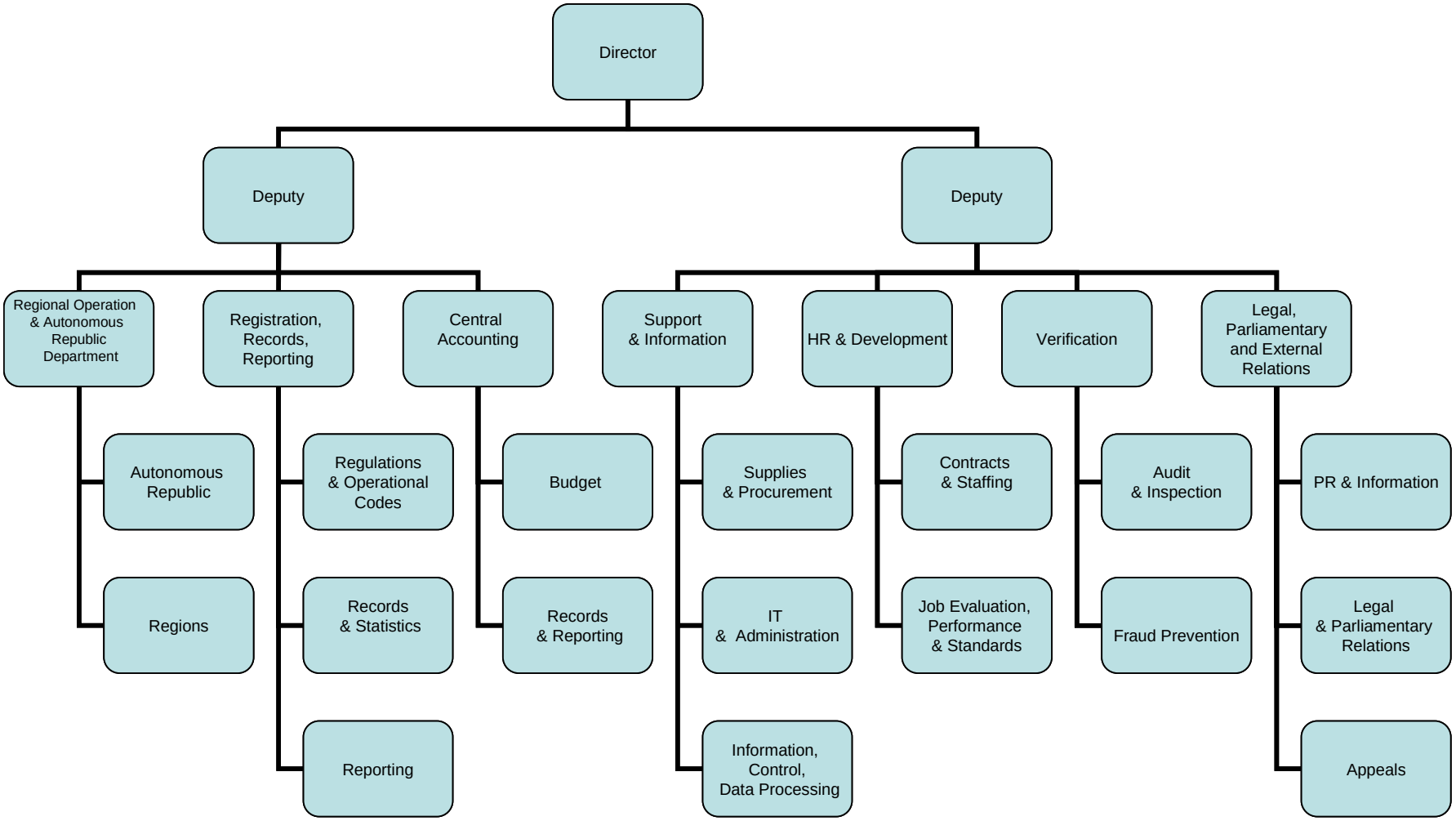
NHIF would monitor and benchmark the performance of the regional branch offices according to criteria such as:

- service expenditures compared to the needs of the population;
- overhead costs of branch office operations;
- percentage of the population who are registered in the Fund;
- customer satisfaction and responsiveness to member needs;
- contribution collection rate from salary earners and self-employed in their regions;
- numbers of provider contracts signed;
- primary care to specialist referral rates;
- Average Length of Stay (ALOS), utilisation and re-admission rates in hospitals;
- pharmaceutical utilisation related to approved guidelines;
- data accuracy and integrity;
- reported incidence of informal payments to providers;
- Immunisation rates and other preventative initiatives.

In order to provide incentives to continually improve system efficiency in their regions, the regional branch office executive would be paid bonuses that would be based on the performance score of their institutions.

Proposed organogram for NHIF is presented below.

National Health Insurance Fund Organogram



Annex III. Provider Payment Methodologies

General Description of Payment Methodologies

Methodology 1

Definition:	Program financing
Typology:	Payment according to the volume of medical service
Conditional unit:	Nosologic standard
Payment category:	Retrospective
Mode of payment:	Directly to the provider by presenting the financial demand
Price-setting:	Tariffs fixed by purchaser
Foreign analogies:	DRG (Medicare)
Technological process:	I: Purchaser - state agency lays down[18] unified standards reflecting: a) tariffs of medical services according to diagnosis, b) specification of medical intervention[19] according to diagnosis (service volume and type), c) tariff of each medical intervention; II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs; III: The provider submits at fixed intervals to the respective state financial institute an invoice[20] (receipt) reflecting the cost of the medical services provided under the program with reference to the diagnosis and corresponding standard cost; IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed at the standard-prescribed tariff irrespective of the volume of the medical intervention actually performed by the provider. V: The invoice presented may be verified by the purchaser.

Methodology 2[21]

Definition:	Conditional standards (case payment model with an agreed protocol of diagnostic and therapeutic procedures)
Typology:	Payment according to the volume of medical service
Conditional unit:	Aggregated Medical Economic Standard
Payment category:	Retrospective
Mode of payment:	Directly to the provider by presenting the financial request
Price-setting principle:	Tariffs set by purchaser's (by fixing the ceiling)
Foreign analogies:	DRG (Medicaid&Blue Cross)
Technological process:	I: Purchaser - state agency lays down[22] aggregated standards reflecting: a) tariffs of medical services according to groups of diagnosis and medical conditions, b) specification of medical

[18] *through a panel of hired experts*
[19] including treatment with medications
[20] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*
[21] *Currently applied payment system*
[22] *through a panel of hired experts*

intervention[23] according to diagnosis (service volume, type and complexity);
II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs;
III: The provider submits at fixed intervals to the respective state financial institute an invoice[24] (receipt) reflecting the cost of the medical service provided under the program financing with reference to the diagnosis and the list of medical interventions and costs provided by the standard;
IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed within the standard-prescribed tariff according to the volume of work actually performed by the provider. The costs of medical interventions performed beyond the standard is not covered. The cost of unused medical intervention is deducted from the amount prescribed by the tariff[25].
V: The invoice presented may be verified by the purchaser

Methodology 3

Definition:	Payment according to bed-days
Typology:	Payment according to the volume of medical service
Conditional unit:	Bed-day according to profile
Payment category:	Retrospective
Conditional unit:	Nosologic standard
Mode of payment:	Directly to the provider by presenting the financial demand
Foreign analogies:	Holland-budget nursing homes (partly France)
Technological process:	I: Purchaser - state agency lays down[26] unified standards reflecting according to *profile*: a) allowable quantity of bed-days, b) bed-day tariffs; II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs; III: The provider submits at fixed intervals to the respective state financial institute an invoice[27] (receipt) reflecting the cost of the medical services provided under the program financing with reference to the medical *service profile* and *number of actually spent bed-days* provided by the standard; IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed within the standard-prescribed tariff according to the volume of work - *number of bed-days* - actually performed by the provider. The cost of medical intervention *(bed-days)* performed beyond the standard is not covered. V: The invoice presented may be verified by the purchaser.

[23] including treatment with medications
[24] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*
[25] *from the total cost prescribed by the tariff.*
[26] *through a panel of experts*
[27] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*

Methodology 4

Definition:	Global budget
Typology:	Fixed annual financial limit
Conditional unit of service volume:	Profile and capacity (number of bed-days or number of registered patients, logistical base, staff schedule, etc).
Payment category:	Subsidy (federal or federal+local budget)
Mode of payment:	Periodic supply of amounts fixed beforehand
Price-setting principle:	Historical or functional
Foreign analogies:	FSU, Veterans' System in the USA, Kaiser Permanente in the USA, Great Britain, Canada
Technological process:	I: Purchaser - state agency forms[28] according to profiles a sectoral budget within the program financing to reflect: according to profile expected *demand* for medical services and required *capacities*. II. Out of the accredited health care providers the purchaser selects (according to competition, as a rule) the health care institutions that together provide the profile-needed capacity and ensure, within the allocated resources, medical service prescribed by the *quality standard* in the accounting period. III: Global budget is drawn up at the beginning of the financial year at prescribed intervals independent from the volume of actually performed work or capacity[29] IV: At the end of the year (or at fixed intervals) the provider presents full statistical and financial report to negotiate on budget for the next financial cycle. Budgeting is made by the so-called *historical or functional* method. V: The need for the purchaser to perform auditing-control is minimal in the accounting period.

[28] *through a panel of experts*

[29] *Some models envisage a selected version: the budgeting relevant to the necessary minimum capacity merged with additional capacity financing at the final stages of the accounting period or payment for each so-called extra-plan service by the case-based system.*

Brief description of the payment methodologies

	Methodology 1	*Methodology 2*	*Methodology 3*	*Methodology 4*
Definition	Program financing	Conditional standards	Payment according to bed-days	Global budget
Typology	Payment according to the volume of medical services performed	Payment according to the volume of medical services performed	Payment according to the volume of medical services performed	Fixed annual financial limit
Conditional payment unit	Diagnosis (standard)	De-facto performed work envisaged by diagnosis (by standard) (sum≤standard)	Bed-day according to profile	Profile and capacity (number of beds or number of registered patients, logistical base, etc)
Payment category	Retrospective	Retrospective	Retrospective	Subsidy (federal or federal+local)
Payment mode	Directly to the provider after the invoice specifying the diagnosis has been presented	Directly to the provider after the invoice specifying the diagnosis and volume of performed work has been presented	Directly to the provider after the invoice specifying the profile and number of bed-days has been presented	Periodic provision of the sums of fixed amount
Price-setting principle	Purchaser's standards (fixed)	Purchaser's standards (semi-fixed)	Purchaser's standards (according to profile)	Historical or functional
Foreign analogues	DRG (Medicare, USA)	Medicaid& Blue Cross	Holland	FSU, Veterans' System in the USA, Great Britain, Canada

Essential features of the Global Budget payment method to providers

The global budget principle for health care institutions/providers is the procedure for the funding of the pre-agreed amount of work according to duly approved state standards, tariffs, rates, and control indices.

- ***Global Budget Calculation***

Taking into account the state program and the specific provider participating in it, the global budget is calculated in accordance with:

- ✓ the annual estimated volume of the performed health care service according to nosologies under the program;
- ✓ the average cost (complexity index) of a medical case calculated at the state health care service standards and tariffs prescribed by the nosology code.

At the same time, the total estimated number of bed/days and the average cost of bed/day determined according to the state health care service standards are also used as the controlling parameter of the global budget.

The production within the state program (the annual number of cases according to nosologies) are calculated by comparison of the expert appraisals of the expected annual number of cases according to nosologies with the actually production for the last two years, - with the number of the same nosologies carried out by the institution participating in the program according to the country, region and particular provider.

The controlling parameters of the estimated budget of the program (provider) are:

- the average price of the medical case;
- the average cost of bed/day.

Itemization of the global state program budget is made according to the economic classifier. The controlling indices for financial and resource items for the particular state program (institution) are:

1. Percentage ratio (%) of direct expenses to total expenses:
   including:
   - the salaries – (% of the total expenses) for direct and indirect personnel;
   - pharmaceuticals and other medical items - %;
   - lab and instrumental tests - %.
2. Percentage ratio of indirect expenses to total expenses (%).
3. The number of general medical personnel (physicians, assisting personnel and attendants) participating in the program shall be determined according to the particular program and institution in accordance with the normative rates determined by the state standards and the standard rates of the medical personnel workload.
4. The minimal and average wages of the general medical personnel shall be determined in accordance with the normative rates by the state standards and the standard rates of workload of the medical personnel.

Indices 3 and 4 are duly determined and approved within the state health program. For particular health care institution/providers the same indices are determined in the contract made with the State Health Insurance Company according to the controlling indices determined by the appropriate program and against the specific functions of the particular health care institution/provider.

Primary Healthcare Strengthening Project: Trip Report on the Study Tour to Estonia

October 9, 2006

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in collaboration with:
Abt Associates, Inc.
Curatio International Foundation
Johns Hopkins University/Center for Communication Programs

1. Summary

During the period 25 September 2006 through 29 September 2006, the PHC Strengthening Project, in cooperation with the World Health Organization (WHO) and the World Bank, escorted a Study Tour Team from Azerbaijan to the Republic of Estonia, in order to examine Estonia's system of health financing and its General Practitioner-based system of primary health care. Dr. Jarno Habict, head of the WHO Country Office in Estonia, prepared the program and accompanied the Study Tour throughout; in addition, the WHO Country Office in Estonia assisted the Azerbaijan delegation to obtain the necessary visas. Dr. Enis Baris, World Bank Task Manager for the Azerbaijan Health Sector Reform Project, participated in the Study Tour as an observer. Dr. Peter Hauslohner, Chief of Party of the PHC Strengthening Project, defined the goals of the Study Tour, assisted the design of the program, and accompanied the Azerbaijani delegation.

2. Background

The PHC Strengthening Project provides technical assistance to the Government of Azerbaijan in a collaborative effort to strengthen the country's primary healthcare (PHC) system. Because fundamental reform of the hospital- and specialist-centered health system inherited from the Soviet Union is still in its early stages, the project concentrates on assisting the government in the development of major national-level health policy and financing changes, while simultaneously supporting the government's efforts to test new approaches to the organization, financing, delivery and quality assurance of primary healthcare services in selected districts that will serve as pilot demonstration sites. The PHC Strengthening Project is implemented by a consortium of organizations led by International Medical Corps (IMC), together with Abt Associates, Inc., Curatio International Foundation, and the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs.

Since the Project began on 1 September 2005, the health policy environment in Azerbaijan has changed dramatically. In October 2005, the long-serving incumbent Minister of Health, Dr. Ali Insanov, was replaced and arrested; his successor, Dr. Oktay Shiraliyev, has on numerous occasions during the past 11 months voiced strong public support for far-reaching, comprehensive reforms of the health system, in particular the system of healthcare financing. In addition, during the first half of 2006 the MoH and the World Bank successfully developed a new, 6-year $86.5 million Health Sector Reform Project (HSRP) project, which is to be financed partly by a $50 million loan from the World Bank; the new loan was officially approved by the World Bank Board of Directors on 29 June 2006 and is expected to become "effective" in the fall of 2006. In response to requests for assistance from the MOH and World Bank, the PHC Strengthening Project played a major role in the preparation of the HSRP. Two of the principal goals of the HSRP are: (1) to prepare and implement a fundamental reform of the system of health system financing in Azerbaijan, including the introduction of mandatory social health insurance, which will lead to substantial increases in public funding for health and for PHC in particular; and (2) to develop and implement in five pilot regions fundamentally new district healthcare systems that strengthen dramatically the role of primary healthcare services—systems that, if successful, will subsequently be "rolled out" to the rest of the country.

In late May 2006, in preparation for implementation of the HSRP, the Azerbaijan Council of Ministers established an inter-ministerial steering commission, the Coordination Council (CC), chaired by the Minister of Health and including 5 deputy ministers (Finance, Economic Development, Justice, Labor and Social Protection, and the National Social Protection Fund). The CC was tasked with the development of proposals to the Cabinet of Ministers on needed measures: to improve the quality of health care; to institute structural reforms of the health system, aimed in particular at strengthening primary health care services; and to carry out comprehensive reform of the health financing system by implementing compulsory social health insurance.

At the invitation of the MoH, the PHC Strengthening Project has provided intensive technical assistance to the CC. In early July, the Project presented to the CC's technical working group a detailed Draft Program for comprehensive health financing reform, which was co-authored by the Project and F. Mehtiyev, director of the Project Implementation Unit (PIU) in the MoH for the HSRP. The Project anticipates that a draft national program for health financing reform will be presented to the Cabinet of Ministers by the end of 2006. If adopted by the Cabinet of Ministers, this program will commit the Government of Azerbaijan to a series of principles for health financing reform (e.g. pooling of funds, separation of the pooling of funds from the purchasing of services, payment of service providers on the basis of outputs and performance), as well as specific health policy goals, targets, and procedures, including: continued annual increases in budgetary support for health from $20 *per capita* in 2006 to $100 *per capita* by 2011 (in constant prices); substantial increases in capital support for rebuilding the healthcare infrastructure (up to $1.2 billion over the next 5 years); creation of a "single payer" national insurance fund that will eventually pool all budgetary, non-budgetary, and mandatory insurance contributions collected by the state and allocated to healthcare; full separation of the revenue mobilization and service purchasing functions; and the introduction of fundamentally new methods of funding health services providers (hospitals, clinics, physicians), based on performance and effectiveness.

Also in May 2006, the MoH requested the PHC Strengthening Project to suggest one or more "transition" countries that have implemented successfully health financing reform, which a small, senior Azerbaijani delegation might visit in order to learn more about mandatory social health insurance. After further discussion, the MoH agreed to support a Study Tour to Estonia that would be composed of the Minister of Health, the Minister of Finance (or his deputy), and the PIU Director. Subsequently, the PHC Strengthening Project requested assistance in organizing a program from Dr. Jarno Habict, head of the WHO Country Office in Estonia. Dr. Habict had earlier in 2006 spent a month in Baku as Acting Head of the WHO Country Office in Azerbaijan, during which time he met with USAID/Baku and the PHC Strengthening Project. Initially, the Study Tour was scheduled for late June 2006, but due to logistics problems it was subsequently rescheduled for late September 2006.

3. Objectives of the Study Tour

During preliminary discussions with the MoH and WHO, the following overarching objective of the Study Tour was defined: to familiarize senior health and finance officials from Azerbaijan with Estonia's experience in transforming its health system following independence from the former Soviet Union, with particular emphasis on

health financing and primary care reform. Estonia is widely regarded as the most successful of the former Soviet Union republics, in terms both of the fundamental changes made in health system organization and financing and in the relative effectiveness of those reforms as measured by such things as access to services, the relative rarity of informal payments, and key health status indictors (Estonia's infant mortality rate is among the lowest in Europe).

In addition, the following more specific objectives were defined:

1. The learn about the essential features and major advantages and weaknesses of Estonia's social health insurance system.
2. To understand the roles played by key government bodies in financing and regulating health care services, including the Ministry of Health, the Ministry of Finance, the Health Insurance Fund, and other government agencies.
3. To understand the roles and responsibilities of local governments, with respect to the organization and financing of health care services, in particular the provision of primary health care services.
4. To learn about the structure and major functions of the Health Insurance Fund.
5. To learn about the main contracting and payment methods used to fund providers of hospital and primary health care services.
6. To understand the main features and advantages and disadvantages of Estonia's General Practitioner-based primary care system, compared to the polyclinic-based model that was common in the Soviet era.
7. To learn about the education and training of General Practitioners, as well as the main legal and institutional foundations of General Practice in Estonia.
8. To understand the strategy that Estonian leaders employed in restructuring the health system inherited from the Soviet Union, including the major obstacles to effective implementation of the new policies and the measures taken to overcome those obstacles.
9. To identify any lessons learned in Estonia that may be applicable to Azerbaijan's circumstances, so that Azerbaijan may benefit in the design and implementation of its own system of mandatory social health insurance, as envisioned in the draft national program for health financing reform.

The Study Tour consisted of three Azerbaijani officials:

1. the Minister of Health, Dr. Oktay Shiraliyev;
2. the Deputy Minister of Finance (for insurance), Mr. Azer Bayramov; and
3. the director of the PIU for the HSRP, Dr. Farhad Mehtiyev.

Dr. Hauslohner, Chief of Party for the PHC Strengthening Project, accompanied the group which was joined in Estonia by Dr. Enis Baris, Task Manager for the HSRP from the World Bank, and by Dr. Jarno Habict, head of the WHO Country Office in Estonia.

4. Study Tour Background Documents

During preparation of the Study Tour, the PHC Strengthening Project identified several key publications providing in-depth background information regarding Estonia's health care system, in particular its system of financing. These publications

were translated into Russian and provided to each member of the Study Tour delegation several weeks prior to the group's departure:

1. Atun, Rifat et al., "Introducing a complex health innovation—Primary health care reforms in Estonia (multimethods evaluation), Health Policy, Vol. 79 (2006), pp. 79-91.
2. Couffinhal, Agnes and Triin Habict, Health system financing in Estonia: situation and challenges in 2005 (Copenhagen: World Health Organization Regional Office for Europe).
3. Koppel, Agris et al., "Evaluation of primary health care reform in Estonia," Social Science and Medicine, Vol. 56 (2003), pp. 2461-66.

In addition, upon arrival of the delegation in Tallinn, each member of the Study Tour received a briefing book prepared by the WHO Country Office in Estonia, including English-language copies of the presentations to be delivered during the program. The briefing book also included English-language copies of the first two documents listed above; and the Russian-language version of the latest European Observatory *Health Systems in Transition* volume on the health care system in Estonia. Following the Study Tour, the WHO Country Office in Tallinn agreed to provide Russian language translations of the presentations. Both the articles provided to delegation members before their departure from Baku and the briefing book prepared by WHO are appended to this Trip Report.

5. Meetings and Activities

The following table provides details of the briefings and meetings included in the program:

Monday 25/09	Tuesday 26/09	Wednesday 27/09	Thursday 28/09	Friday 29/09
Arrival 13.00 bus @airport	9.00-9.30 **Overview of the programme and topics covered** Jarno Habicht 9.30-13.00 **Estonian health system. Presentations and discussion with special emphasis to health care reforms starting from early 90s** Maris Jesse *Venue: SAS Radisson*	9.00-10.30 **The health care and health financing reforms during nineties – view from Minister and politician** Eiki Nestor *Venue: SAS Radisson* 10.30 bus @hotel 11.00-12.45 **Meeting with Ministry of Finance** Veiko Tali *Venue: Ministry of Finance*	8.45 bus @hotel 9.00-10.30 **Meeting with the management board** Arvi Vask *Venue: Estonian Health Insurance Fund* 10.30-13.00 **Health services planning and needs assessment, contracting service providers** Helvi Tarien *Venue: Estonian Health Insurance Fund*	08.30-09.30 **Experience with NHA in Estonia** Natalja Jedomskihh 12.00 bus transfer to airport (Shiraliyev, Bayramov)
	13.00 – 14.00 Lunch (SAS, Seasons)	13.00 – 14.00 Lunch (on own)	13.00 – 14.15 Lunch (Olümpia, Senso)	14.00 – 16.00 Lunch (On Own)
16.00-18.00 **Courtesy visit to Minister of Social Affairs** Jaak Aab, Peeter Laasik *Venue: Ministry of Social Affairs*	14.00 bus @hotel 14.30-16.00 **Visit to the hospital (East-Tallinn Central hospital) incl. diagnostic centre** Ralf Allikvee, Peeter Ross *Venue: East-Tallinn Central Hospital* 16.00 bus transfer 16.30-17.15 **Visit to the Viimsi PHC centre** Tiina Talijärv *Venue: Viimsi GP Centre* 17.15 bus to hotel		14.15 bus transfer 14.30-16.00 **The role of Health Care Board in Estonian Health System and licensing of professionals/institutions** Üllar Kaljumäe *Venue: Health Care Board* 16.00-17.00 **Meeting with the Society of Estonian Family Doctors** Madis Tiik *Venue: WHO Office* 17:00-18:00 **Wrap-up session with World Bank and WHO** *Venue: WHO Office* 18.00 bus to hotel	
18.00-20.30 **Dinner hosted by Minister of Social Affairs of Estonia**			19.00-21.30 **Dinner hosted by Minister of Health of Azerbaijan**	

6. Findings/Accomplishments

Each member of the Azerbaijan Study Tour praised the program and its execution and declared that they found the trip and the information presented to be "very useful."

All of the presentations, without exception, quickly became transformed into informal, direct, friendly, and substantive discussions back and forth between presenters and delegation members that typically lasted much longer than scheduled. The Azerbaijani delegation members asked numerous questions covering a very wide range of topics. Estonian presenters and officials were able and willing (with only one exception) to conduct the dialogue in Russian, which greatly facilitated the exchange and minimized the amount of lost information.

The Azerbaijani delegation members were chiefly interested in acquiring as much factual information possible on various topics, principally: organization and operations of the insurance fund; contracting procedures used with different providers; methods of setting prices for services; the organization, financing, and provision of essential pharmaceuticals; and the training of General Practitioners (more commonly called "family doctors").

In the course of the discussions, it became apparent that members of the Azerbaijani delegation are concerned with a number of key problems, both technical and political in nature. These questions were, chiefly:

- the fate of medical personnel made redundant by the closure and/or merging of hospitals and other providers, and policies and programs to minimize the impact of such redundancy;
- the reliability of various methods used to determine contract prices for services;
- policies and mechanisms for determining the number and location of General Practitioners; and
- the ways in which the knowledge and skills of General Practitioners are different from those of area therapists and pediatricians in the old Soviet polyclinic system. [With respect to this last issue, Azerbaijani delegation members tended to focus on the training of GPs, and paid less attention to the ways in which the actual practice of family medicine in Estonia may differ from the way medicine was practiced in the Semashko system.]

7. Next Steps

During a wrap-up meeting with WHO and the World Bank, Azerbaijani delegation members identified several key next steps in the further development of Azerbaijani's health financing reform.

1. <u>Review of legislation and preparation of a Presidential order (ukaz).</u> Delegation members acknowledged that numerous changes in existing Azerbaijani legislation and governmental regulations would be necessary in order to permit many of the essential features of the health financing reform (and other, related reforms such as the development of family medicine) to be implemented. It was suggested that an expert group should be formed and tasked with developing a comprehensive

list of necessary changes; and that these changes should be included in a draft Presidential order that might be considered as early as November 2006.

2. Establishment of a national insurance fund. Delegation members supported the idea that an insurance fund should be established, which would pool all public funding for health, including mandatory social insurance contributions paid by employers and/or employees; and purchase healthcare services on behalf of the government. It was suggested that the necessary legal basis and organizational structure of this fund should be defined as quickly as possible; and that plans should be made to recruit and train needed staff.

3. Determination of the cost and/or contract prices of essential health care services. Delegation members agreed that an urgent priority is to determine the overall cost of the proposed health financing reform to the government, in particular the cost of providing a package of essential services to the population; and to develop a basis for establishing contract prices to be offered to service providers.

8. Persons Contacted

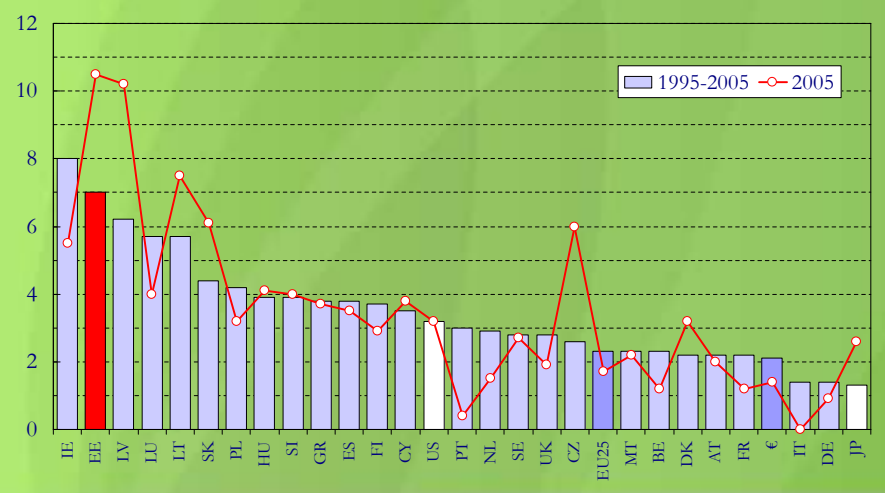
The following persons met with the Azerbaijan Study Tour in Tallinn:

1. Jaak Aab – Minister, Ministry of Social Affairs
2. Peeter Laasik – Assistant Minister, Ministry of Social Affairs
3. Ivi Normet – Deputy Secretary General on Health, Ministry of Social Affairs
4. Veiko Tali - Deputy Secretary General, Ministry of Finance
5. Arvi Vask – Member of the Management Board, Estonian Health Insurance Fund
6. Helvi Tarien – Head of Department Health Care Services Department, Estonian Health Insurance Fund
7. Üllar Kaljumäe – General Director, Health Care Board
8. Eiki Nestor – Member of Parliament (Former Minister of Social Affairs 1999-2002)
9. Tiina Talijärv – General Practitioner, Viimsi Family Medicine Centre
10. Ralf Allikvee – Chairman of Management Board, East-Tallinn Central Hospital
11. Peeter Ross – Director of Research and Development, East-Tallinn Central Hospital
12. Madis Tiik – Head of Estonian Association of Estonian Family Doctors
13. Natalja Jedomskihh – Analyst, Health Information and Analysis Department
14. Maris Jesse – Senior Health Specialist, World Bank (former Head of Estonian Health Insurance Fund 1997-2002)
15. Jarno Habicht – Head of Country Office, World Health Organization Regional Office for Europe

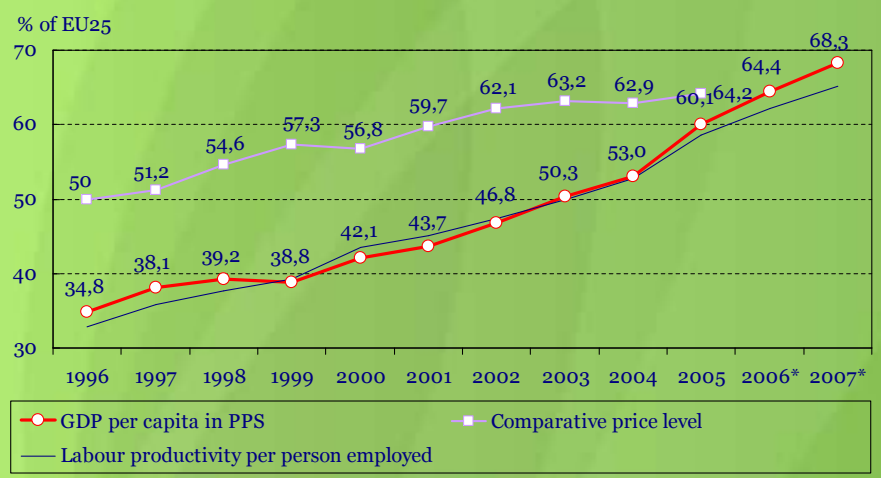
Main economic policy principles

- Currency board system
- Balanced government budget
- Liberal foreign trade policy combined with the maintenance of a favourable investment climate
- Structural reforms (privatisation, pension system)

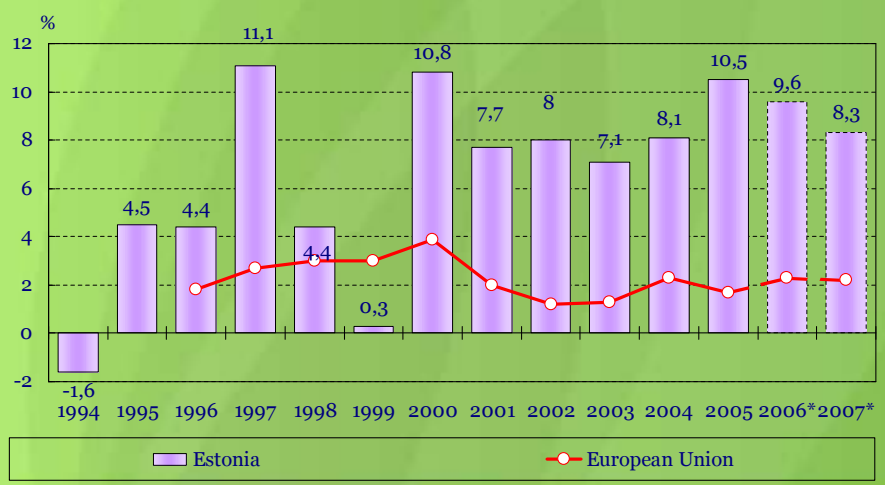
Average economic growth in 1995–2005



Estonian real convergence with the EU



Rapid economic growth



Highly valued economic environment

- High economic freedom.
  - 7th position in Heritage Foundation Economic Freedom Index for the year 2006.
- Competitive.
  - 20th in World Economic Forum's 2005–2006 Growth Competitiveness Index ranking.
  - 20th in IMD World Competitiveness Yearbook 2006 ranking.
- Not corrupted.
  - Least corrupted country in Eastern and Central Europe according to Transparency International's Corruption Perception Index.

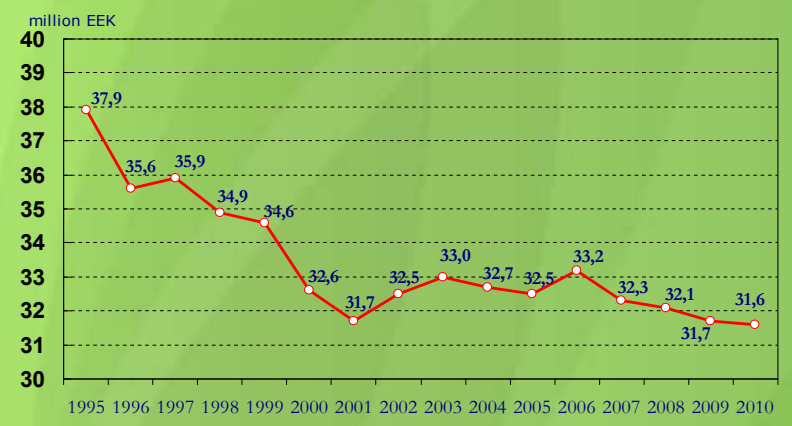
Fiscal policy

- General government budget will be kept in balance.
- Tax burden will be kept close to the 2003 level.
- Long-term sustainability of public finances.
- Euro adoption as soon as possible.

Main principles of tax policy

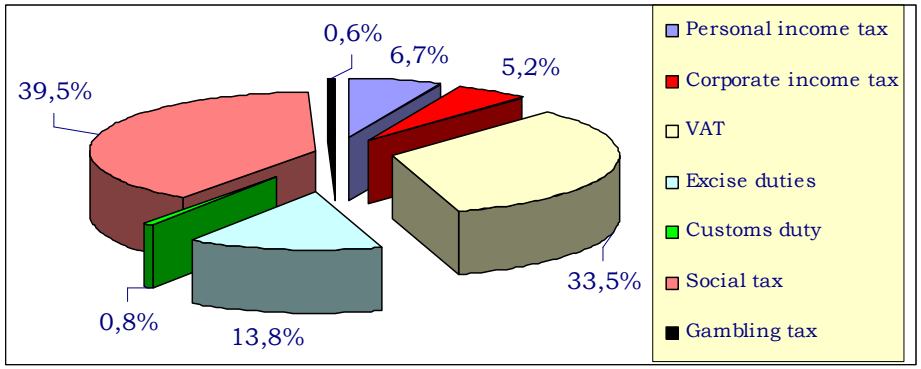
- Simple, transparent, stable and favourable (investments) tax system
- Moderate tax burden (decreasing)
- Broad tax base, low (flat) tax rates
- Low administrative cost for tax administrators and taxpayers

Tax burden (% of GDP)



Tax Revenue structure 2006

Total tax revenue **3 365 billion EUR**



Source: Ministry of Finance

Social tax (1)

Tax Base

- Employers' payments to natural persons (**wage income**) – tax payable by employers
  - ✓ in cash
  - ✓ in kind (fringe benefits)
- **Business income of sole proprietors** – tax payable by self employed persons

Social tax (2)

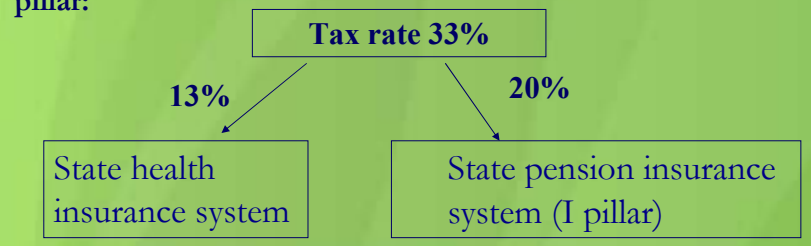
Period of taxation

- Calendar month for wage income
- Calendar year for business income of sole proprietors

Social tax (3)

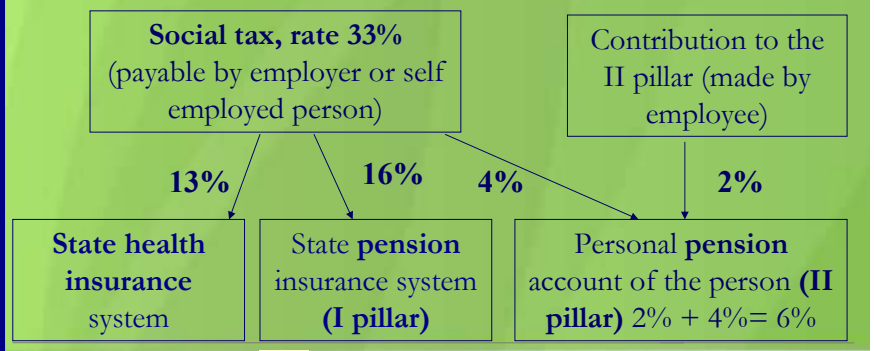
- Tax rate is **33 %** of the taxable amount
- Social tax payable is personificated and in making pension payments will be taken into account.

Tax allocation, if the person has NOT joined the II pension pillar:

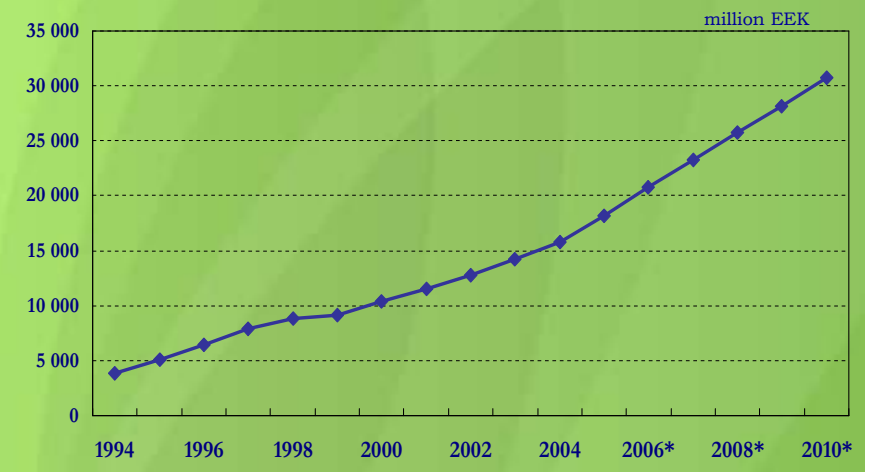


Social tax (4)

- **Tax allocation IF the person has joined the II pension pillar** (compulsory for the persons who have born in 1983 or later; voluntary for older people)



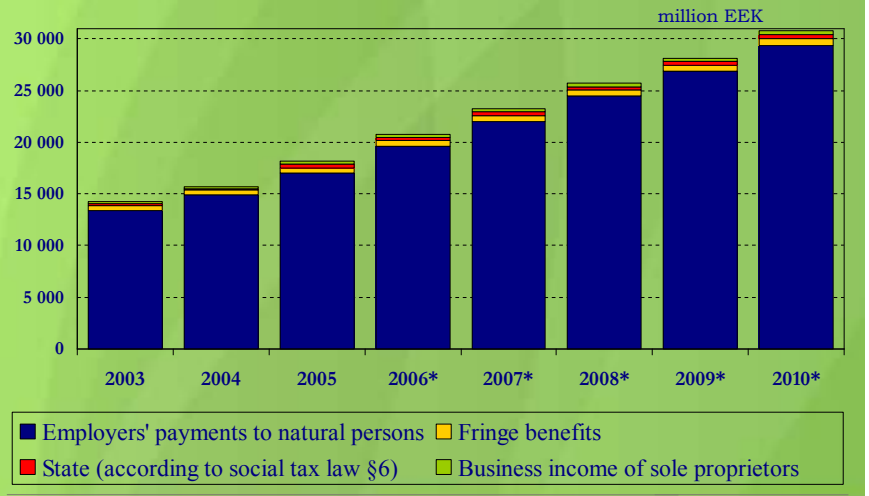
Social tax revenue 1994-2010



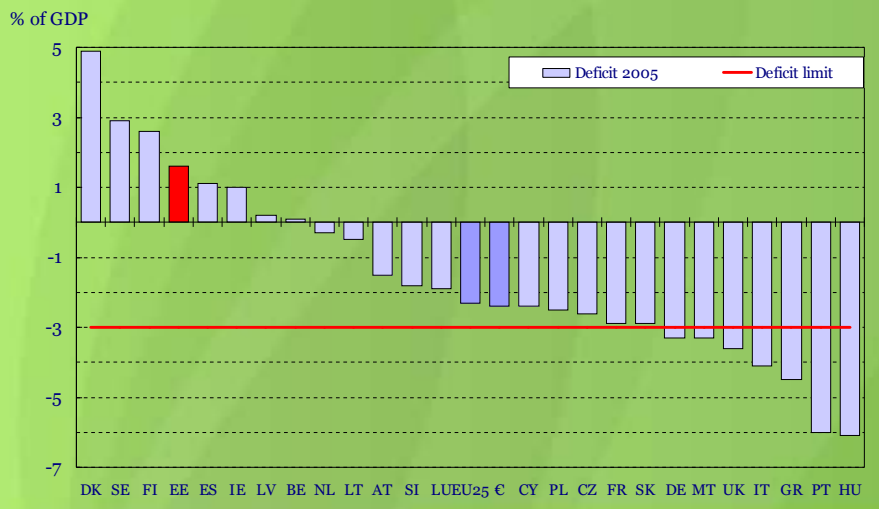
Main choices of tax policy

- Tax burden (incl. ? % of non-tax revenue)
- Fiscal or regulatory instrument (neutrality, revenue vs. impact to behaviour)
- Tax structure
  - Direct / indirect
  - Labour / capital / consumption
  - Redistribution effect

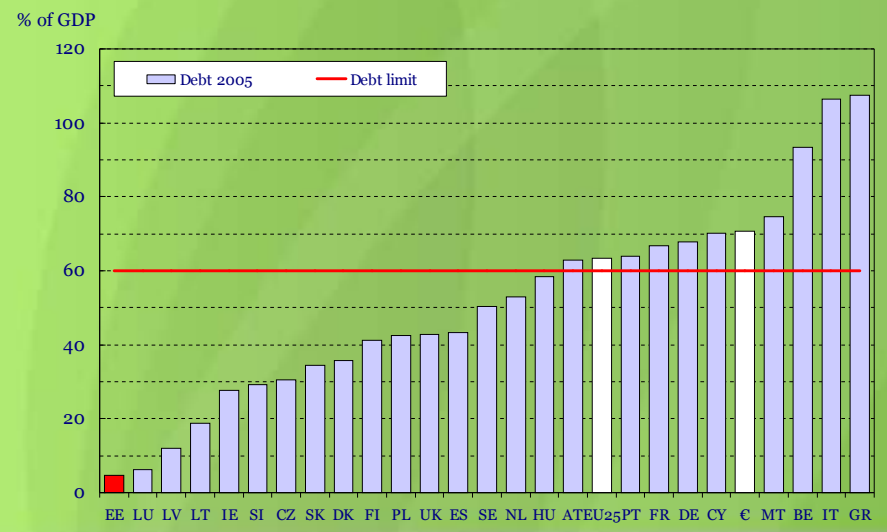
Structure of declared social tax 2003-2010



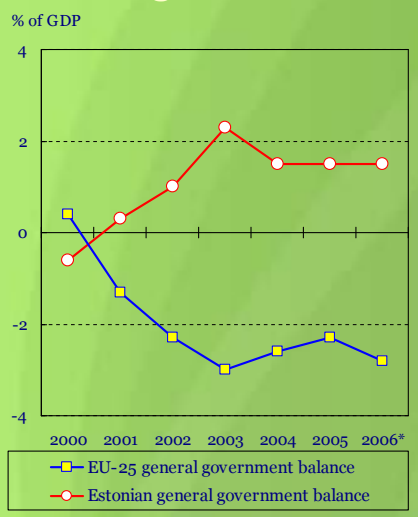
General government budget balance in 2005

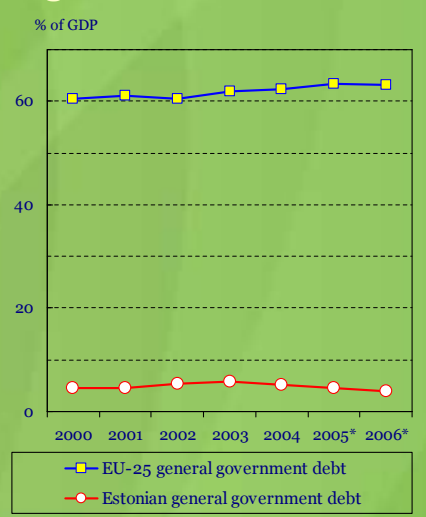


General government debt in 2005

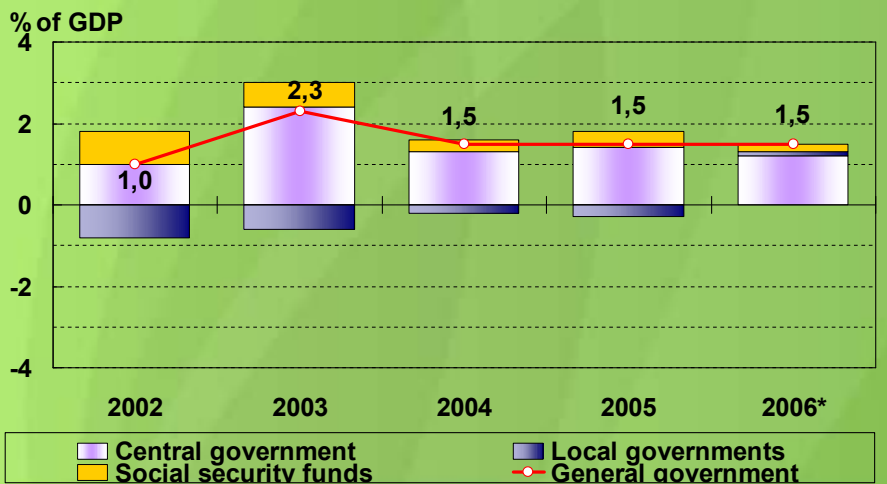


General government budget balance and debt

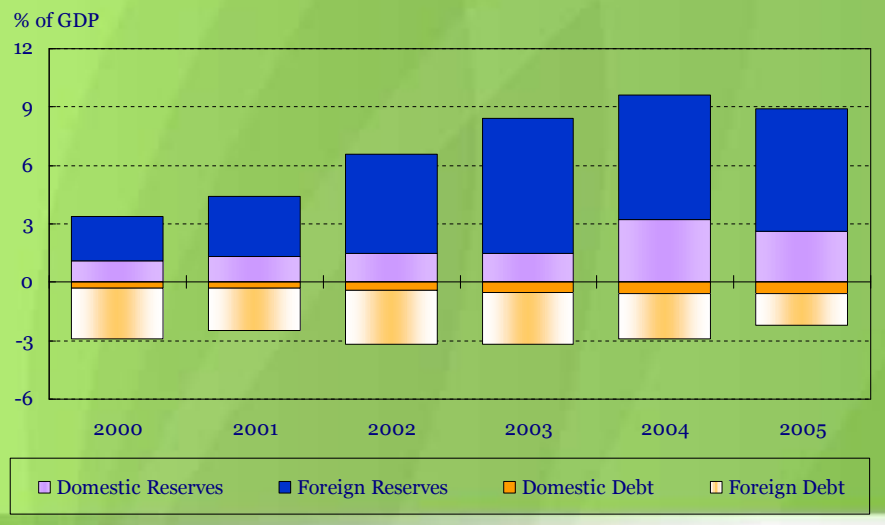




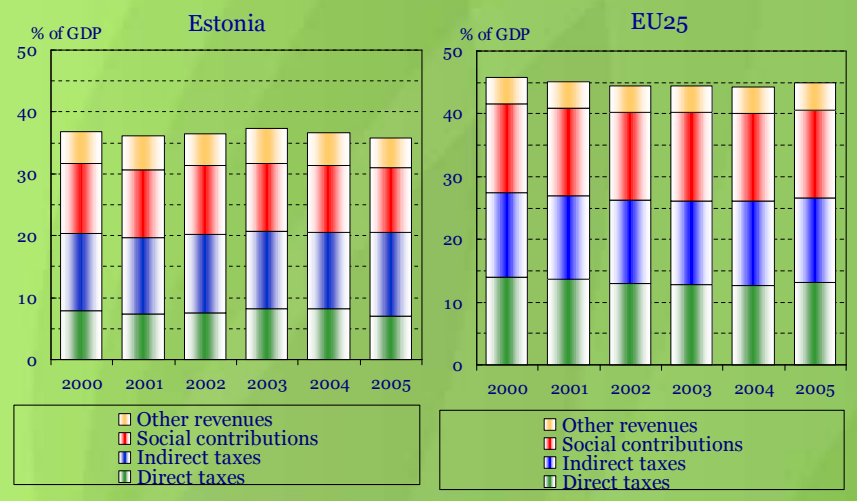
Estonian budget balance



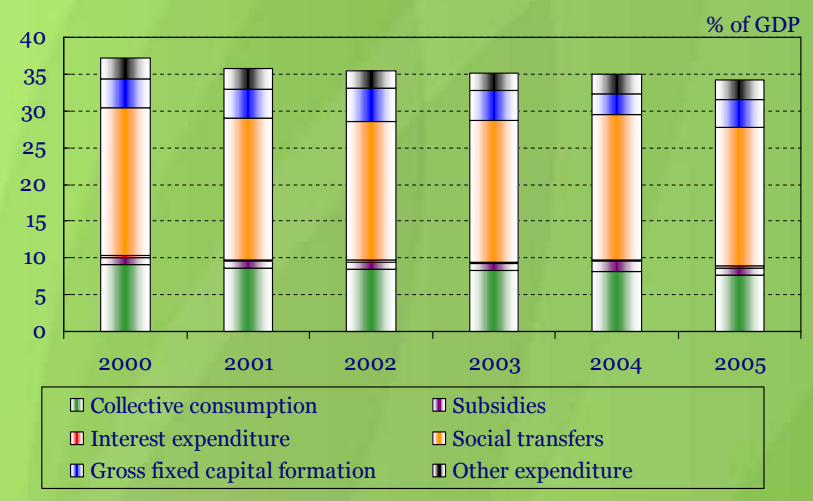
Central Government Debt and Reserves



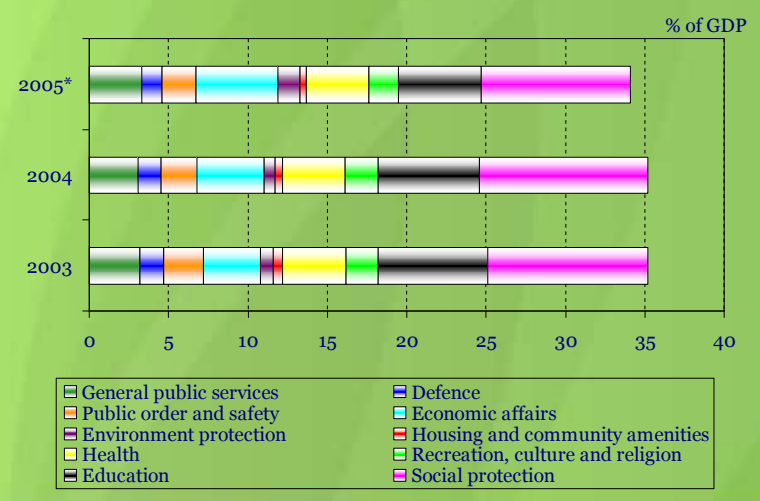
General Government Revenues



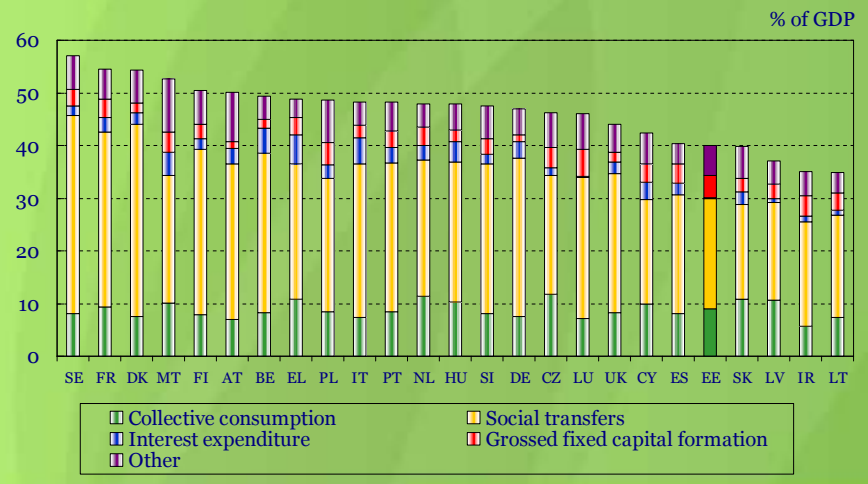
General Government Expenditure in Estonia



General Government Expenditure in Estonia



General Government Expenditure in EU member states in 2005



Annual State Budget Act

- Cash based
- According to administrative and economical classification
- Additional text paragraphs
- A sizable explanatory note

Budget Preparation Process

- The budgeting period is the following year + 3 years
- Budget year starts on the 1st of January and end on the 31 st of December
- Timetable is set by the Government

State Budget Strategy (SBS) in Estonia

- Based on State Budget Act since 2002
- 4-year rolling perspective
- Contains:
  - macro-economic analysis and forecast (inc. revenue forecast)
  - macro-economic and fiscal policy principles (strategy)
  - objectives and priorities of Government action
  - financial framework
- Includes **all** revenues, expenditure and financial transactions of ministries and constitutional institutions

SBS preparation: general framework

- Prepared by MoF in co-operation with other ministries
- Based on ministerial development plans and there-by the sectoral strategies
- Adopted by the government; by end of May the latest
- Forms the basis for yearly state budgets
- SBS 2007-2010 adopted in May 2006
- Volume: 334,9 bln EEK (21,4 bln EUR)

SBS preparation: ministerial inputs

- Based on the uniform methodology set forth in MoF letter
- Foundations: Organic Budget Law, strategic planning decree, last SBS, legislative and contractual commitments
- Ministries present their development plans and respective financial plans to MoF in March
- These inputs include requests for additional financing or activities (desired expenditure)

SBS preparation: MoF analysis

- MoF thoroughly analyses the ministerial inputs to prepare the SBS draft
- Emphasis on 2 aspects:
  - analysing the necessity and priority of actions: alignment with policies and strategies, with national developmental needs
  - analysing the soundness of financial requests: the cost evaluations
- Budget execution is later evaluated periodically during the preparations of yearly state budgets

SBS preparation: Cabinet decision-making

- MoF presents draft SBS with questions-to-be-solved and decision-points to the Cabinet
- This year, there were 2 Cabinet discussions of SBS + final adoption of the respectively corrected SBS
- Decisions are made on the overall budget; new policy proposals, additional requests for financing having additional focus
- Package of measures in SBS adds up to expenditure ceilings: additional priority list formed

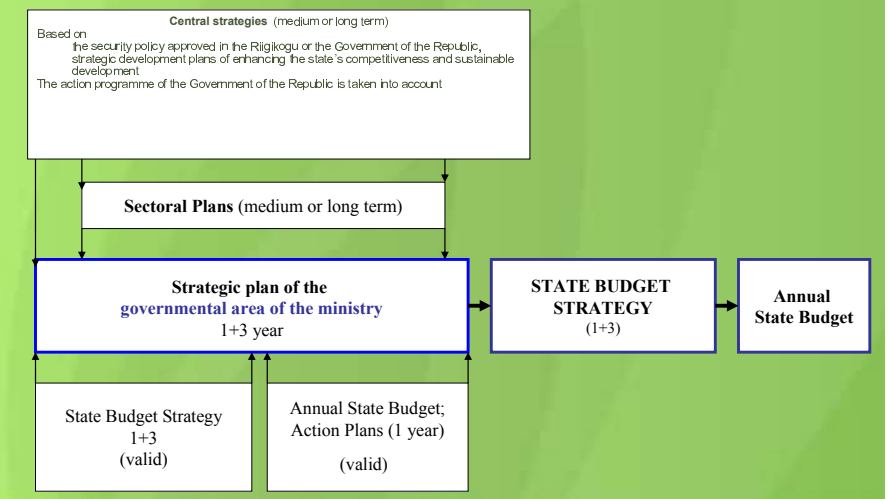
SBS preparation: yearly state budgets

- Expenditure ceilings set for ministerial responsibility areas
- Ministries present in June state budget requests – based on SBS, updating it upon need and including additional requests
- These will be reviewed by MoF and Cabinet based on updated macro-economic and fiscal revenue forecasts in August
- MoF presents to the first Cabinet discussion the differences between SBS and ministerial requests, Cabinet decides upon them
- Draft state budget by end of September

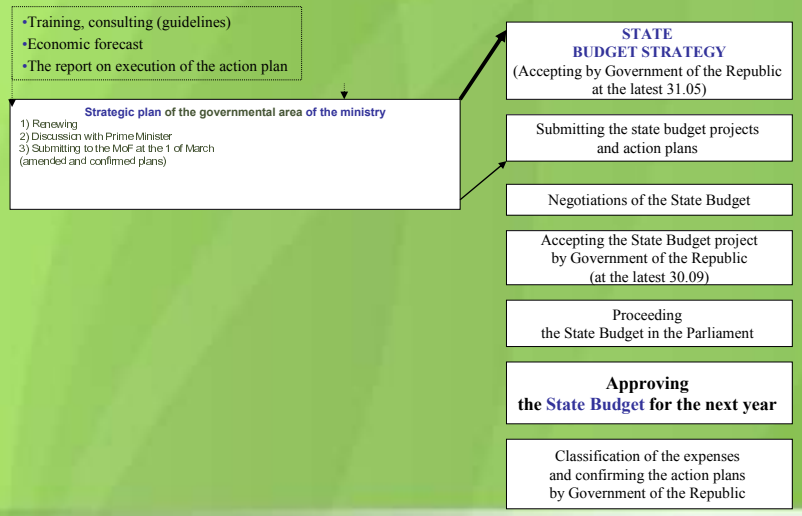
Latest developments in SBS preparation

- Planning of EU structural support fully integrated into SBS from now on
- SBS preparations in 2006 based on the Government decree of strategic planning: uniform regulative foundation
- negotiations on ministerial development plans were held between PM and other ministries in March 2006
- SBS fully adopted by the Government
- expenditure ceilings set in the SBS 2007-2010

Linkage between strategic planning and the budget process



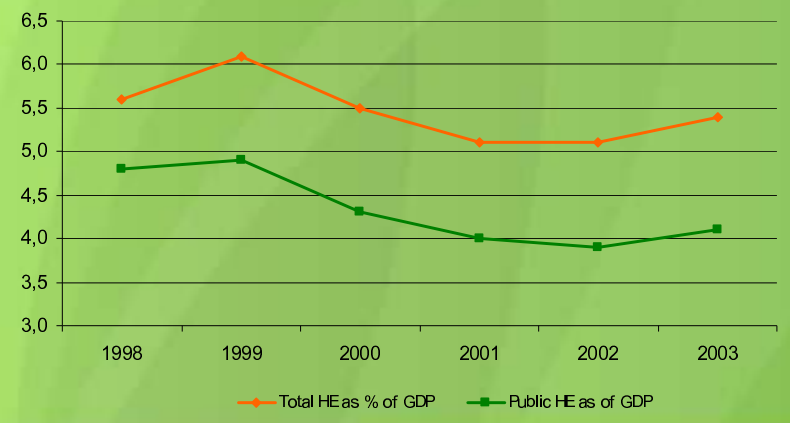
Linkage between ministries strategic plans and budget process



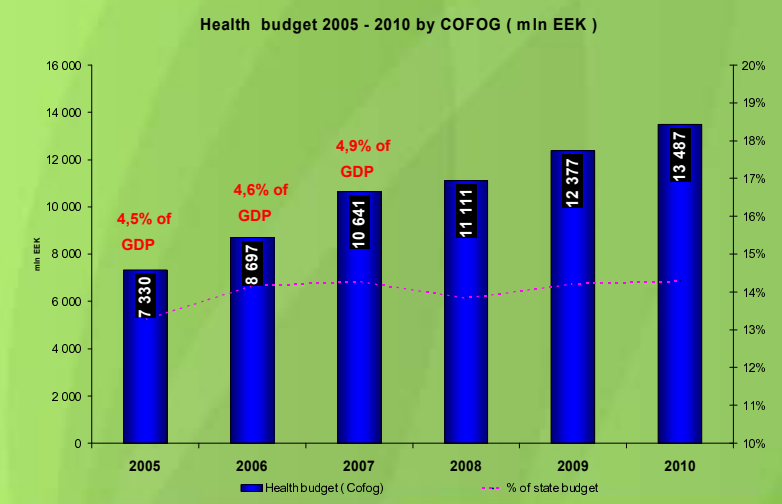
Budget process and timetable 2006

February	Budget Decree circulated to all budget agencies
March	Budget strategies and budget bids from line-ministries from line ministries (during March – spring economic forecast)
March-May	Development of State Budget Strategy in MoF
May	Approval of the State Budget Strategy in the Government
June - Sept	Development of State Budget in MoF (during August – summer economic forecast)
September	Approval of the state budget 2006 in the government
September	Presentation of the Act to the Parliament

Trends in health expenditure



Health care budget 2005 – 2010 by COFOG



Health care budgeting 2007

Health care budget 10 640 mln EEK for year 2007

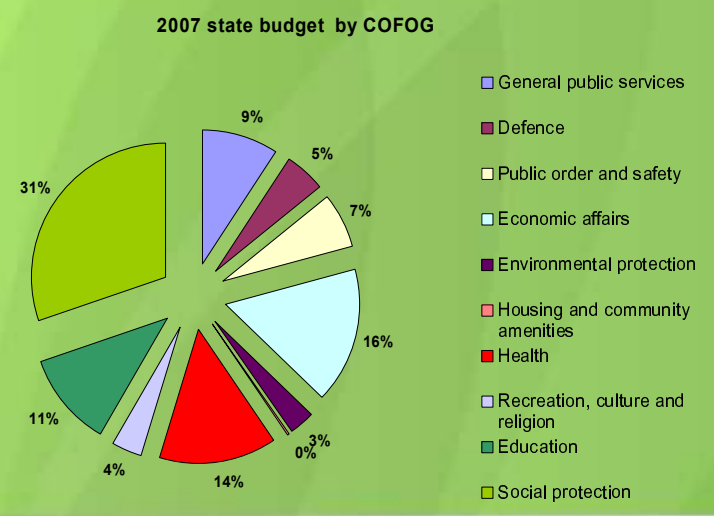
Ministry of Social Affairs 99,8 %

Estonian Health Insurance Fund	9 705
National Institute for Health Development	125
Medical aid for persons without health insurance	109
Investments for medicines	29
Investments for vaccines	21
State Agency of Medicines	19
The Estonian Genome Foundation	8

Ministry of Defence 0,2% (17 mln EEK)

By Estonian Health Insurance Fund (EHIF) Act Art 9, is Finance minister one of the EHIF Council members

State budget 2007 by COFOG



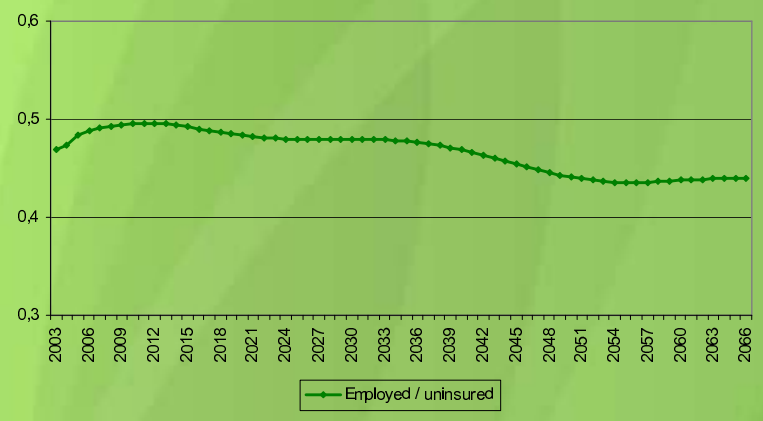
Development of Financial Management

- Development activities in MoF underway: to improve the state financial management system as a whole
- The development concept focuses on the following main aspects:
  - choice of planning and accounting principles (accrual vs. cash-based)
  - further development and implementation of medium-term planning
  - increasing objective- and result-orientation of financial management

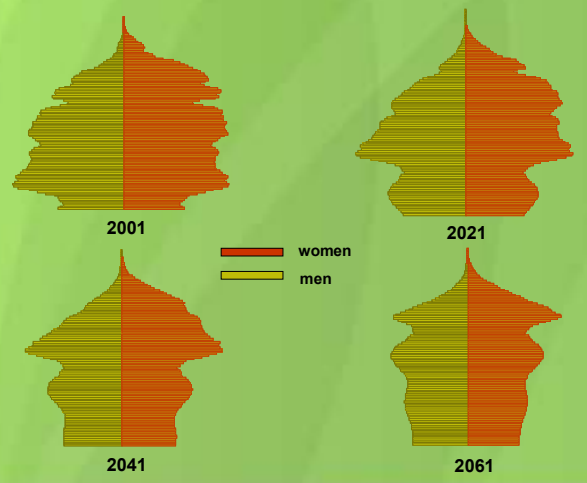
MODEL - Objectives and factors

- Sustainability
- Demographical impact
- Technology change
- Health care inflation
- Pharmaceutical development
- Reform effects

Demographic dependency ratio (projection)



Demographic development



MODEL - revenues

- Demographic projections (by age and gender)
- Labour force projections (by age and gender)
  - Employed
  - Unemployed
  - Inactive
- Inflation, productivity etc.

= Social tax (13%)

+ Other revenues (marginal)

MODEL - expenditure

- Disease prevention
- General medical care
- Specialized medical care
- Long term nursing care
- Dental care service benefits
- Health promotion
- Expenditure for benefits for temporary incapacity for work
- Medicinal products compensated for insured

Private medical insurance

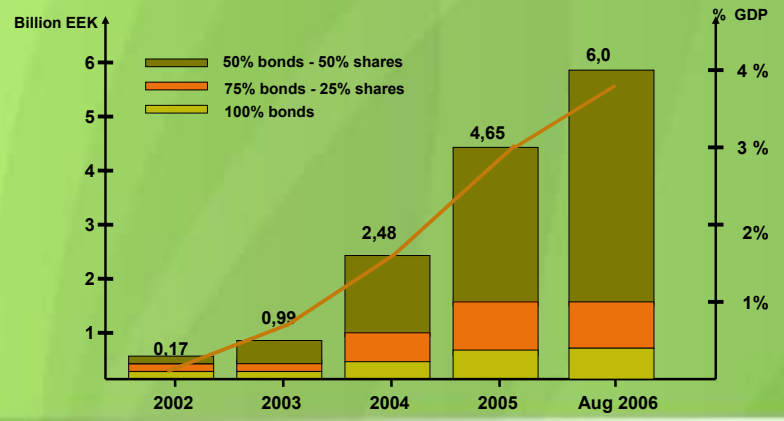
- Marginal importance
- Only one commercial insurer (from 2002)
- Basic insurance for uninsured people + additional options

+ Health care travel insurance

➢ Insurance of occupational accidents and diseases – under discussion

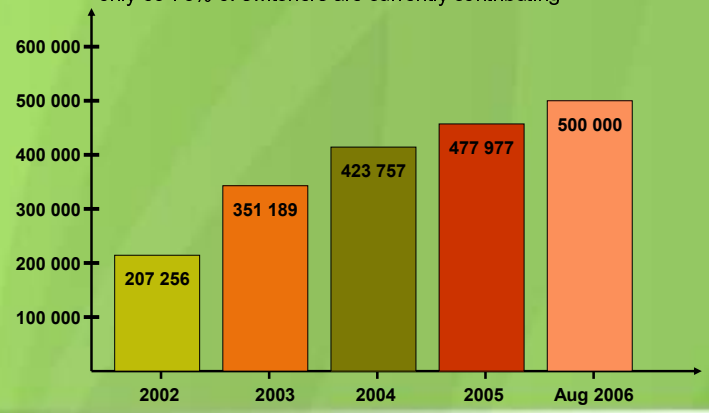
Penison reform – II pillar assets

- 21.08.2006 – 6,0 billion EEK (3,5% of GDP)



Pension reform - switchers

- 01.08.2006 – 499 825 switchers
- only 60-70% of switchers are currently contributing



Estonian experience: primary care and hospital reform

Maris Jesse, Senior health specialist,

The World Bank

Director of Estonian Health Insurance Fund 1997-2002

Home

Estonia

-Population 1 346 500 (2005)

-GDP per capita 8329.6 € (2004)

-ALE at birth 71.6 years (2003)

- Increasing from 1994 – 66.9 y

-Total Health Expenditure (2003)

- 5,4 % of GDP
- Per person € 323
- Public expenditure 75.5%
  - -Social health insurance 66%

-Ministry of Social Affairs

-Administratively 15 counties

-Local governments: 241

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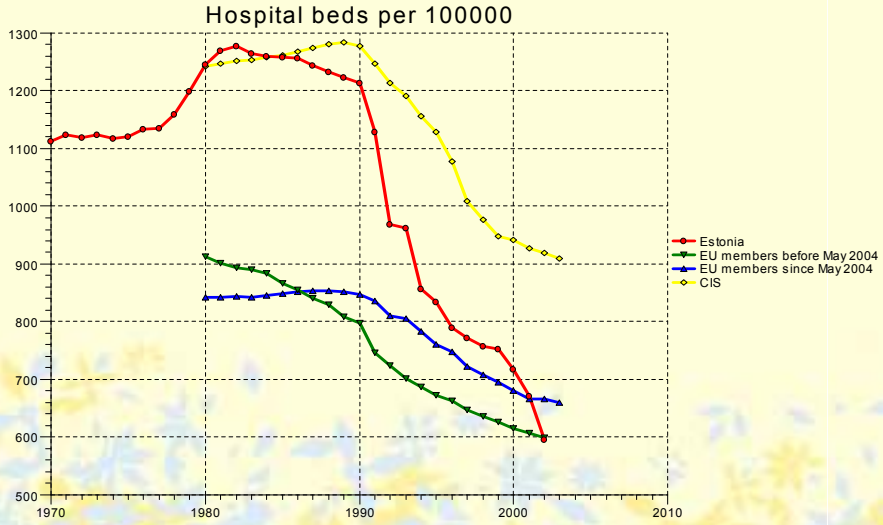
1990-2003: nr of hospital beds decreased by more than half



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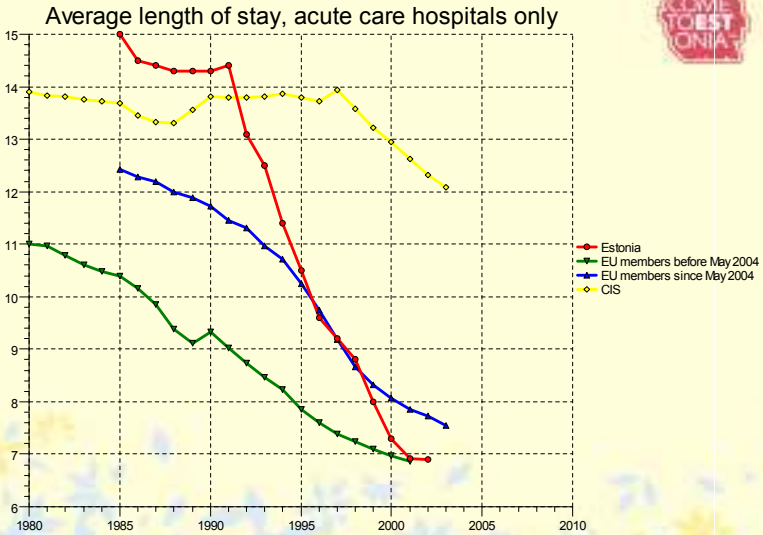

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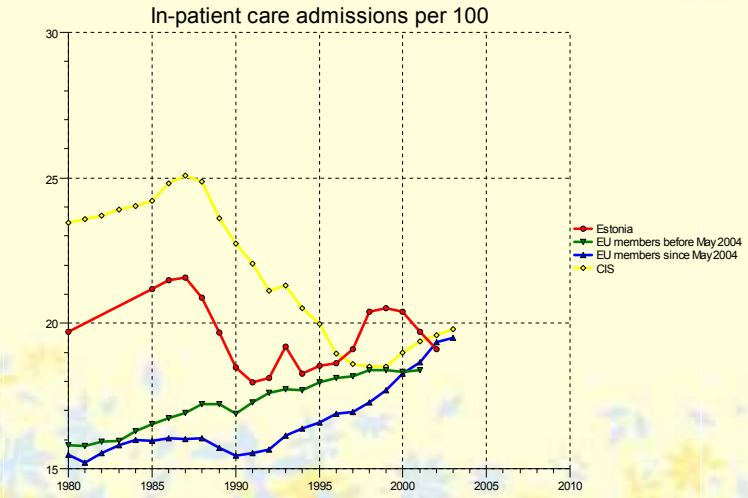

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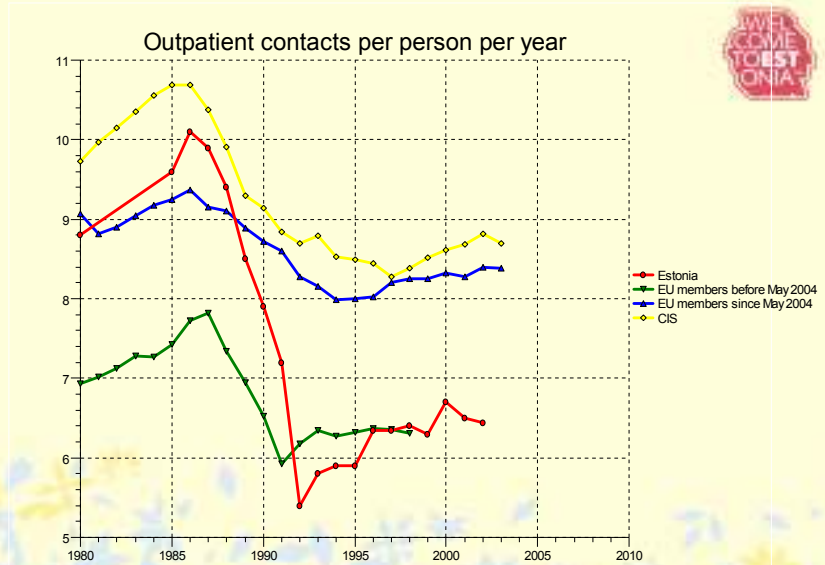

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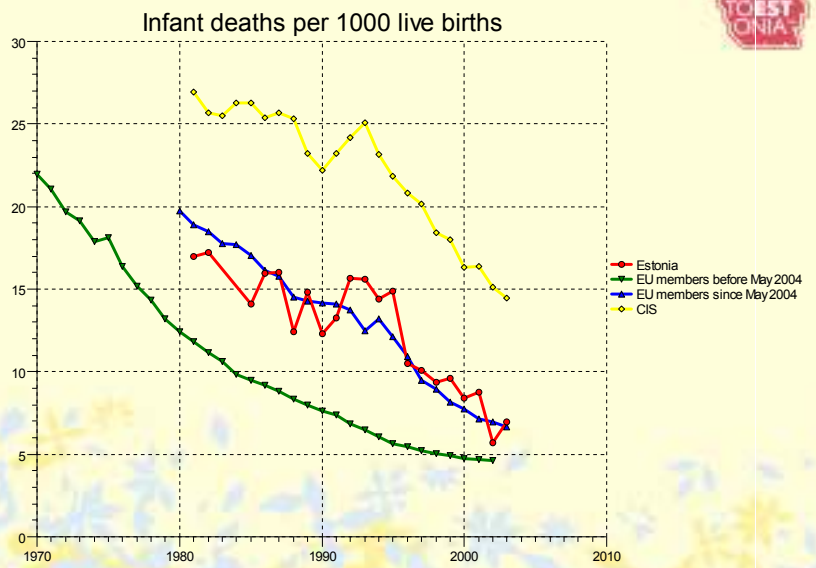

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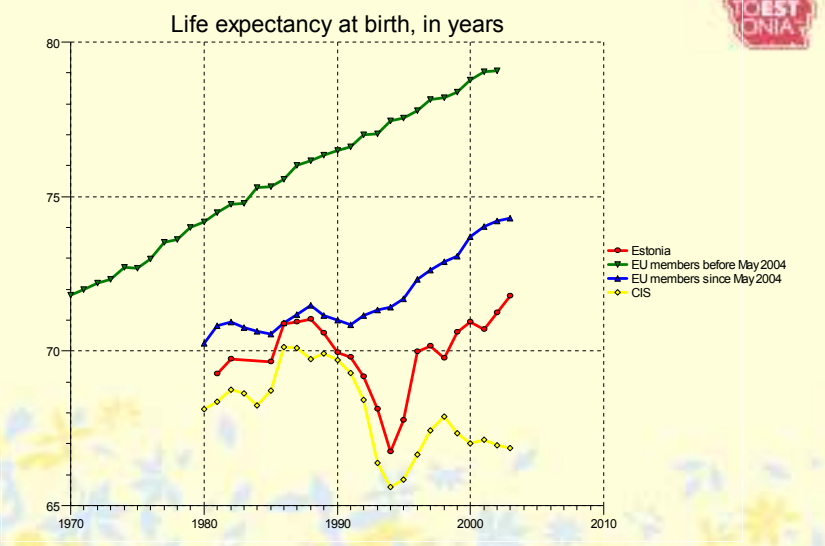

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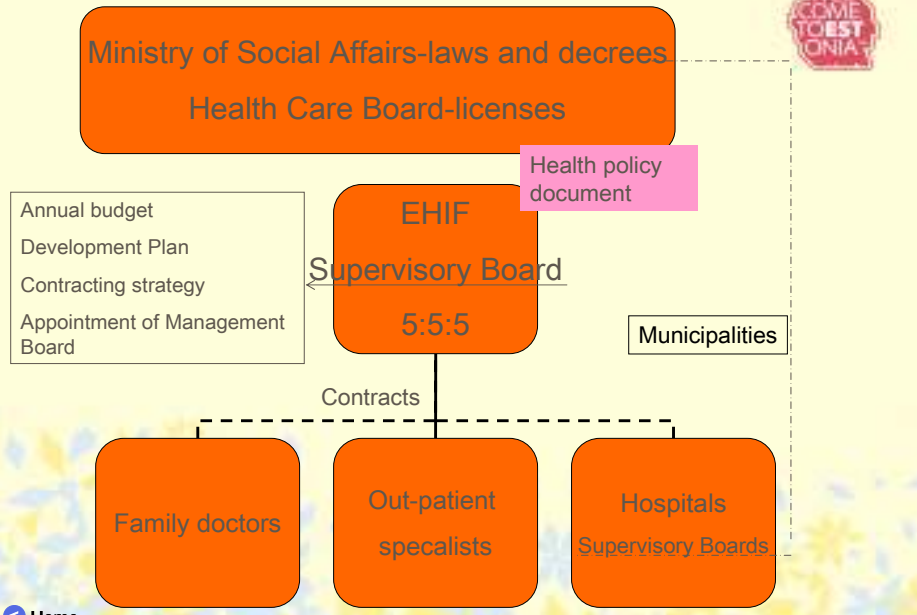

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State representatives in EHIF Supervisory Board:

- Chair-Minister of Social Affairs
- Minister of Finance
- Chairman of Parliament Social Committee
- Member of Parliament
  - Nominated by Parliament
- 1 civil servant from MoSA
  - Nominated by Government

Home

Role of and relationship with Ministry of Social Affairs/Health

- Function of the Ministry when no direct access to main health finance
- Learn to regulate and to be a steward of the whole system
- "Can not do health policy when the Fund controls the money"
- Threat of the Ministry turning into provider representative

Home

Monitoring of finance: EHIF

- EHIF expenditure
  - Monthly monitoring of overall expenditure
  - Quarterly reports
    - To Supervisory Board of EHIF
    - Public on EHIF internet
  - Annual report
    - Audited by independent auditor
    - Audited by State Audit Office occasionally
    - Public on EHIF internet
  - Public Sector Transparency Award 2002,2003,2004
- Provider contract monitoring
  - Monthly status of expenditure by services

Home

Monitoring of finance: providers

- Management Board/director of provider
- Quarterly report to Supervisory Boards of hospitals
- Annual report audited by independent audit
- Obligation to make annual report public from 2005
- Statistics to Ministry of SA

Home

Problems in 1990

- Overcapacity of hospitals
  - 120 hospitals; ALOS 17 days; acute 14
- Weak, but overused primary care

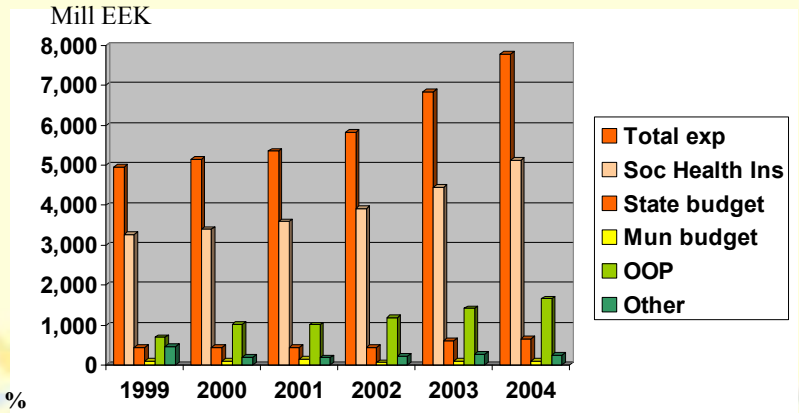
Home

Main reforms

- **Health financing reform 1992**
  - Introduction of health insurance
  - Autonomy to health care providers
  - New payment methods for health services
- **Primary care reform**
  - Training in family medicine from 1993
  - Autonomy and new contracting/financing model from 1998
- **Hospital reform**
  - Administrative closers 1994
  - Masterplan and implementation from 2000

Home

Estonian health expenditure



% of GDP	6.1%	5,5%	5,1 %	5,1 %	5,4 %	5,5%

Home

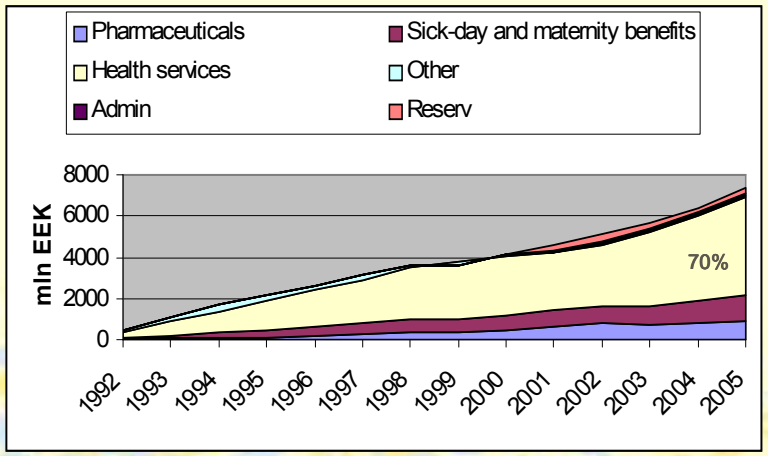
Source: National Health Accounts, MSA

Finance - from budget to earmarked tax

- Health Insurance Law in force since 1992
- Financed: 13 % earmarked health insurance tax on salaries paid by employers
  - Collected by Tax Agency from 1999
- Coverage: 93-94 % of population
- Covers:
  - health services – closed contracts with providers
  - Pharmaceuticals – open ended obligation
  - Sick-day and maternity benefits – open ended obligation
- Administration by Health Insurance Fund (EHIF)
  - Public independent institution
  - Supervisory Board 15 members (5:5:5)

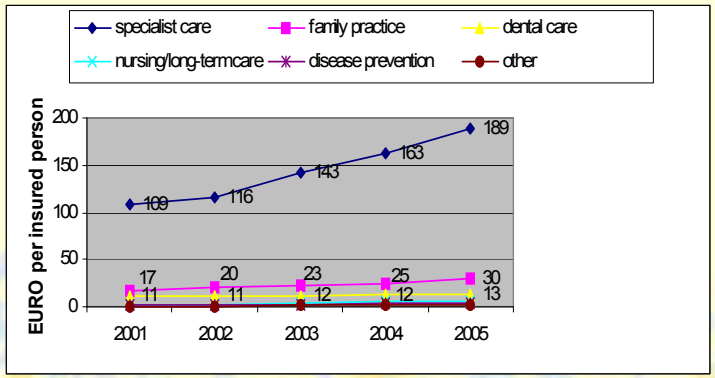
Home

Health insurance annual expenditure: per insured 2005: 5493 EEK /352 Euro



Home Source: Estonian Health Insurance Fund

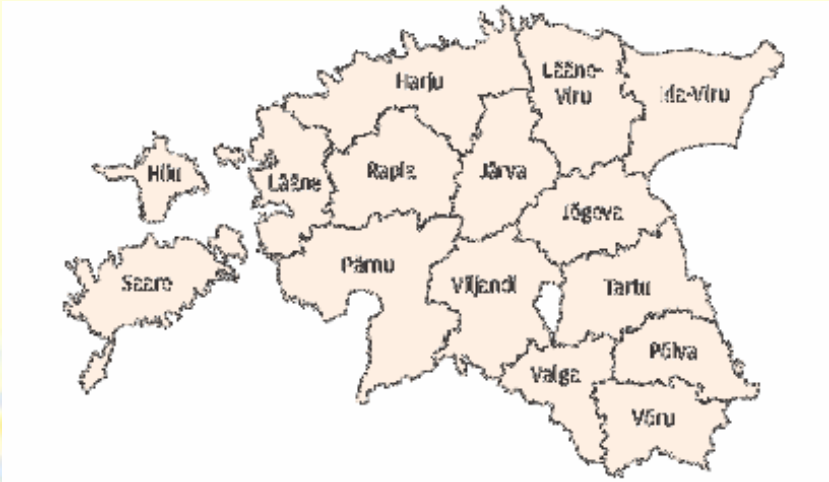
EHIF expenditure on health services per insured - 243 € in 2004



Home Source: annual reports of Estonian Health Insurance Fund

Allocating to regions:

from 22 regions – 17 – 7 - 4



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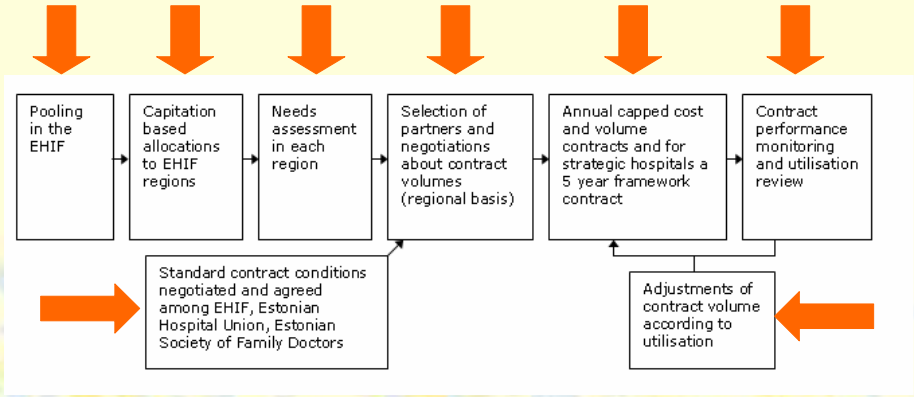
Health care providers: Specialist care

- Hospitals - mostly public providers
  - Autonomous, working under private law
  - Foundations or joint stock companies
- Ambulatory specialist care
  - Mostly private providers
- Closed contracts with EHIF
- Fee for service, partial DRG-s
- Co-payment for visit or up to 10 bed-days
- In case no referral from FP, when required, person pays the whole price

Home

Contracting process by EHIF for insured persons



Home

Specialist Care Contracts: from funding providers to purchasing services

- First years: block contracts – 1 page
  - Payment fee for service
  - Invoice per patient,
  - DGN and services according to price list
- Mid- 90-ies: block contracts + specification of number of cases in high cost services or those with waiting-lists
  - Hip-protheses, cataract surgery
- From end 90-ies: case-volume contracts
  - Specifies services, nr cases, average cost per case

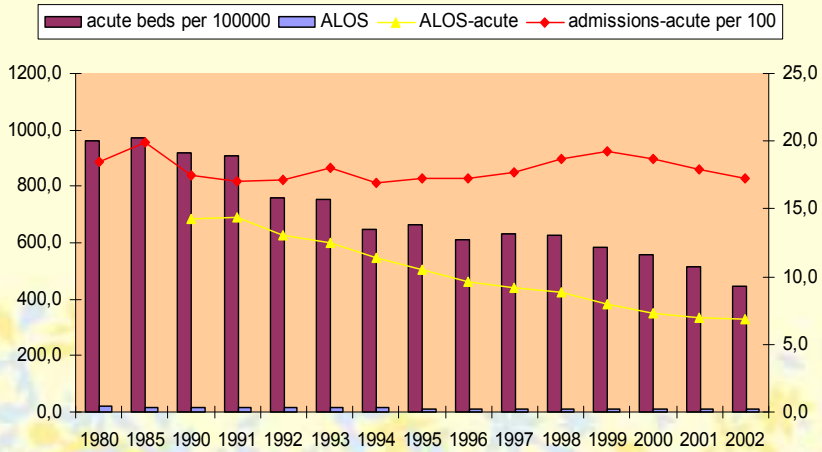
Home

Structure of EHIF cost-volume contract

Specialty	Out-patient cases	Sum	In-patient cases	Sum	Total
Cardiology	100	30000	100	500000	530000
General Surgery	100	30000	50	300000	330000
…					
Contract reserve (up to 15%)					94600
Total					946000

Home

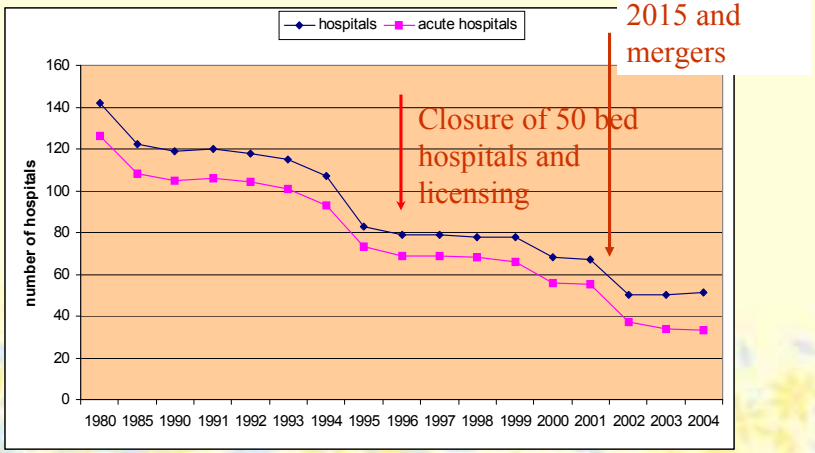
Payment method, purchasing and adoption of technology driving hospital efficiency



WHO HFA database, Jan 2004

Home

3-time decrease of hospitals



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Primary Care Reform

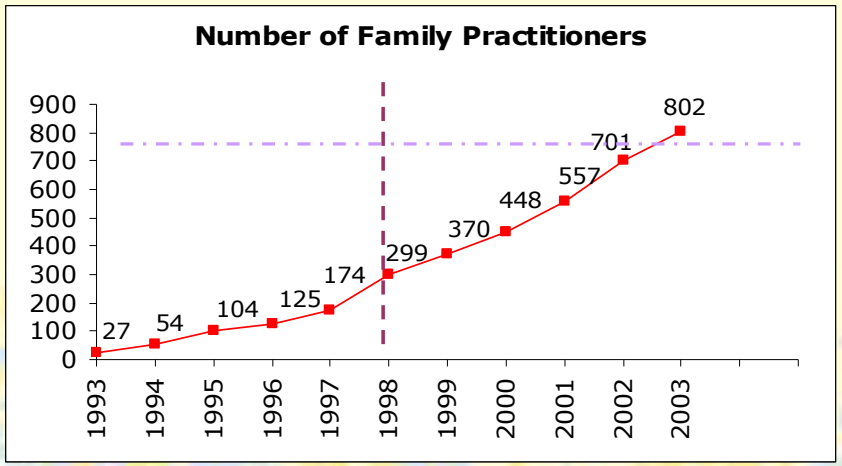
Home

2-stage reform of turning primary care into family medicine

- **Adding content and quality to primary care:**
  - Recognition of family medicine as distinct speciality in 1993
  - Residency specialisation program (3 years) from 1993
  - Re-training programme (2-year) for doctors without (general doctors) and with other specialities
- **Choosing financing model:**
  - Support to increasing role of primary care
  - To make family medicine financially attractive

Home

Critical mass of trained FP-s existed before finance reform



Home Source: Medical statistics, Ministry of Social Affairs

Aims in 1997: to increase FP role in reality

- To support strengthening of primary care
- To support increasing of doctor's responsibility for patients
- To make primary care financially attractive for Estonian doctors
- To make working outside bigger towns financially attractive

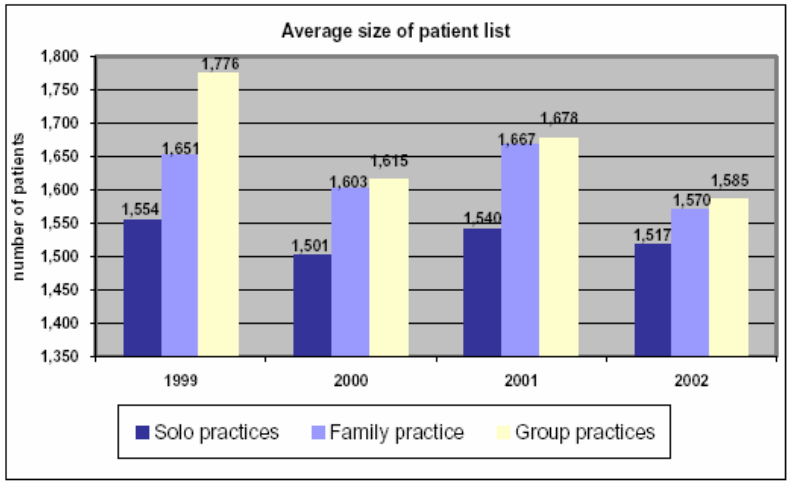
Home

Primary Care from 1998

- All family practicioners are private
  - single and group-practices
- Registered lists of persons:
  - Originally 1500-2300 registered people/ FP
  - From 2003: 1200-2000 registered people/FP
- Partial gatekeeping:
  - direct access to gynaecologists, ER, ophthalmologists
- Referrals to specialists paid by EHIF separately
- No responsibility for 24-hour availability
- Timely access requirements:
  - acute case – same day, non-acute case – within 3 days

Home

Patient-lists per doctor decrease to increase access



Source: EHIF and WHO report Estonian Primary Care Evaluation Project

Principles in preparing financing reform:

- Overall allocation to primary care remained proportionally the same
  - 16 % of health care services in health insurance
- Simple financing formula
- New financing scheme only applied to independent contractors/family practitioners
  - Demotivation for those remaining salaried doctors in policlinics

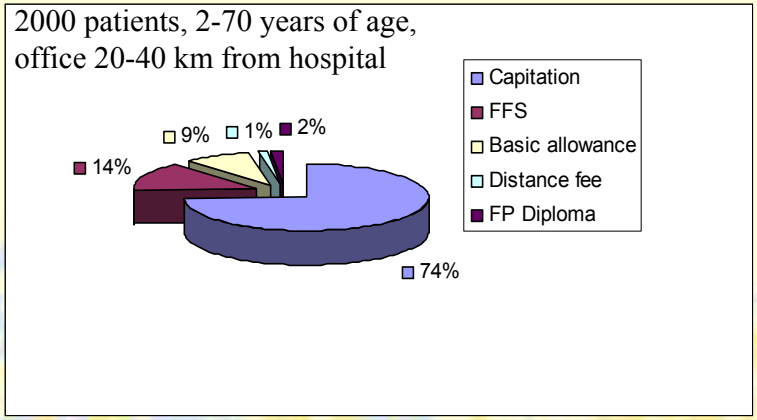
Home

Family practice financing formula:

- Capitation (weighted from 2nd year of reform)
- Fee-for-service
  - List of services and tests, Capped at 16-20,5 % of capitation
- Basic allowance for infrastructure
  - For defined infrastructure and equipment
  - Training of doctor and nurse - minimum 60 hours /year
- Additional payments:
  - for distance from hospital
    - 20-40 km from secondary hospital
    - over 40 km from secondary hospital
  - for FP diploma – being transformed into performance target payment

Home

Monthly revenue of a hypothetical FP: 3818 EURO in 2004



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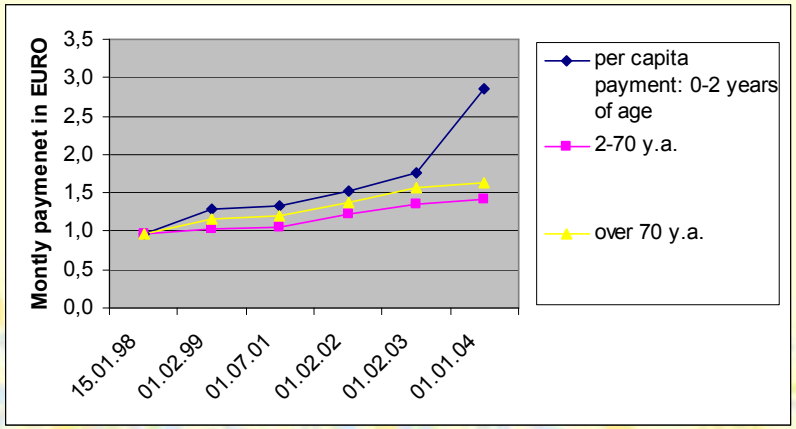
Age-weighted capitation payment per month: 1998-2004



Home

Quality enhancement and monitoring: from control to reviews and feedback

- Treatment guidelines
- Medical audits by EHIF:
  - Annually 30% of FP according to random sample- EHIF
  - More specifyed topics/problems
- Utilisation reviews and feedback (pharma, referrals)
- Quarterly telephone survey by EHIF on access:
  - Problems with timely access to FP over 2300 persons
- Control over infrastructure (rooms and equipment)- county level administration
- Annual public opinion surveys

Home

Nr of visits to FD increasing

Table 21. Appointments by family physicians in 2000-2005

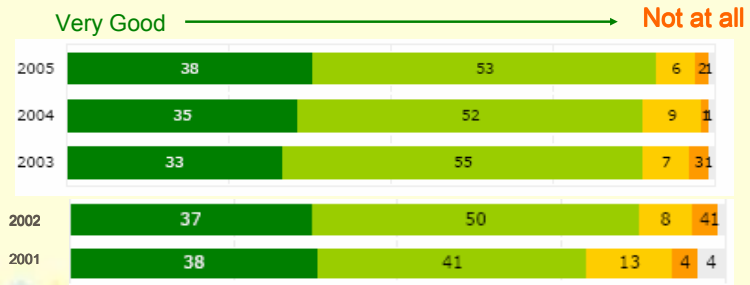
	2000	2001	2002	2003	2004	2005
Appointments by family physicians (total number)	2 572 076	4 338 268	3 987 121	3 935 504	4 194 373	4 513 223
Total family practices	482	668	813	820	783	788
Appointments per family physicians per year	5 336	6 494	4 904	4 799	5 357	5 727
Appointments per family physicians per month	430	546	413	400	446	477

3,47 FP appointments per capita 2005. (4513223)

2,6 Specialized medical care appointments per capita 2005. (3411785)

Home

Population satisfaction with family doctors



Source: Annual population satisfaction survey, 2001-2005

Home

Issues/problems

- Will the FDs cope with management?
- How to motivate doctors who want to provide broader scope of services?
- Relationship between local governements and FD centers

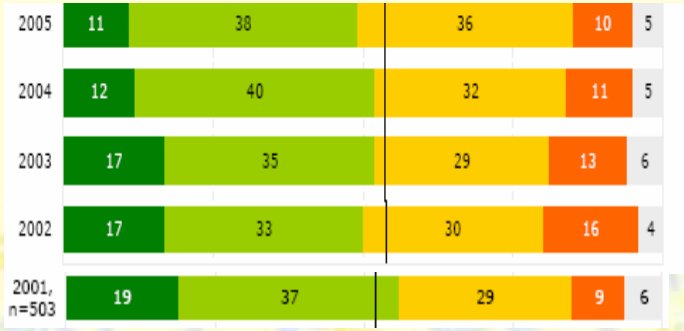
Home

Public opinion of quality: 2001 - 2005 all respondents

Source: Annual population satisfaction survey, 2001-2005

Home

Public opinion of access: 2001-2005 All respondents



Source: Annual population satisfaction survey, 2001-2005

Home

Evaluation of the primary health care reform in Estonia

R. Kalda, M. Lember, K. Põlluste, K. Meiesaar, H.-I. Maaroos
University of Tartu
Estonia

Background

- Reorganization of the PHC started in 1991 by commencing training of FDs
- In 1998:
  - a new financing scheme
  - patient list system
  - partial gatekeeping function
  - independent status of FDs were established

The aim of the reform of the primary health care in Estonia

- To provide patients:
  - with an all Estonian primary health care (PHC) system
    - easily accessible everywhere
    - based on trained and fully responsible family doctors (FD)

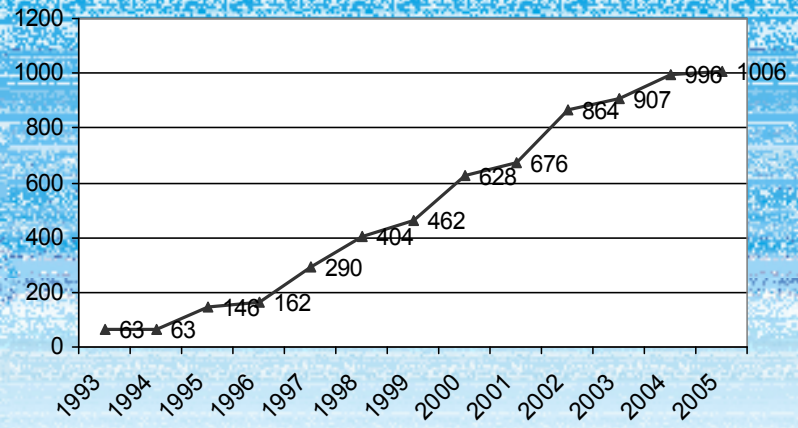
Indicators of the reform

- Number and location of FDs
- Number of visits
- Waiting time
- Quality of services
- Technical efficiency (existence of necessary equipment in family practices)
- Population satisfaction with family doctors

Sources of the data used in the analysis

- Central Sick Fund of Estonia
- Estonian Health Statistics
- Population surveys of Estonian citizens in 1998, 2002 and 2004
- Family practitioners' survey in 1992, 1998 and 2000
- Published original papers

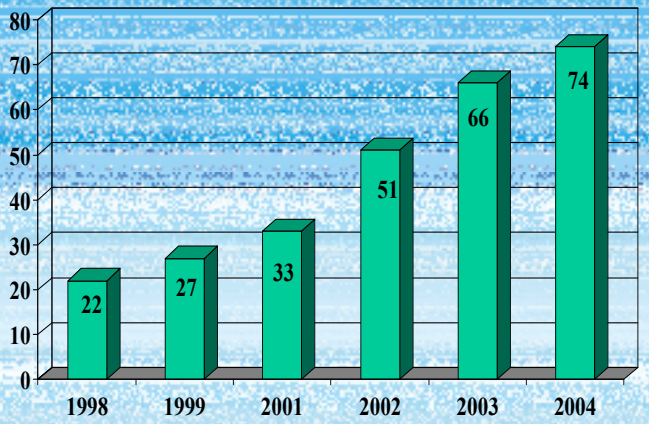
Results of the analysis



The number of FDs 1993 -2005

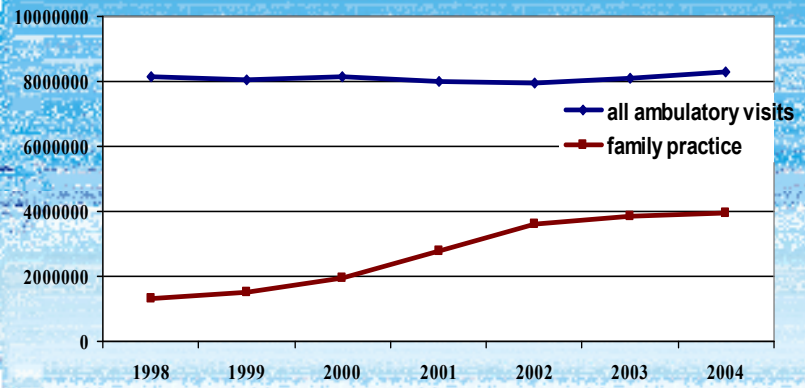
Source: Estonian Health Statistics

The number of FDs per 100, 000 people in Estonia



Source: Estonian Health Statistics

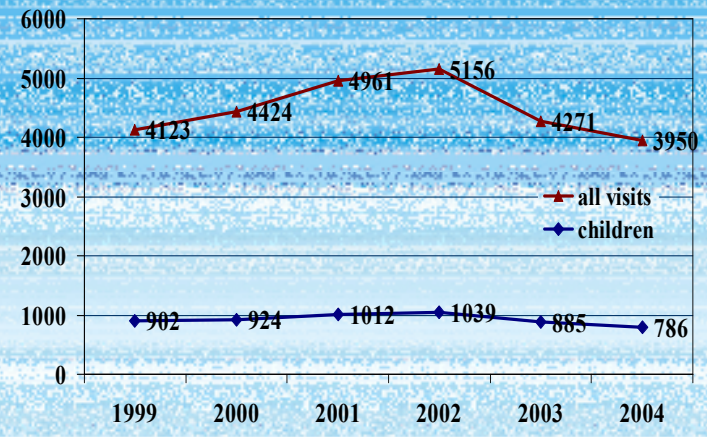
Number of ambulatory visits per year



In 2004 – 2.9 FD visits per one inhabitant in Estonia

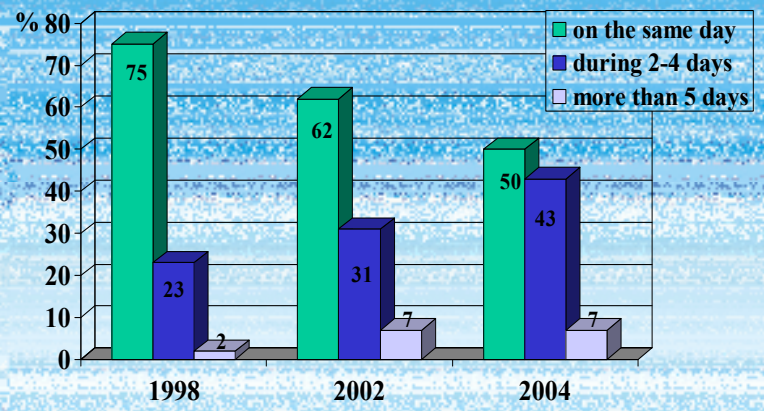
Source: Estonian Health Statistics

Average number of visits per one FD per year



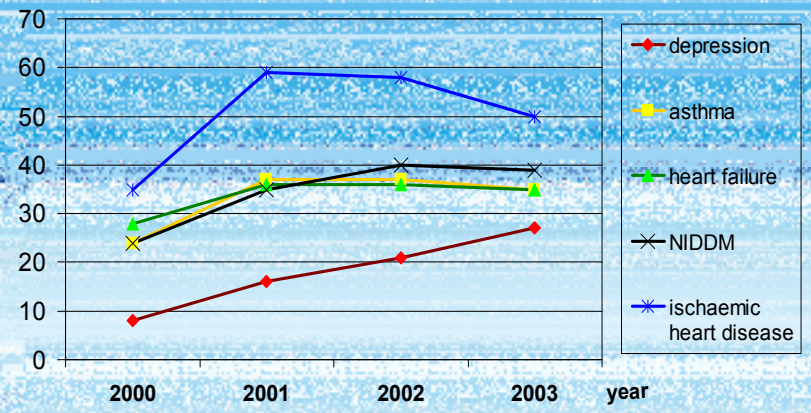
Source: Estonian Health Statistics

Waiting time for an appointment to the FD



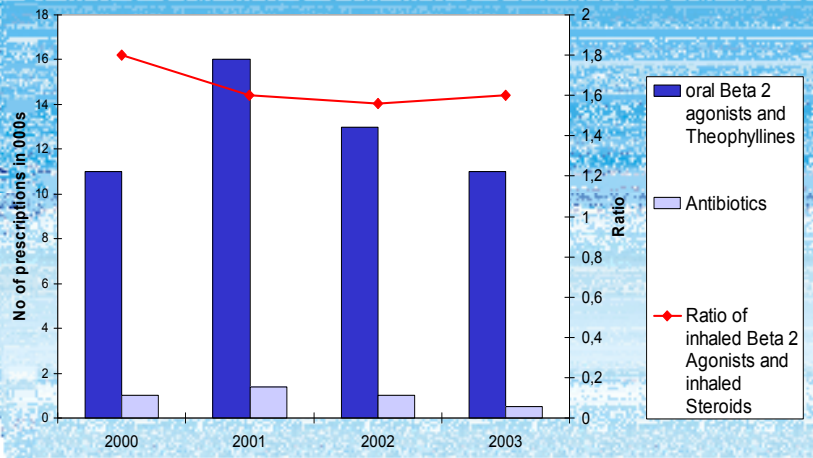
Source: Population surveys of Estonian citizens in 1998, 2002 and 2004

Number of annual consultations in PHC (in 000s), for common chronic illnesses



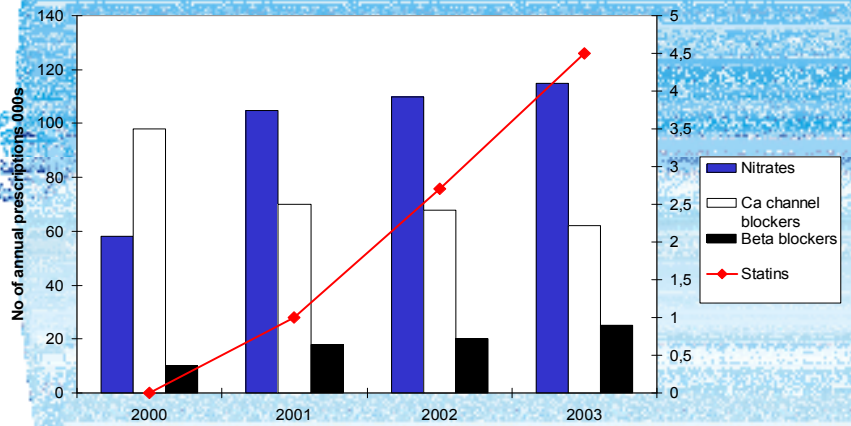
Atun RA et al. Introducing a complex health innovation-primary health care reform in Estonia. Health Policy 2006; Jan 4

Prescribing patterns of FDs for asthma



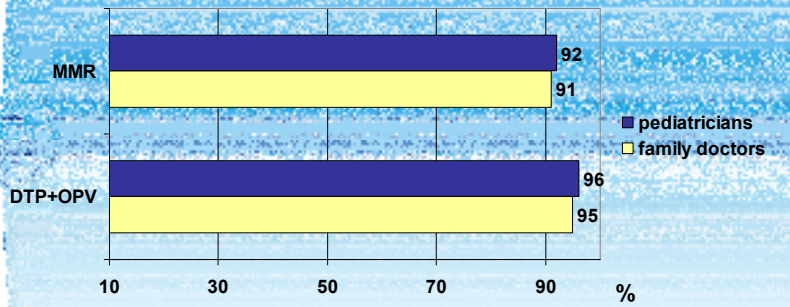
Atun RA et al. Introducing a complex health innovation-primary health care reform in Estonia. Health Policy 2006; Jan 4

Prescribing patterns of FDs for ischaemic heart disease



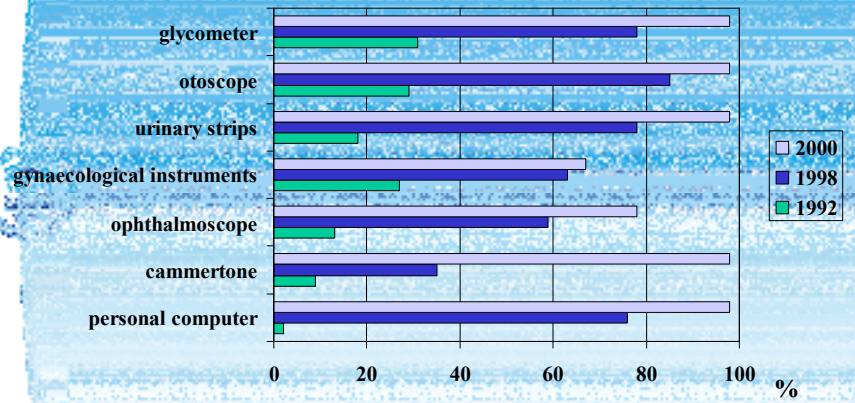
Atun RA et al. Introducing a complex health innovation-primary health care reform in Estonia. Health Policy 2006; Jan 4

Immunization of children (vaccination coverage)



R.Kalda, G.Sontak, M.Hapunova, H.Sarapuu, M.Lember. Family doctors and pediatricians vaccinate their children with same quality. Family Medicine 2002, Nov-Dec;34(10):714-5

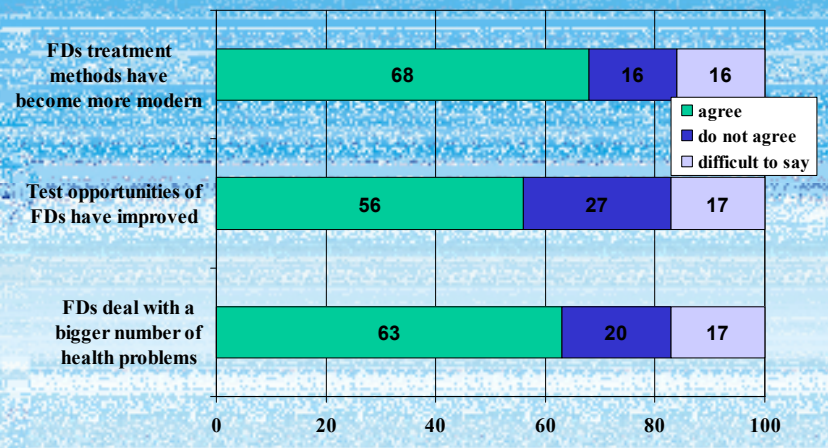
Changes in the basic equipment of the FDs



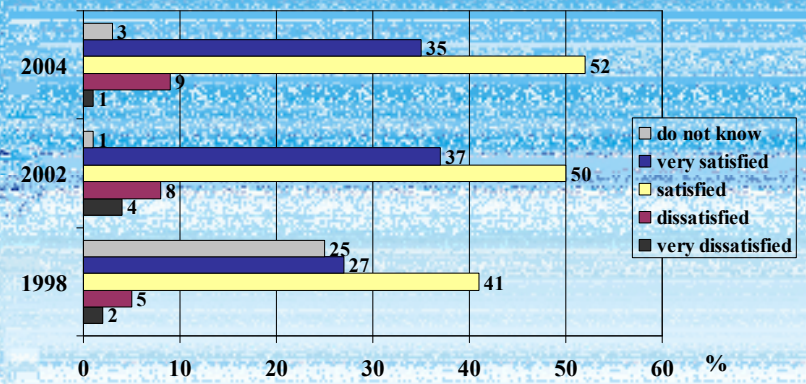
Percentage of the FDs possessing needed equipment

Source: Family doctors' survey

Respondents' views on the comparison of the present and previous PHC system (population survey in 2002)

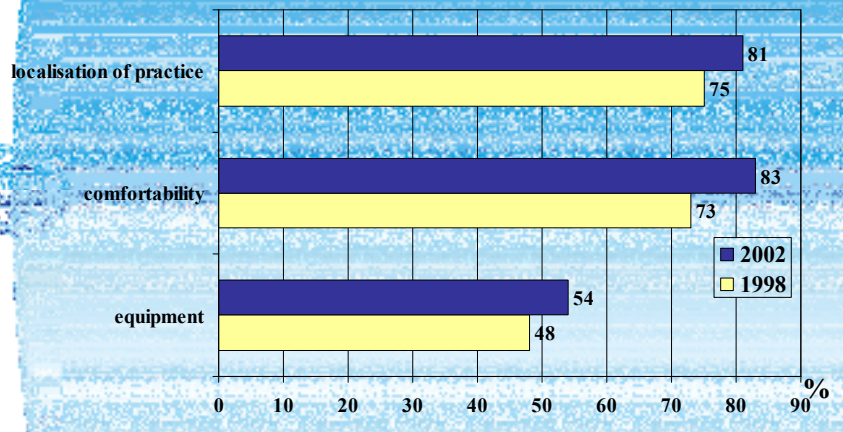


Satisfaction with FDs (population surveys in 1998, 2002 and 2004)



Percentage of persons who were satisfied or dissatisfied

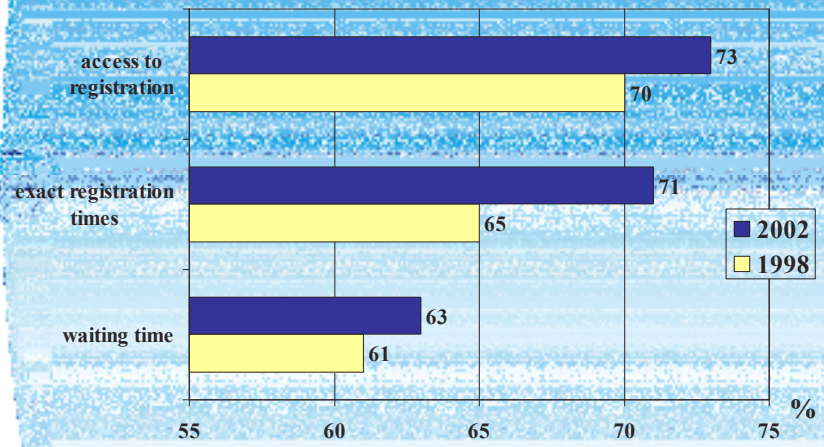
Patients satisfaction with technical aspects of family practice



Percentage of patients who were satisfied or very satisfied

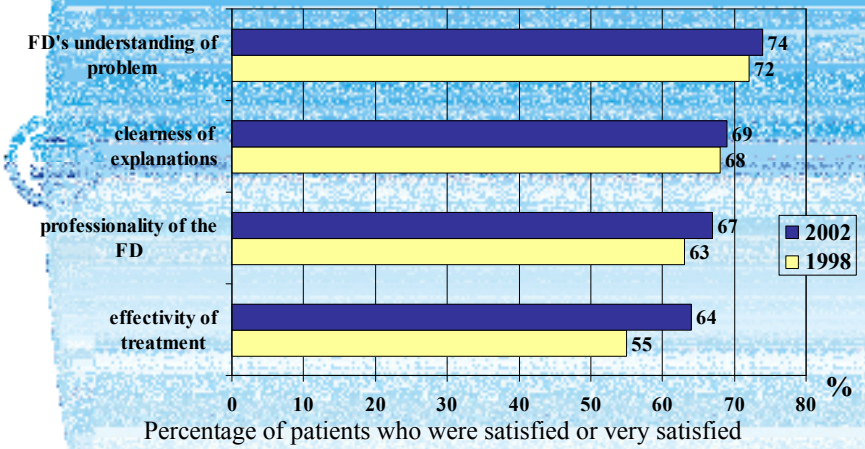
R.Kalda 2003

Patients' satisfaction with organisational aspects of family practice



Percentage of patients who were satisfied or very satisfied

Patients' satisfaction with professional aspects of family practice



R.Kalda 2003

Conclusions

- The average number of visits per family practitioner a year, the number of visits per person a year all have increased during 1998 to 2004, owing to available and well functioning system of family medicine and delegation of more tasks from narrow specialist to the FDs.
- The accessibility of family medical care is good – about 50 per cent of people can visit their FD the same day.

- The equipment at family practices meets the requirements. The survey of 2000 showed that family practitioners have most of the required equipment. Compared to the survey of 1992, the situation has improved a lot.

- The quality of the services of FDs has been enhanced, as evidenced by improved management of key chronic conditions by FDs

- Compared to district physicians, the test opportunities of FDs are considered better and their treatment methods more modern.

- The population of Estonia is generally satisfied with FDs. 87 per cent of the respondents were fully satisfied or satisfied with their FD in 2002 and 2004.

East-Tallinn Central Hospital (Estonia)

Tallinn, 26.09.2006

Factors affecting development

- Health Insurance:
  - 5,7% of GDP for healthcare in 2003, 5,2% in 2004
  - Fee for service since 01.01.1992.
  - Health insurance tax – 13% (paid by employer)
    - Income tax – 23% (flat tax)
- Health care service is private, municipal or governmental
- Wide range of e-services
- High bandwith connectivity
- Internet
  - 52% of population (15-74 years) use regularly internet (2004)
  - Free Wifi service in many places all over Estonia
    - More than 400 areas

East-Tallinn Central Hospital (ETCH)

- Founded in 1785
- Municipality owned legal entity since 2001
  - Established by merging 7 separate health care institutions
    - 4 hospitals
    - 2 policlinics
    - 1 diagnostic centre

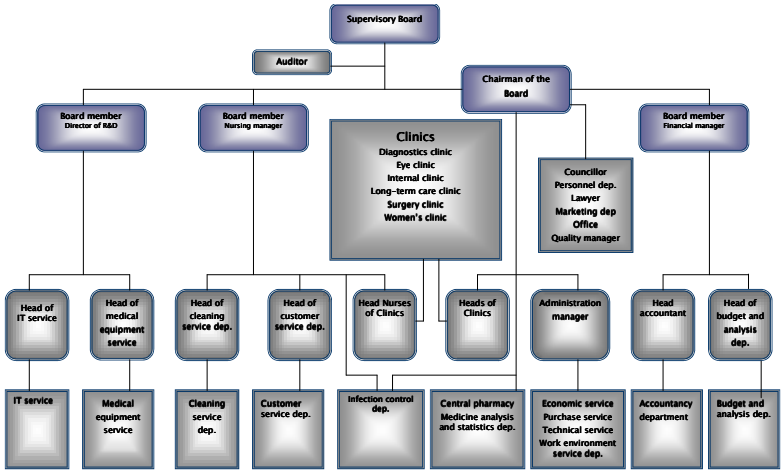
East-Tallinn Central Hospital

- Current situation (2006)
  - 6 clinics
    - Clinic of Internal Medicine
    - Clinic of Obstetrics and Gynaecology
    - Clinic of Long Term Care
    - Clinic of Surgery
    - Diagnostic Clinic
    - Eye Clinic
  - ca **1815** employees
    - **287** doctors, **743** nurses and **313** assistants
  - Turnover – **30,3** mio EUR (2005)

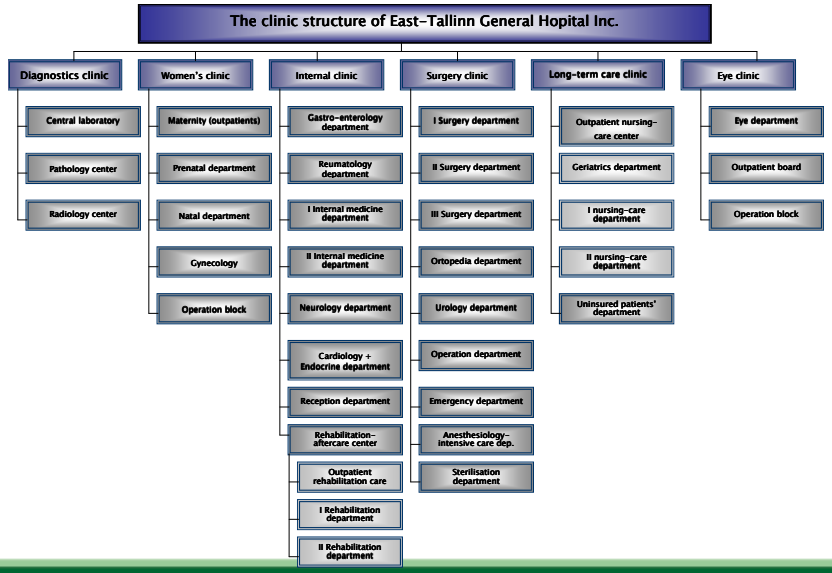
East-Tallinn Central Hospital

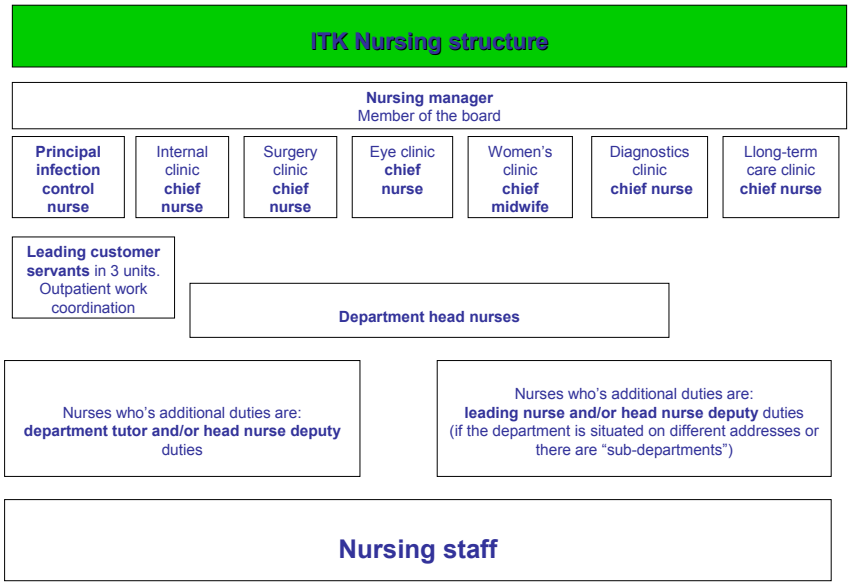
- Located in 5 remote locations in Tallinn
- 555 beds (incl 465 active care beds)
- Hospital covers the most of the specialities
  - lacking only neurosurgery, cardiac surgery, nephrology, haematology, child diseases and psychiatry
- Patients hospitalised annually
  - 2002 – **26 406**
  - 2003 – **25 856**
  - 2004 – **25 994**
  - **2005 – 25 894**
- Outpatient visits annually
  - 2002 – **380 380**
  - 2003 – **373 443**
  - 2004 – **357 314**
  - **2005 – 425 450**

ITK general structure



ITK clinical structure





*On the 31.01.2005 nursing purview included alltogether **1255** natural persons, **68% of the institutions staff**

East-Tallinn Central Hospital

- Hospital Information System (HIS)
  - Implemented in 1992, renewed 2003
    - Local provider
  - HIS integrates all six remote buildings
  - Today all electronic patient record figures except diary
  - Picture Archiving and Communication System since 2003 for radiology.

Radiology

- 130 651 exams/year (2005)
- 21 radiologists, 35 tech´s
  - Radiologists report is partly outsourced
- Approx. 100 000 exams archived in PACS annually
- Soft copy reading since 2003
- Distribution of images via web

Partners

- Health care
  - ETCH has more than 200 customers
    - General practitioners
    - Other hospitals
    - Private health care providers that are buying different kinds of services from ETCH
    - Pharmacy companies
    - Etc.
- Teaching and research
  - Medical Faculty of Tartu University
  - Faculty of Science of Tallinn Technical University
  - Teaching of nurses

Internationa cooperation

- ETCH has been partner in two EU Baltic Sea Region Interreg projects. Currently ETCH participates as a partner in the Baltic Sea Region Interreg IIIB program Baltic eHealth.
- The hospital has close cooperation with Helsingi University and Heinola Rheumatism Foundation Hospital, Finland.

Wish you very nice stay in Tallinn!

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Feedback of 15-year Family Medicine Training in Estonia

Heidi-Ingrid Maaroos
Department of Polyclinic and Family Medicine
University of Tartu, Estonia

Content of the lecture

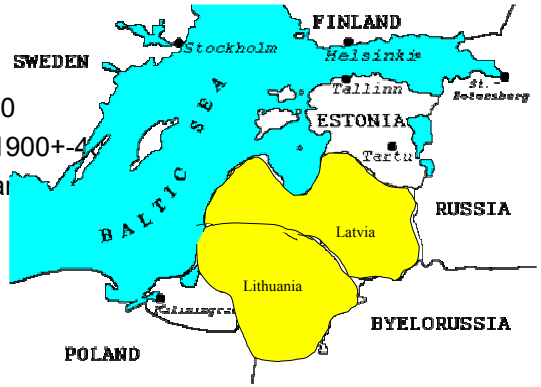
- Who we are? About the Department of Family Medicine in the University of Tartu
- Whom we teach?
- What methods we use?
- What is content and duration of teaching?
- How to join research and teaching?

Who we are?

- About the Department of Family Medicine in the University of Tartu

Estonia

- 47000 km^3
- 1.4 million inhabitants
- 32 physicians per 10000
- 1 family physician per 1900+-4
- 800-850 family physicia
  are needed



Traditional university from 1632- University of Tartu

Department of family medicine from 1992.

History of academic family medicine of Estonia

- from 1991 retraining
- 1992 family medicine department, professorship, Tartu University
- 1993 PhD programme
- 1993 residency training
- 1993 professional organization of family doctors
- 1998, 2001 and 2003 international evaluation of the teaching and research

Persons

Faculty members –12 persons

- Assistants
- Docents
- Professor
- Researchers
- PhD students
- Technical staff

Tutors >80 practicing family doctors
(for students and residents)

Implementation of family medicine teaching in 1991-1992

- Use capacity of own university
- training of faculty members with academic positions and tutors on international courses
- calling teachers from countries already existing family medicine system

Main task

Development of *(undergraduate, residency, retraining, teachers)* programmes for family medicine;

Inside the faculty of medicine

Co-work with different specialities

- training of family physicians
- development of research in family medicine

Selection of faculty members

- the university criteria for academic posts
- speciality of family physician
- clinical practice in family medicine

The university faculty members are

- vocationally trained family physicians
- PhD degrees
- conducting their PhD in the field of family medicine
- part-time working in family medicine practice

Whom we teach?

- 2nd year students
- 6th year students

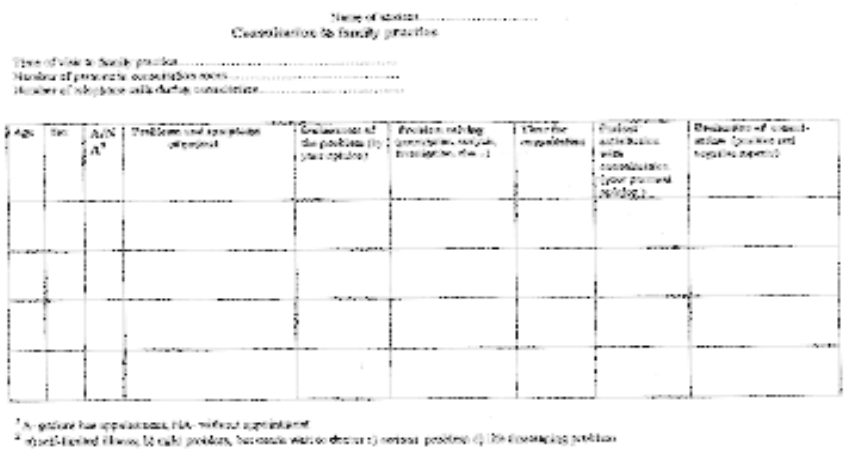
- Residents –15 in every year (whole 45-50 in training)
- Trainees on retraining courses (>900) up to 2004
- CME for FDs

Trainees from Armenia,Turkmenistan, Uzbekistan, Tajikistan, Russia

What methods we use?

- Lectures
- Small group work
- One-to-one practical work
- Practical skills training
- Videoconsultation training
- Research training
- Distance learning courses

Consultation evaluation form



Teaching of communication skills in family medicine

Main principles

- Teaching of communication should:

  * start in early undergaduate years, before and beyond history taking

  * be done gradually

  * include different methods (observation, discussion, seminars, lectures, presentations, role-plays etc.)

  * include an assessment of the skills

Teaching of 2-nd years students

- **Begin to develop basic communication skills and strategies**

  learning methods: seminar, exercises, video analysis, role playing

Teaching of 6-th years students

- **Begin to learn how to deal with specific topics and situations encountered in family practice**

  learning methods: seminar, exercises, discussion, role-play

Teaching of postgraduate students (residency training)

- **To learn how to deal with difficult patients (e.g. dying patient, angry patient, non-cooperative patient, uncommunicative patient**)

  learning methods: seminar, video-analysis, role play, case-analysis, discussion

assessment: at the end of residency training, based on self-recorded consultation

Exam of practical skills for for trainees

Basis for teaching

- Network of teaching practices with newly trained family physicians as tutors

Basis for teaching

- New educational materials (manual in family medicine, problem-based interactive computer-based programmes)

What is content and duration of teaching?

Undergraduate programme of family medicine

- 2nd year students- 24 h (8 h lectures, 16 h practical works, exam)
- 6th year students - 96 h practical works (48 h one-to-one with tutor)
- 6th year students 3 weeks practice

Training of family physicians

Training in residency - 3 years at least 50% of which is family medicine practice and 10 % is theoretical part

- 1993-2003 has finished 45 family medicine residents

Certificate: family physician

Retraining of previous PHC physicians- 3 years

80% of which is independent work in practice and 20% is theoretical part (lectures and seminars)

- from 1991-2003, altogether 863 retrained physicians

Certificate: family physician

The content of the training bases

- background of PHC physicians
- job description of family physician in Estonia
- to local structure of population (age, rural, urban, family structure)
- to local morbidity and epidemiological situation and health care priorities in Estonia.

Main tasks of family physician in Estonia

- curative care for all age groups and gender
- preventive care
- palliative care
- management of practice
- co-ordination between team members

Important courses for family physicians

- legal aspects of starting independent practice
- computer skills
- practice management

Continuous programme evaluation

- evaluation of teaching process
- evaluation of family medicine curriculum

Feedback from 2nd and 6th year students

- Regular questionnaires at the end of family medicine programmes
- regular every-year over-university feedback evaluation organized by students

How to join research and teaching?

Research and teaching

- Students –
  - A new elective course ”Research methods in family medicine”
- Vocational training –
  - studies/courses on research methods for residents
  - every resident has to perform a research project and present data on mini-conference
- PhD studies:
  - to ensure with academic degrees more practicing family doctors who are working as tutors for students and residents.

Research and teaching

- training for scientists, PhD students
  - epidemiology
  - biostatistics
  - computer studies
  - qualitative research
  - other topics

❑ courses organised by University of Tartu

❑ other international courses (Forum Balticum)

Whole concept of the research:

- Risk factors, prevention, natural course, diagnosis and treatment of common chronic diseases in the families and different age groups, the quality of the doctor-patient interaction and family doctors job

Research projects

Focus to family.

A different approach to problems connected with family is covered by different research projects of the department:

- involvement of families in management of health problems, influence of diversity in family forms of the risk of chronic diseases, consultation in family medicine, doctor-patient-family relationship, adolescents , family planning, risk factors of depression

Research projects

Epidemiology and natural course of diseases

- *Helicobacter pylori* epidemiology, connections with gastritis in children and adults, chronic diseases such as peptic ulcer and gastric cancer,

Telemedicine

- System of telephone counselling: evaluation of telephone consultations structure, patients and family doctors satisfaction cooperation with Estonian Health Insurance Fund and the Estonian Ministry of Social Affairs
- It is one part of the telemedicine project started as Bitnet from 2000.

Projects, publications, thesis

- 2 Target research projects
- 6 grants from Estonian Science Foundation
- 4 EU projects: Eurohepygast, Eurocommunication, Forum and Predict project
- Defended PhD thesis- 8
- Ongoing PhD studies and preparation of dissertations - 4

Examples of topics of PhD thesis

- Structure and outcome of family practice quality in the changing health care system of Estonia
- Dyspepsia and Helicobacter pylori in PC
- Health damaging risk behaviours in adolescence
- Consultation as a work method of a family physician
- The methods of family planning and the factors that influence their choice in primary health care.
- Possibilities of risk assessment and prophylactics of one of the most frequent psychiatric problem – depression – in primary care
- Effectiveness of the system of telephone counselling: evaluation of telephone consultations structure, patients and family doctors satisfaction and development of an algorithm-based counselling system

Cooperation

- intra-university cooperation
  - Institute of Microbiology
  - Department of Immunology
  - Department of Public Health
  - Clinic of Internal Medicine
  - Children's Clinic
  - Surgery Clinic
- international cooperation
  - Karolinska Institute (Huddinge Hospital)
  - Lund University
  - University of Helsinki
  - Turku University
  - Tampere University
  - University of London
  - Different European States within EU projects

Research and teaching

- EPCRN (European Primary Care Research Network) meeting and pre-meeting workshop on research methodology in primary health care was in Tartu October 20-23, 2005

Estonian Health Care System Overview

September 2006 Tallinn

sotsiaal ministeerium

sotsiaal ministeerium

ESTONIA

- Population – 1.3 million
- 45 285 km²
- Re-independence since 1991
- Parliamentary republic
- Parliament – Riigikogu (101 members)
- 15 counties, 247 municipalities
- Urban population 69% (EU15 average 80%)
- 16,7% population aged 65+
- 14% population aged 0-14
- Currency: Estonian kroon (1 € = 15.6466 kroons)

sotsiaal ministeerium

Estonian Ministry of Social Affairs (1993)

Regulatory body, policy development, strategic planning and monitoring

Labour sector: the management of employment, the labour market and working environment

Social Welfare sector: the management of social security, social insurance and social welfare, promotion of the equality of men and women

Health sector: the management of public health protection and medical care

sotsiaal ministeerium

Health sector

- Public Health Department (16 employees): health promotion and disease prevention policies and strategies
  - National Health Protection Inspectorate
  - National Institute for Health Development (2003)
- Health Care Department (16 employees): planning and regulating the health care system, state medicines policy
  - Health Care Board (2002)
  - State Agency of Medicines (1991)
- Health Information and Analysis Department (13 employees): collecting and analysing statistical data, developing the health information system, incl e-health
  - Foundation E-health (2005)

Health Insurance Fund (2001)

- Health insurance budget is administrated by Health Insurance Fund
- Autonomous body
  - legal person in public law established by the Act (2001)
  - Supervisory board (15 members)
  - Managment board (3-7 members)

Health insurance budget (2005)

- Health insurance budget 7,347 billion Estonian kroons
  - Specialist care 53%
  - Primary care 8%
  - Drug reimbursement 12%
  - Benefits for temporary incapacity for work 17%
  - Prevention 1%
  - Administrative costs 1.2%
  - Reserve 7.8%

Sources of financing, 2004

- public health insurance (66%)
- state budget (8,5%)
- municipal budget (1%)
- out of pocket payments (21%)
- other private sector undertakings (3%)

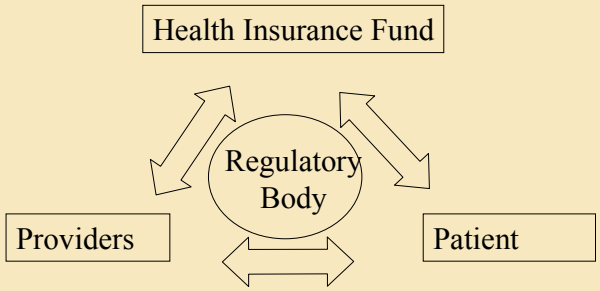
State budget

- Emergency medical aid
- Emergency care provided to persons not covered by health insurance
- Medical aids for disabled persons
- Capital investments

Health Care Board (2002)

- Registration of health care workers (doctors, nurses)
- Issuing of activity licences
- State supervision and surveillance
- Organizes the emergency medical care

Provider/Purchaser split



Health Care Organisation

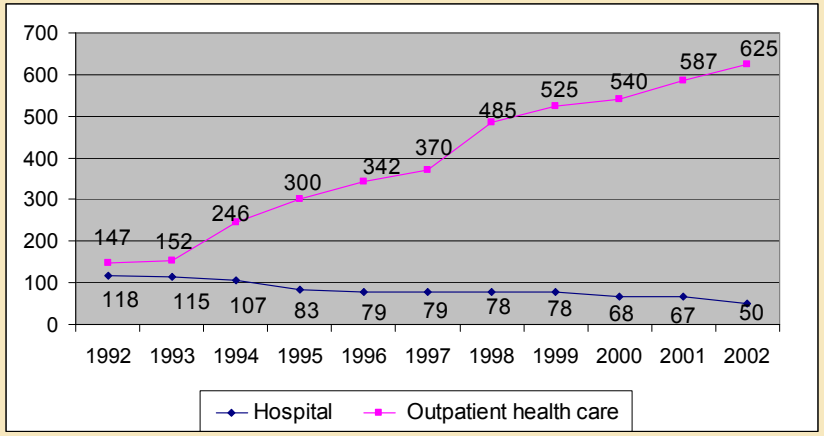
- Health Care Services Organisation Act (2001)
  - Different organisational forms of care
    - Primary Care
    - Specialist Care
    - Emergency Care
    - Independent provision of nursing
  - An activity licence is required for:
    - the provision of emergency medical care;
    - the provision of specialised medical care;
    - the independent provision of nursing

Organisational form	Legal form
Primary care	sole proprietors or companies
Specialist care (outpatient)	companies, foundations or sole proprietors
Specialist care (inpatient)	joint stock company or foundation
Emergency Care	company, sole proprietor, foundation or a state or local government rescue service agency
Independent provision of nursing	companies, foundations or sole proprietors

Changes in hospital sector in 1991-2005

- 1991: 120 hospitals, 18 000 beds
- Closing down or reorganization of small hospitals into nursing care or primary care facilities
- 1998 reorganization of Tartu University Hospital
- In 2000 the "Estonian Hospital Master Plan 2015" was completed by the Swedish consultants
- 2001 reorganisation of hospitals in Tallinn
- 2003 list of 19 acute care hospitals was approved by the Government
- 2004: 50 hospitals, 7850 beds

Reducing hospital capacity



Estonian Hospital Masterplan 2015 (2000)

- **Aims to**
  - Reduce the share of inpatient care
  - increase the share of outpatient care, daycare and nursing care
  - concentrate the more sophisticated and expensive specialist care to fewer hospitals

	2001	2015
Acute care hospital beds*	6500	3200
Average length of stay	6,7	4,6
Bed occupancy rate	67%	83%

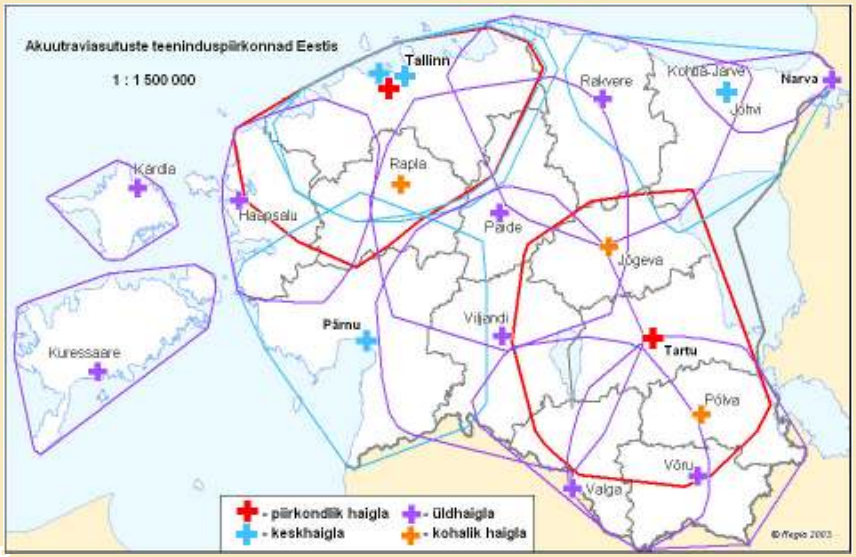
* Psychiatry, tuberculosis, rehabilitation and nursing not included

Hospital sector in figures

	2001	2002	2004	2015
Acute care beds	6500	6046	5750	3200
ALOS	6,7	6,6	6,2	4,6
Average bed occupancy rate	67%	67,7%	68,4%	83%

Hospital Network Development Plan 2003

- List of acute care hospitals approved by the Government in 2003
  - 3 regional hospitals
  - 4 central hospitals
  - 11 general hospitals
  - 1 local hospital
- Underlying principles:
  - equality – access to health care in all geografical location
  - accessibility within 70 km (one hour of transportation) from an acute care hospital
  - catchment areas must be
    - sufficient to maintain the professional skills of the medical specialists
    - based on present shares



Health care personnel

- All health care professionals must apply for registration in the Health Care Board
- 5085 registered doctors (3.2 doctors per 1000) including 935 general medical practitioners working in the primary care
- 9784 registered general nurses (6,9 nurses per 1000) including 673 registered primary health care nurses working in the primary care and 106 registered school nurses working in the primary care

Compared to

Finland	22	nurses	per	1000
Denmark	9,6	nurses	per	1000

The need for health care workforce in Estonia

3,2	doctors	per	1000
6,6	dentists	per	1000
8-10	nurses	per	1000
5,5	midwives	per	1000

Number of doctors needed by the year 2015 is **4051**
Number of nurses needed by the year 2015 is **12153**

Expected nurses and doctors ratio:	**nurses**	**doctors**
1:2	8102	4051
1:3	12153	4051
1:4	16204	4051

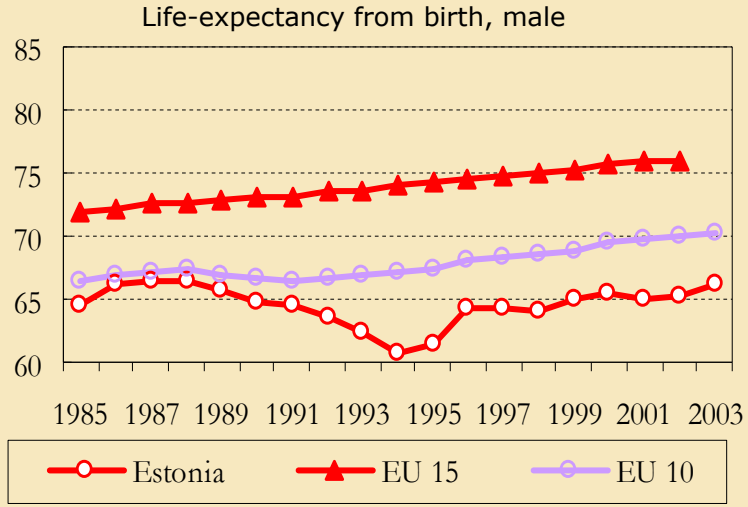
Health system performance (WHO)

How is the system performing

in terms of three main goals:

- Population health
- Population satisfaction
- Financial protection of people

Health status of the population



Population satisfaction

In 2005:

- 59% satisfied with the quality of medical care
- 49% satisfied with the accessibility of medical care

In 2001:

- 65% satisfied with the quality of medical care
- 56% satisfied with the accessibility of medical care

Financial protection

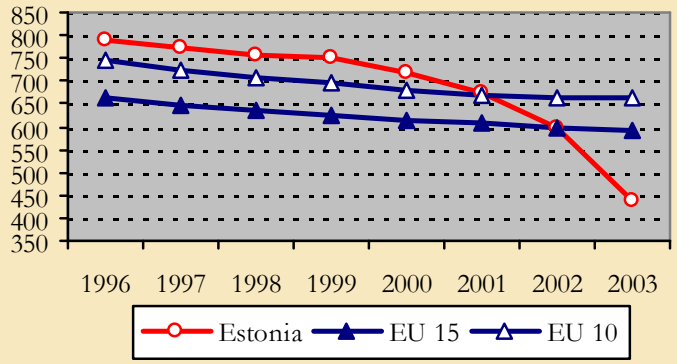
- Good insurance coverage (94,7% of the population)
- 6% of population not insured against health risks
- Share of out-of-pocket payments is increasing (13% in 1996, 21% in 2004)
- Less well-off households face the risk of impoverishment as a result of high health expenditure (1,4 % of households in 2002)
- Elderly chronic patients and households with low income are the main risk groups
- Cost of drugs is the main source of out-of-pocket payments

Conclusions

- The reforms in the health care system have contributed to more efficient use of resources
- Despite the positive achievements
  - the availability of nursing and rehabilitation services is limited
  - the capacity of acute care hospitals remains scattered
  - there is little coordination and cooperation in the system

Need to further restructure the services to meet the uncovered need for nursing care services

Hospital beds per 100 000



Main challenges

Taking into account that:
- Population is decreasing and aging
- Epidemiological transition – more chronic illness
- Technological developments

Main challenges in health care are:
- Strengthening primary health care
- Developing the nursing care services
- Integrating the services
- Optimising the capacity of acute care hospitals and upgrading the infrastructure
- Long-term sustainability of health care financing

- Ministry of Social Affairs http://www.sm.ee
- Health Care Board http://www.tervishoiuamet.ee
- Health Insurance Fund http://www.haigekassa.ee
- State Agency of Medcines http://www.sam.ee

Thank you for your attention!

Health system in Estonia

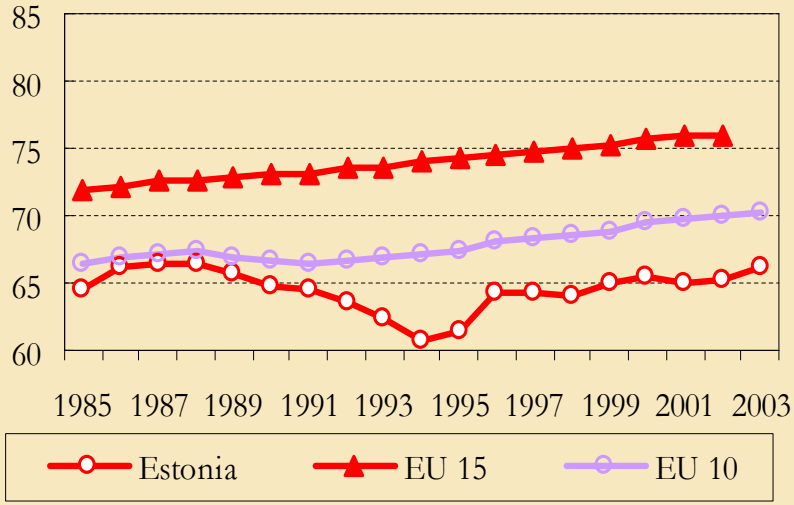
Peeter Laasik
Deputy Minister

June 2006

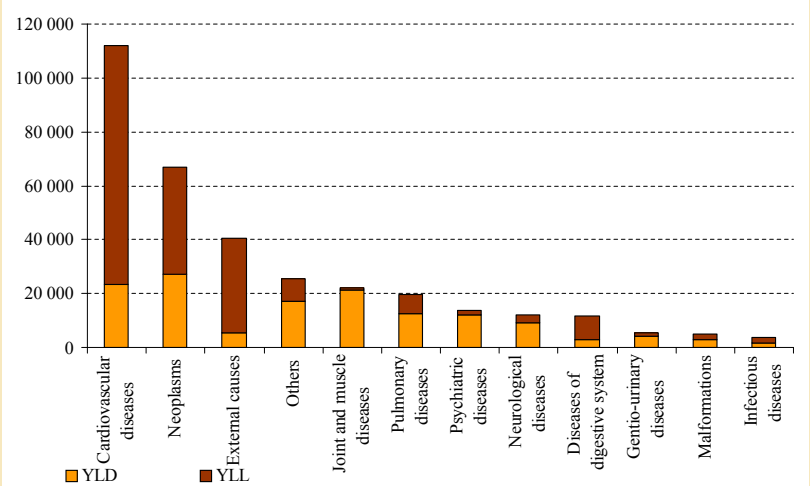
Content of the presentation

- Brief overview of the context
- Main reforms
- Current developments
- Key challenges

Life-expectancy from birth, male

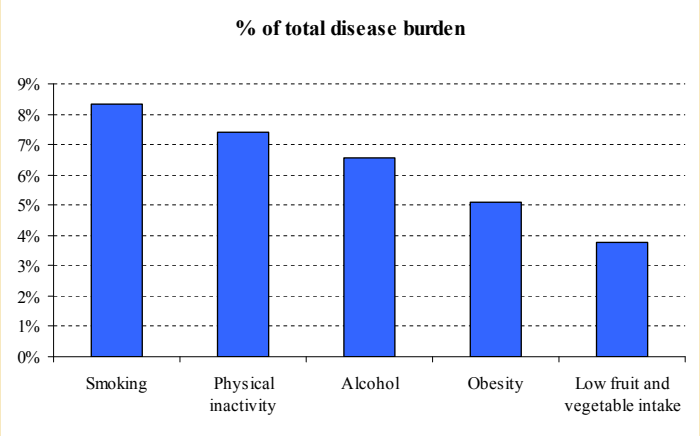


Burden of Disease in Estonia (DALY)



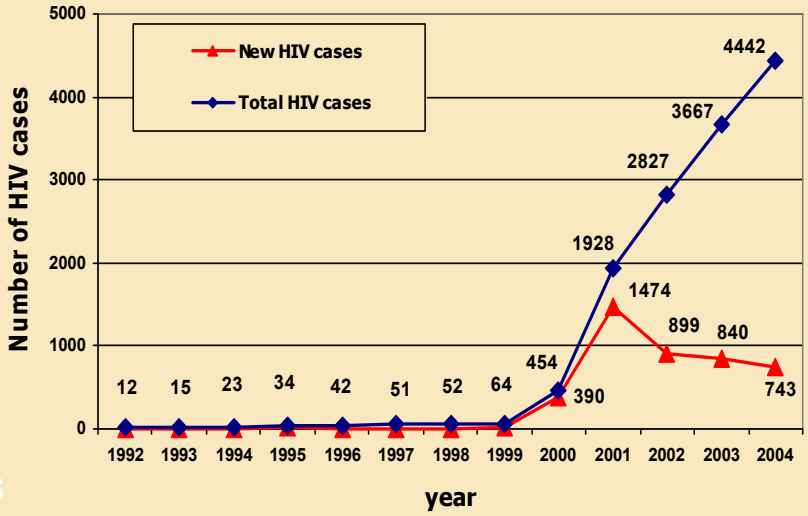
Source: Years lost due to burden of disease: links with risk factors and cost effectiveness to reduce risks. Ministry of Social Affairs in Estonia 2004. (available in Estonian)

Burden from main risk factors in Estonia

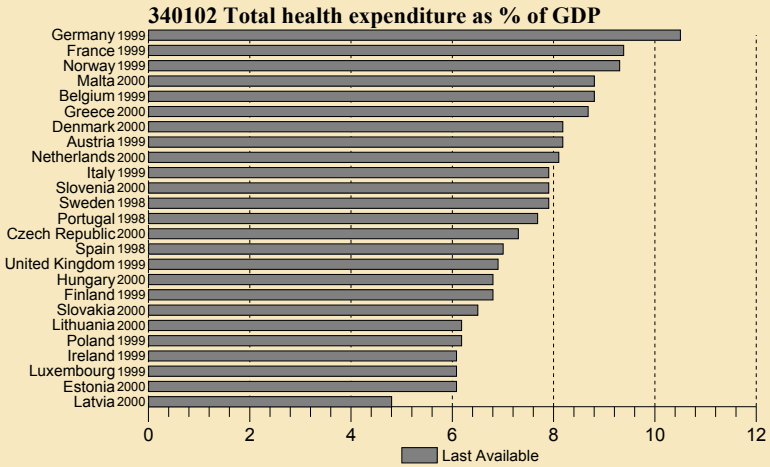


Source: Years lost due to burden of disease: links with risk factors and cost effectiveness to reduce risks. Ministry of Social Affairs in Estonia 2004. (available in Estonian)

HIV in 1992-2004



Total health expenditure as % of GDP



Health System Reforms in Estonia (1)

- **A twofold process of change:**
  - from centralised and state-controlled health care delivery system towards a **decentralised** one;
  - from a general state funded system to one based on **health insurance**.
- **Three main reasons:**
  - no relationship between health care expenditure and the national economy;
  - too much hospital capacity and too many specialist-doctors for the needs of the Estonian population;
  - a disproportionally weak and underdeveloped primary health care system.

Health System Reforms in Estonia (2) First wave

Reforms during 1991-1995 focused on improving health care financing, decentralization of health care planning and increasing the health system's responsiveness

- **Three main issues:**
  - launching of the health insurance system
  - introduction of the family practitioners system
  - restructuring and reorganising of health care system
- **The Health Insurance Law (1991)**
- **The Health Care Organisation Act (1994)**
- **Public Health Law (1995)**
- **Medicinal Products Act (1995)**

Health System Reforms in Estonia (3) Second wave

- **Reforms 1996-2004** - concentrate on regulation of various sectors
- **Three main issues:**
  - re-centralizing planning,
  - defining financing responsibilities,
  - strengthening regulatory functions and purchasing power and legalizing provider autonomy
- **2000/2002 Health Insurance Fund Act**
- **2001 Health Services Organization Act**
- **2001 Law of Obligations**
- **2002 Health Insurance Act**
- **2004 Communicable Diseases Prevention and Control Act**

Reforms in financing

- Social health insurance
  - mandatory
  - based on solidarity
- Tax paid by employers
  - proportional as a flat 13% surcharge on salaries paid to employees
- Coverage 94,6% of the population
  - wider than actual contributors

Main reforms in Primary Care Sector

- Until 1998 - **polyclinics and ambulatories**, owned by the Municipalities
- Since 1998 - primary care organised around **Family Practice**
- Sole proprietors or found companies
- Every practitioner has a list of patients (up to 2000 persons)
- Organized at the county level

Main reforms in Hospital Sector

- Reducing hospital capacity
  - closing down or reorganization of small hospitals
- Introducing provider autonomy
  - joint stock companies or foundations
  - mainly owned by the state or municipality
  - seven types (regional, central, general, local, special, rehabilitation, nursing hospital)
- Estonian Hospital Masterplan 2015

Main reforms in Public Health

- The Public Health Act passed in 1995
- Rerganisation of the health protection system (shift from the Soviet sanitary-epidemiological service)
- Establishment of the national public health institute – Institute for Health Development
- Development of multisectoral and longterm health strategies and programmes

Current developments in health system

- Setting vision and goals in health policy (in collaboration with WHO)
- Streamlining public health services and structures (in collaboration with WHO)
- Strengthening primary health care (development plan) (in collaboration with WHO)
- Developing emergency care (development plan)
- Restructuring hospital sector (development plan)
- Developing integrated e-health services and health information systems

Challenges and future developments of health system

- Elaboration of the new public health act
- Developing an integrated and comprehensive health information, surveillance and monitoring system
- Ensuring sustainability of social health insurance
- Improving the efficiency of health system
- Integrating different services (health care, public health and social services) for greater effectiveness and continuity of care
- Improving equity in health system
- Strengthening the stewardship role of health system

Eesti Haigekassa
Estonian Health Insurance Fund

Health services planning and contracting

Helvi Tarien
Health Services Department
EHIF

Eesti Haigekassa
Estonian Health Insurance Fund

Strategic purchasing

Purchasing is understood as the allocation of financial resources to providers, differentiating passive forms of allocation from proactive or strategic allocation in light of health gain, responsiveness and efficiency goals

Health expenditure´s share of GDP

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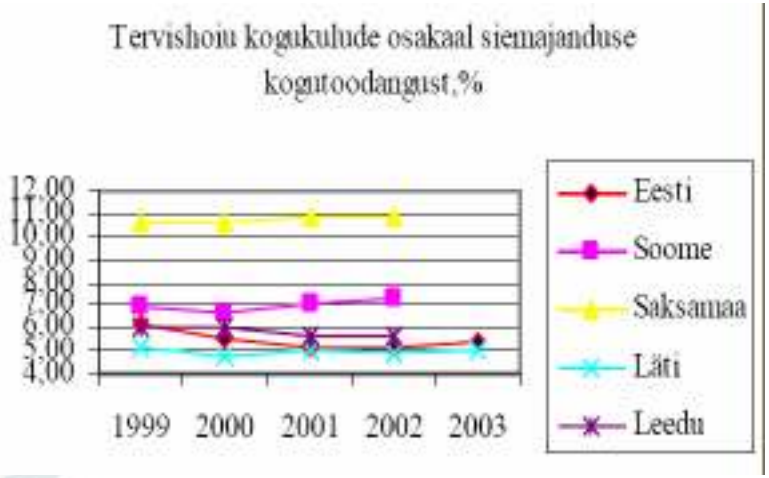

Public expenditure´s share of health expenditure

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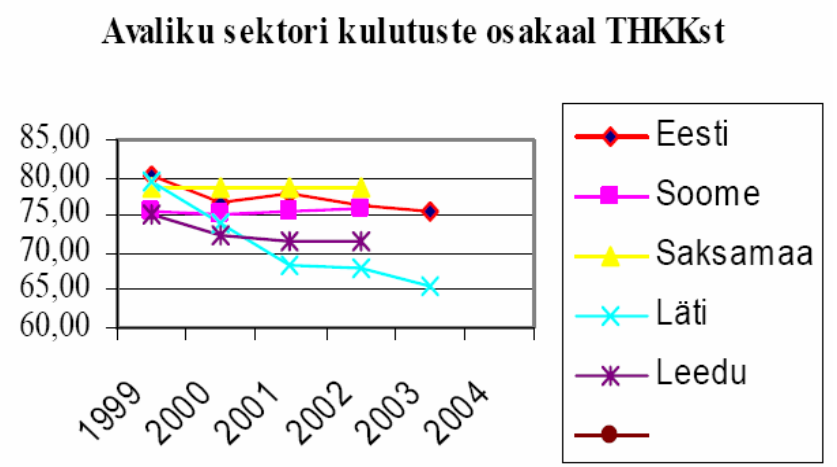
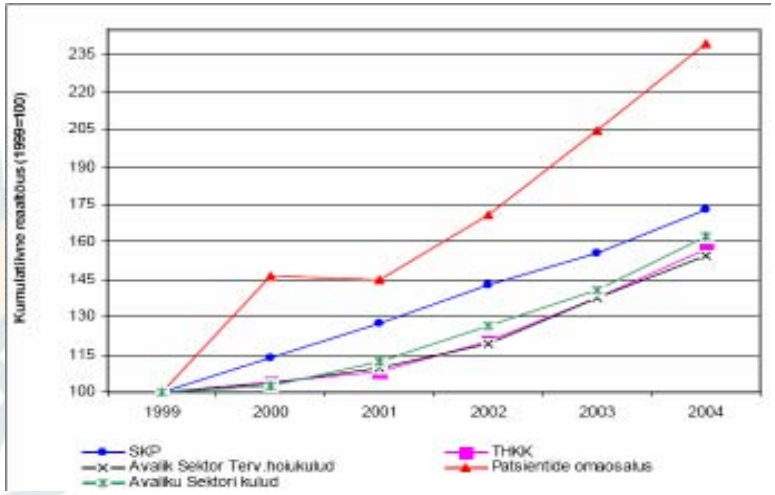
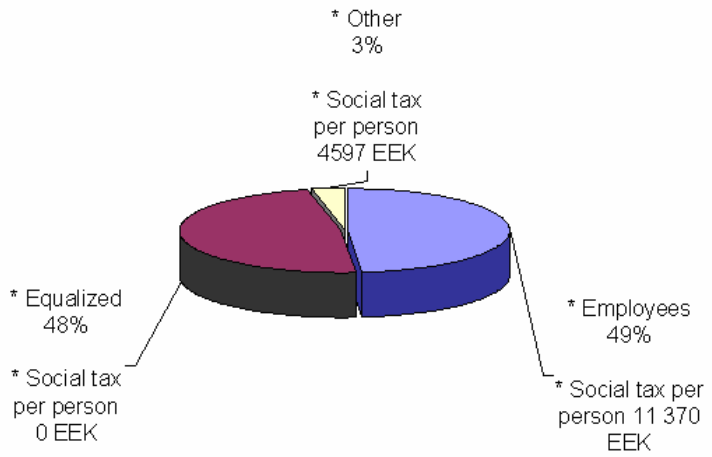
Estonian Health Insurance Fund



Health expenditure – decreasing share of total public expenditure



Solidarity in Estonian health insurance (Jan, 2006)



Expenditure on health insurance benefits

Expenditure "controlled" by the EHIF (covered by contracts):

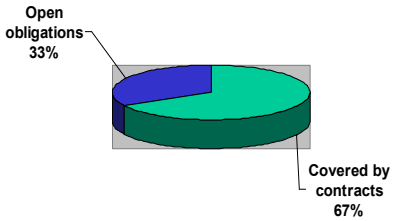
- Health services
- Health promotion costs

Open obligations

- Pharmaceuticals
- Sick-leave benefits

(for incapacity for work)

- Other cash benefits



Planning

Stages of the planning process cont

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Estonian Health Insurance Fund

Health care needs assessment – starting point of the planning

- For all budget sections
- Number of cases
- By regional branches

Our tools in needs assessment:

- Utility data (number of cases, queues)
- Comparative analysis (by regional branches&average in Estonia)
- Development plans of specialities
- "Corporate view" from purchasing stuff

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Estonian Health Insurance Fund

Stages of the planning process cont

Establishment of the budget

- Determination of priorities & pooling ressources
- Planning cases to ensure the access
- Number of cases x average price = amount
- Budget: cases x average price=amount
- Verify budget with assessed needs (establishing maximumwaiting times by board)

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Stages of the planning process cont

1. 3-years (4-years) budget prognosis
- setting priorities
- to give prognosis of the financial sustainability

2. Prospective quarterly planning
- to improve competence of planning
- basis for management decisions
- to give prognosis for the current year

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EHIF budget allocation

EHIF budget allocation between 4 branches based on simple capitation formula (for PHC, specialized care, nursing care, dental care)

Insured pools of 4 branches in EHIF (March 31, 2006)

- Harju 515 198
- Tartu 321 797
- Viru 251 848
- Pärnu 185 118
- Total 1 273 961

Examples as to the amounts of public services provided by the EHIF

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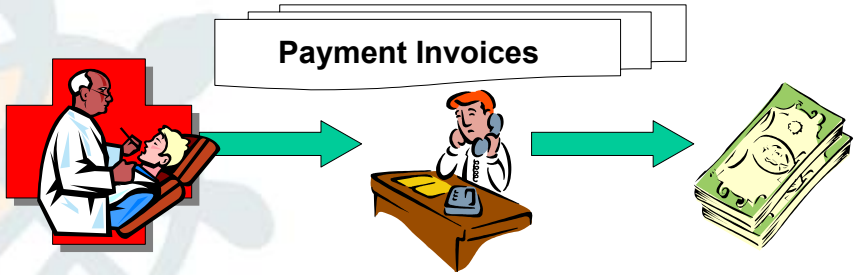
Estonian Health Insurance Fund

	2 003	2 004
Medical treatment invoices to be processed	6 508 000	6 052 000
Prescriptions entitling to a discount to be processed	4 529 000	4 627 000
Certificates of incapacity for work to be processed	445 000	524 000
Medical treatment documents to be checked	13 660	13 400
Contract annexes to be managed	1 320	1 120

Controll of invoices - past

Eesti Haigekassa
Estonian Health Insurance Fund

- **The client desk processed /controlled almost every payment invoice (there are over 10 millions invoices a year)**



Hospitals,
Farmacies,
Dentists, etc

Client desk processed, controlled and communicated with the partners

Accountants processed the payment

The project TORU-now

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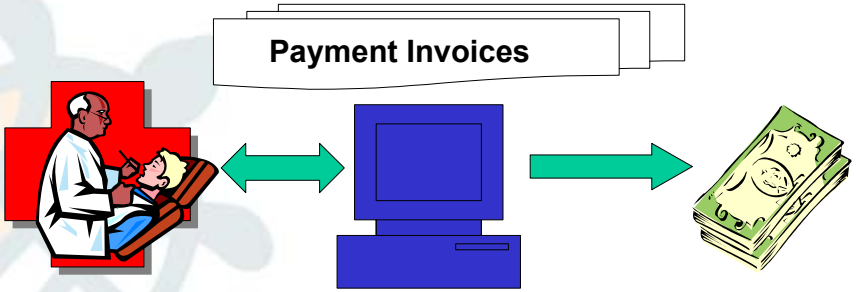
Estonian Health Insurance Fund

- **Almost all controlling activities are processed automatically: the client desk controls minimal number of payment invoices**



Hospitals,
Farmacies,
Dentists, etc

All controlling processes are done automatically.

Accountants processed the payment

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Contract

Contract – with whom?

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EHIF isn´t required to enter into a contract with all providers

Provider can be offered a contract:

- a hospital specified in the Hospital Masterplan through negotiations
- through selection of providers (limited competition)
- GP – have to compete, competition is organized by county governor in cooperation with EHIF

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Basic principles: selection of providers

Limited use of competitive selection

- specialist ambulatory services in areas and specialties where many providers
- dental care
- criteria: qualification, user charges, proximity to patients, price (GP preference)
- "competition" for supplemental contracts (marginal pricing)

Providers who agree to the terms of contract

Contract with economically viable health care providers

Follow hospital masterplan

Conditions of contract

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Estonian Health Insurance Fund

- the term of the contract;
- the amount of obligations;
- the price payable for the provision of the health service;
- the the minimum volume of health services provided;
- the list of professionals who provide health services;
- the number of hours during which the provider is required to provide services;
- the term to submit information to the EHIF;
- cases where needed prior written approval from the EHIF;

Conditions of contract

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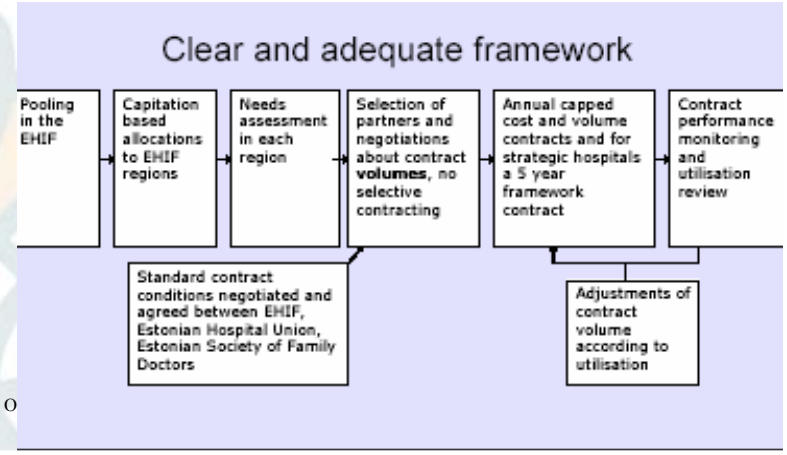
Estonian Health Insurance Fund

- cases where the parties have the right unilaterally to terminate contract;
- submitting information to the EHIF - waiting lists and services provided;
- the procedure and term for giving notice of services provided outside the waiting list;
- the scope of the reporting obligation of the health care provider and the obligation to submit information;
- the indicators of the quality and efficacy of the health services;
- the liability of the parties upon violation of the contract;
- other conditions necessary for ensuring the efficient and purposeful use of health insurance funds.



Contracts: Basic Principles

Health insurance law approves basic conditions of contract

EHIF board approves the basic principles for contracting

- EHIF contracting should support Estonian health care reforms
  - primary health care reform
  - hospital masterplan
  - EHIF's own structural reforms
- contracting should focus on accessability, quality and efficiency improvement
- EHIF should have instruments and rights for contract supervision and monitoring

Basic principles: access to services

Guarantee access to agreed services during the time the entire contract is valid

Define management of queues and increase transparency of long queues

Define maximum waiting times in contracts

- emergency - no delay
- elective - PHC - 3 days; outpatient specialist 4 weeks; in-patient – up to 6 months (exc)

Opportunity for the GP-s - register patients by phone to specialists

Monitoring waiting times

Standard waiting times reporting introduced since 2002

- reported by hospitals, breakdown by specialty and by EHIF branch
- standardised for population (per 100 000 people)

Masterplan-hospitals report every month, other providers quaterly

EHIF monitor queues of hospitals and GP-s

Accessability to GP-s

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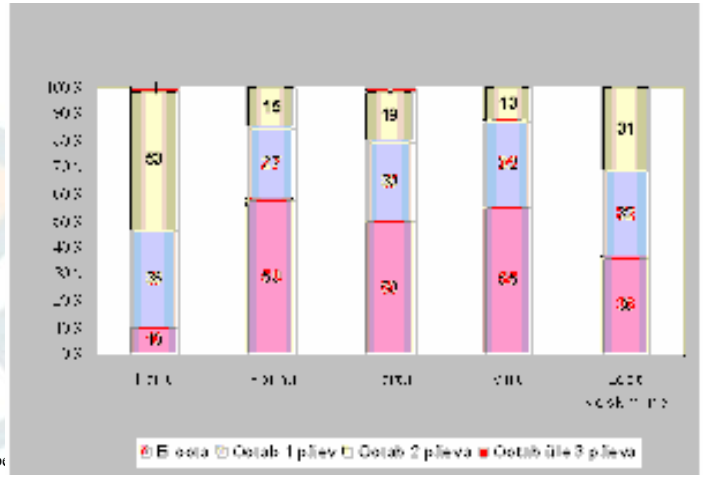

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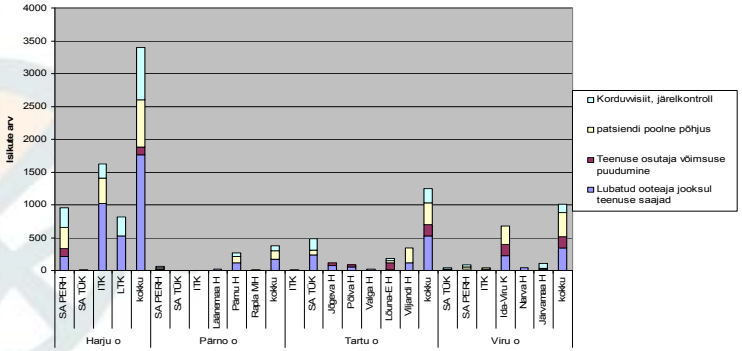
Cardiology – queues by EHIF branches



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Prioritizing queues

Application of prioritization protocols

- joint replacement, cataract surgery and cochlear implantation queues
- evaluate need, e.g.
  - physical impairment (visual aquity, functional mobility)
  - pain
  - ability to work, give care to dependents, live independently
- protocols based on New Zealand experience

People with higher needs are treated faster

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Risk management in EHIF

Hospital contract level

- hospitals can reallocate up to 5% among different specialities inside a contract
- typical hospital contract has additional unallocated up to 15% of total contract amount for reallocation among specialities inside the contract (but in coordination with EHIF)

Regional EHIF department level

- up to 3% of budget remains uncommitted in the beginning of the year

EHIF level (past – costly cases, now centralized planning of endoprosthesis and cataracts)

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Risk management in EHIF cont

Legal reserve

- For the reduction of the risk which macroeconomic changes may cause to the health insurance system
- Since January 2005 6% from the EHIF´s budget (up to then 8%)

Cash reserves

- Can be used by management board for financing the expenditure of EHIF in the case of temporary cash squeeze
- Up to 2% from EHIF´s budget

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Cost containment in EHIF

Capped Cost-and-volume contracts with providers

- caps are applied for every quarter
- development of the cumulative monitoring
- monitoring volumes (measured in cases per specialty)
- monitoring costs (average cost per case in specialty)

Marginal pricing for supplemental services

- uses marginal cost/marginal price concept (since last year 30% of list´s price)
- applied to cover services that were produced over the agreed contract amount

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Structure of EHIF cost-volume contract

Specialty	Out-patient cases	Sum	In-patient cases	Sum	Total
Cardiology	100	30000	100	500000	530000
General Surgery	100	30000	50	300000	330000
...					
Contract reserve (up to 15%)					94600
Total					946000

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Lepingu nr:	6057104
Lisa nr:	3-05-2
Eesti Haigekassa:	Tartu osakond
Lepingu kuupäev:	22.03.2004
Lepingu muudatuse kuupäev:	17.03.2005
Tervishoiuteenuse osutaja:	Viljandi Haigla SA
Periood:	01.01.2005 - 31.12.2005

	I kvartal 05							
	Ambulatoorne		Päevaravi		Statsionaarne		Kokku I kvartal 05	
	Ravijuhud *	Summa	Ravijuhud *	Summa	Ravijuhud *	Summa	Ravijuhud *	Summa
	arv	krooni	arv	krooni	arv	krooni	arv	krooni
Kogusumma	13 052	4 086 752	260	735 102	1 849	14 084 983	15 161	18 906 838
▽ **Eriarstiabi**	13 052	4 086 752	260	735 102	1 845	12 689 323	**15 157**	**17 511 178**
▽ **Kirurgia**	2 173	804 940	55	289 230	466	3 783 920	**2 694**	**4 878 090**
▷ üldkirurgia	2 173	804 940	55	289 230	466	3 783 920	**2 694**	**4 878 090**
▷ **Otorinolarüngoloogia**	981	215 626	52	187 166			**1 033**	**402 792**
▷ **Neuroloogia**	831	308 391					**831**	**308 391**
▽ **Oftamoloogia**	1 015	211 350					**1 015**	**211 350**
Muu oftalmoloogia	1 015	211 350					**1 015**	**211 350**
▽ **Sünnitusabi ja günekol**	2 684	956 243	135	249 608	261	1 415 410	**3 080**	**2 621 261**
▷ Muu sünnitusabi ja güneko	2 684	956 243	135	249 608	143	606 930	**2 962**	**1 812 782**
▷ Sünnitused					118	808 479	**118**	**808 479**
▷ **Pulmonoloogia**	253	63 262			20	261 180	**273**	**324 442**
▷ **Dermatoveneroloogia**	1 172	195 681					**1 172**	**195 681**
▷ **Pediaatria**	299	49 503			233	517 387	**532**	**566 891**
▷ **Psühhiaatria**	1 225	212 880			250	2 932 875	**1 475**	**3 145 755**
▽ **Sisehaigused**	2 127	818 165	18	9 098	540	3 408 362	**2 685**	**4 235 625**
▷ reumatoloogia	57	17 834					**57**	**17 834**
▷ endokrinoloogia	329	111 493					**329**	**111 493**
▷ gastroenteroloogia	95	38 200					**95**	**38 200**
▷ kardioloogia	871	439 587					**871**	**439 587**
▷ sisehaigused	775	211 052	18	9 098	540	3 408 362	**1 333**	**3 628 512**
▷ **Esmane järelravi**					25	133 925	**25**	**133 925**
▷ **Taastusravi**	223	221 185			50	236 265	**273**	**457 450**
▷ **Klassifitseerimata mitte**	69	29 525					**69**	**29 525**
▷ **Valvekulud**					4	1 395 660	**4**	**1 395 660**
▷ **Eriarstiabi reserv**								

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Contract monitoring & utilisation review

- Introduction of the prospective contract monitoring during the year
- Negotiations with providers
  - about contract amounts
  - amendments of the contract due to the access problems

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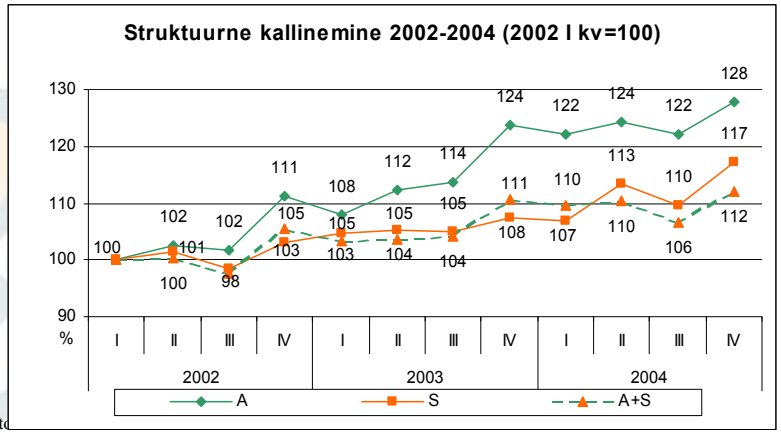
Average price of the case 2002-2004



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New payment policy for GP-s

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Goals of the new payment policy:

1. **To promote GP´s results in disease prevention and monitoring patients with chronic diseases**
2. **To involve more praxis-nurses in the preventive activities**
3. **Applied universally - chances for all GP´s**

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Payment by result for GP´s

- Government approved regulation on payment principles for GP-s – bonus payment for reaching preset performance targets
- payment will be made according to the results from previous year (monthly lump-sum)
- EHIF checks bills and creates the reports on the basis of its reimbursement database

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Priority areas:

- Vaccination coverage
- Screening procedures
- Chronic disease monitoring

Prevention - vaccination

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0–18-a isikud	Kood	Hõlma-tus	Punk-te	Selgitused	
0–2-a laste vaktsinee-rimine	9020	90%	5	*Läkaköha*	Teost. lastele vanuses 3,4½,6 kuud - märgitakse vaktsin lõpetamise järgselt ja 2 av I RE vaktsin järgselt
	9021	90%	5	*Difteeria*	
	9022	90%	5	*Teetanus*	
	9023	90%	5	*Poliomüeliit*	
	9024	90%	5	*Leetrid*	Teost. lastele vanuses 1a. - märgitakse vaktsin lõpetamise järgselt
	9025	90%	5	*Parotiit*	
	9026	90%	5	*Punetised*	
	9027	90%	5	*B-hepatiit*	Teostatakse lastele vanuses 3-5 päeva, 1 kuu, 6 kuud - märgitakse vaktsin lõpetamise järgselt.

GP´s out-patient visits I quarter 2006 vs I quarter 2005

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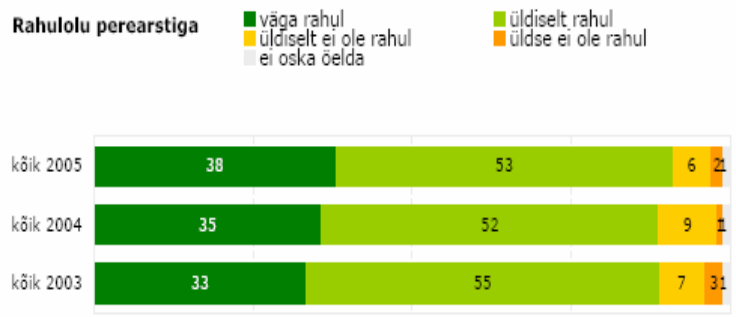
Perearsti v	2005 I kvartal tegelik		2006 I kvartal tegelik		Osakaal % 2006/2005	
	Vastuvõtud	Arveid	Vastuvõtud	Arveid	Vastuvõtud	Arveid
Esmane vas	522 993	494 675	503 500	502 828	96%	102%
Korduv vas	661 429	394 286	552 484	376 830	84%	96%
Profülaktilir	86 933	77 010	112 724	110 116	130%	143%
Koduvisiit	52 224	47 934	50 285	46 480	96%	97%
Pereõe ises	31 395	27 468	44 116	38 518	141%	140%
Kindlustam	2 678	2 175	3 273	2 692	122%	124%
Pereõe kodu	4 624	3 132	4 918	3 430	106%	110%
Telefonikor	36 479	28 069	45 393	41 308	124%	147%

GP´s who provided for EHIF lists of patients with Diabetes II and high blood pressure

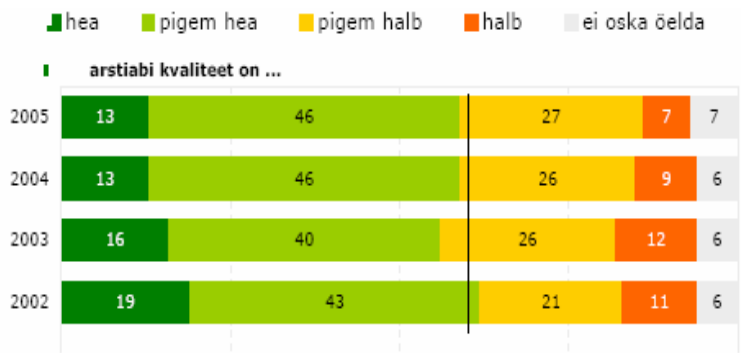
	Nimistuid kokku	Esitanud nimekirjad	%
Harju	313	171	55
Pärnu	115	65	57
Tartu	198	75	38
Viru	164	73	45
Kokku	**790**	**384**	**49**

Patient satisfaction survey – GP-s



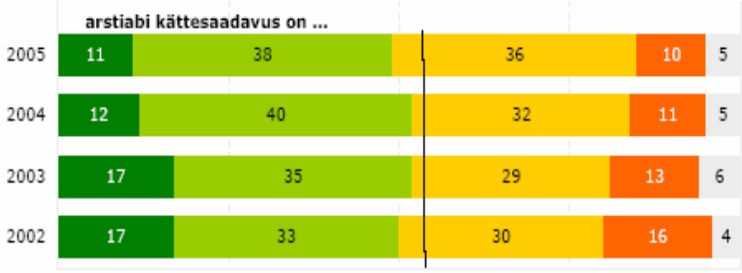
Public opinion of quality: 2001 - 2005

All respondents



Public opinion of access: 2001 - 2005

All respondents



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Estonian Health Insurance Fund

Thank You!

www.haigekassa.ee

Estonian Society of Family doctors

28.09.2006

Madis Tiik

Chairman of the board

Membership

- ESFD was established 1991
- 765 members, more that 95% FD are member of society
- In the future - supporting members (pharmaceutical companies)

ESFD development I period

- 1991 - academic society, main target - recognition of family medicine
- 1992 - courses for family doctors
- 1994 - first course on FD finished
- 1997 - legislation of family medicine

ESFD development II period

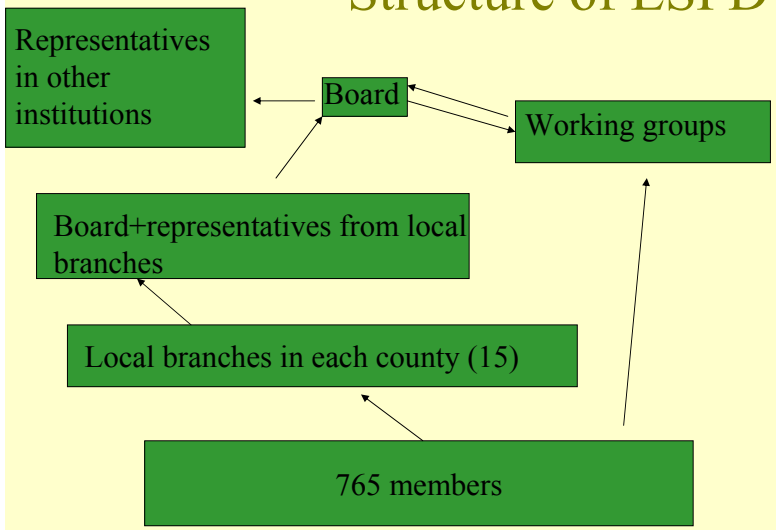
- 1998-2002 rapid growth of membership
- new tasks
  - negotiations with EHIF
  - working conditions of FD-s
  - division of work
  - labour division
  - management

ESFD as a trade union

ESFD development III period

- 2002-
- Publicity
- Public interest
- Active role in health policy

Structure of ESFD



ESFD role in primary care reform

- Best competence
- Active partner in negotiations
- Represents all FD-s
- General view for healthcare
- Patients advocate
- FD-s position in public health and curative care

ESFD budget

- Membership fees (32 € per year)
- Sponsorship
- Courses (distance learning)
- Certification of doctors
- Conferences

2 employees - chairman and secretary

- Annual turnover 50000 €

ESFD development in the future

- Balancing between academic society and trade union
- Representing FD-s
- New services for FD-s
  - economical counselling
  - juridical counselling
  - IT solutions for FD-s

IT solutions for FD

Madis Tiik

28.09.2006

Tervisepank

History

- 1998 EHI started electronic reporting system for FD-s.
- All FD sent bills electronically to EHI
- 1998 - 2004 development software for FD-s
  - prescription
  - electronic patient records
  - statistics

Tervisepank

Driving force

- EHI
- Software's were made to help make billing and reporting system easier for FD-s
- FD were pioneers in computerisation, all practises have computers

Data in local databases

Tervisepank

Development - outsourcing

- 2004 - web paste software for FD-s was made in collaboration between ESFD and IT companies (Public-private partnership)
- ESFD- customer, but also adviser
- IT - financial and software know-how
  - Tervisepank - Health account

Data in central database

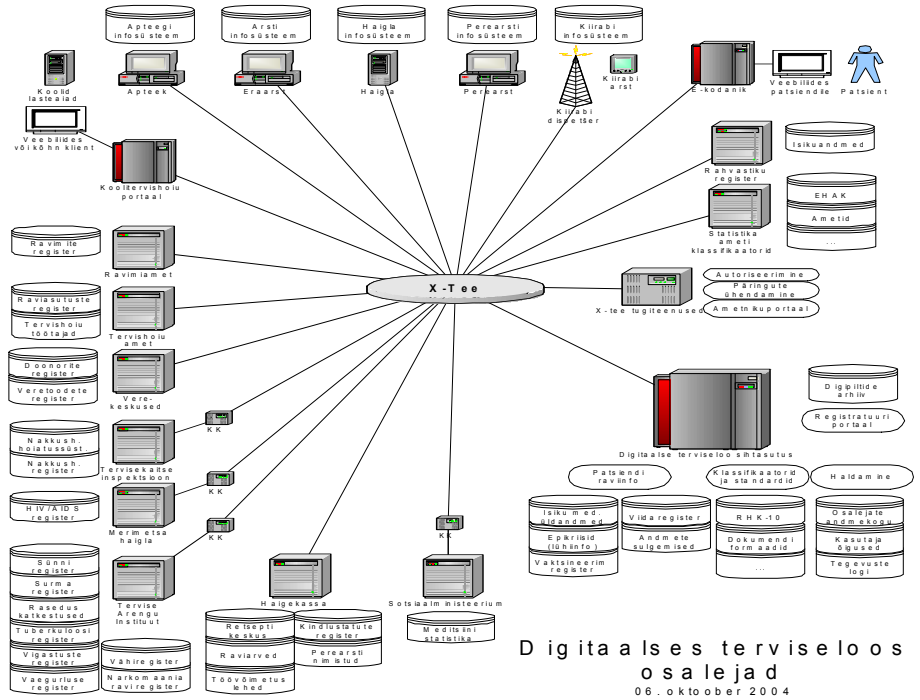
Tervisepank

Future- integration

- Electronic registry of appointment times
- Electronic referrals for tests and consultations
- Electronic prescribing
- Nation-wide electronic patients records

2005-2007

Tervisepank



eHealth -Integration between healthcare providers

- 2005-2007 - nation-wide, paperless, 7/24/365 available healthcare information system
- Financing
  - EU
  - Estonian government
  - healthcare providers
- Outcomes
  - Less paperwork for doctors, more time for patients
  - online statistics and outcome indicators
  - patients can see who and when have looked his/her data
  - less unnecessary test and investigations

Tervisepank

Supporting services

- Call-centre
  - 7/24/365
  - occupied with nurses
  - medical advise via phone
- Web-paste registration
  - outsourcing
  - patients can access via internet

Tervisepank

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Estonian Health Insurance Fund

Estonian Health Care

Arvi Vask
Member of the management board
Estonian Health Insurance Fund
2006

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Estonia

Population 1 356 045 (01.01.2003)
1/3 in Tallinn and nearby
Minister of Social Affairs (health, social care and employment)
Administratively 15 counties
Local Governments 227

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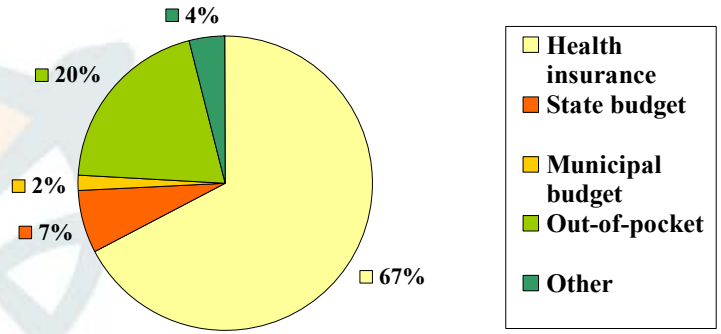
Health Care Expenditure 5,1 % GDP 382 mill EURO, 2002



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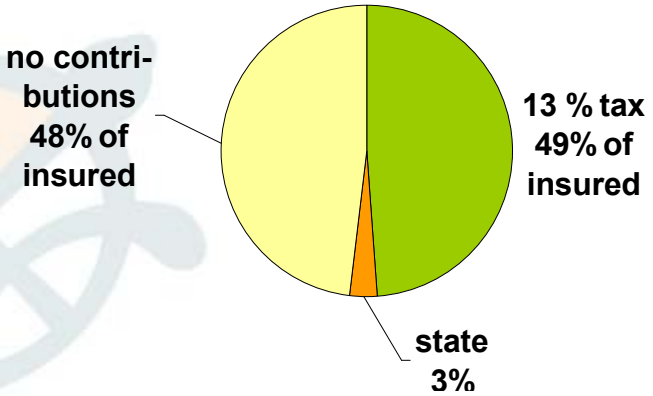
Solidarity in Estonian health insurance: contributions (2005)



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Finance - from budget to earmarked tax in 1992

Health Insurance Law in force since 1992

Financed: 13 % earmarked health insurance tax on salaries paid by employers

- Collected by Tax Agency from 1999

Coverage: 94% of population

Administration by Health Insurance Fund (EHIF)

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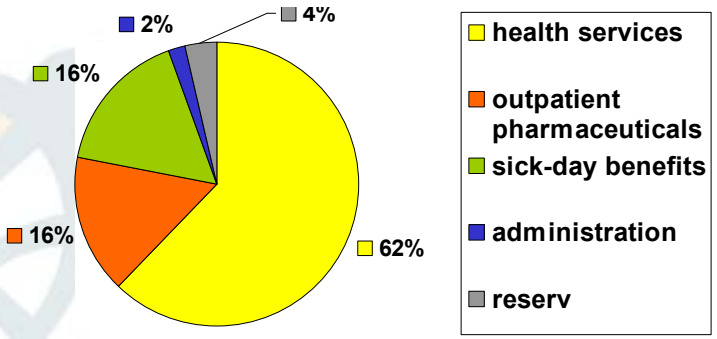
EHIF budget 2005 - 460 mill EURO



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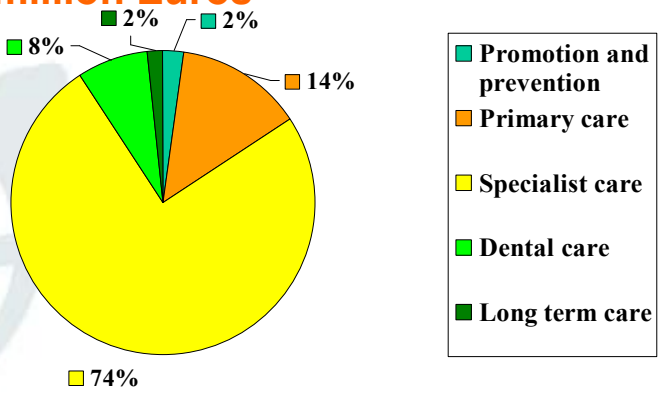
EHIF budget for health services 2005: 301 million Euros



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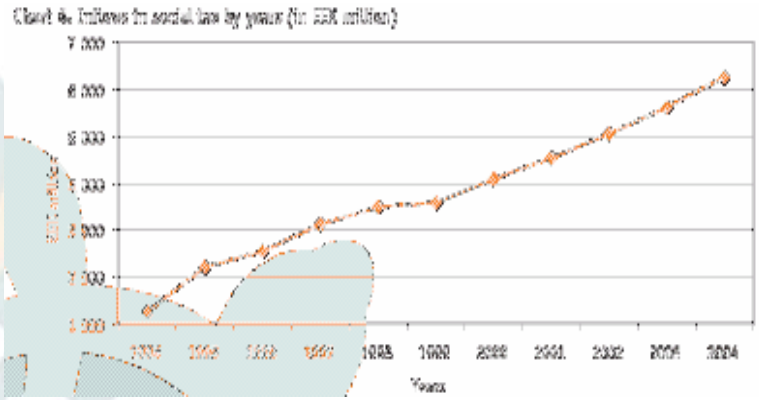

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Medical people

One Medical Faculty in Tartu University

Physicians	4426	30,8/10 000 pop.
Dentists	1012	7,0 /
Nurses	10196	70,7/

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1991 Estonia regained independence and 1992 start the health reform

From Semashko model to Bismarck , public-contract´model

- Separation of purchasing and provision functions
- Establishing EHIF and earmarked payroll tax (social tax)

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PHC reform

1993 FM was designated as a speciality (3-year residency and in-service training programm)

1997

- Provision delegated to PHC units owned by family practioners, (separation PHC from specialist care)
- EHIF contracted with PHC units
- Estonian sitizens was required to register to FPs
- Ministerial regulations defined responsibilitis of FPs and introduced a new payment system

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Primary Care

Private family practitioners

- 1500 - 2300 registered people/ FP
- Overall 788 FP in 2005/ 562 in 2001

Health insurance financing

- weighted capitation
- fee-for-service
- basic allowance
- bonuses

Gatekeeping for referrals to specialist care

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Capitation

- Monthly payment per every registered insured
- Re – calculated according to number of insured 4 times in year
- Equal for everybody in 1998, age-weighted since 1999 (3 age groups)
- Defined list of services and tests

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Fee for service

- Paid according to submitted bills retrospectively
- Defined list of 44 services (minor surgery) and 47 tests
- Limited by 23% ceiling of total capitation payment
- All referrals to specialists are paid by the Health Insurance Fund separately and directly to specialised care provider

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Estonian Health Insurance Fund

Rationalising the hospital sektor (Masterplan 2015)

13 acute hospitals - 3 500 beds

In 2001 in Tallinn 17 hospitals

In 2002 in Tallinn 4 hospitals

- 2 children hospitals merged into 1 foundation, 1 building was closed in 5 months
- 7 state hospitals into 1 foundation
- 16 hospitals and polyclinics into 2 joint-stock companies

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Hospitals

1993	1999	2003
number 115	78	50
beds 14 377	10 358	9160
ALOS 15,4 days	9,9 days	6,8

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Hospitals 2005, total 50

Regional	3
Central	4
Specialized	5
General	11
Rehabilitation	3
Care	24

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Specialist Care

Hospitals mostly publicly owned, working under private law

- Foundations
- Joint-stock companies

EHIF contracts with centers and hospitals

Payment mostly fee-for-service and DRG basis up to the limit of the contract

Block-contracts have developed to very detailed contracts, specifying patient numbers and case-costs per speciality

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Public Private Collaboration

EHIF, public law and public ownership

↓

contract

↑

Health care service provider, private law and public or private ownership

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Example of cost-volume contract

Specialty	Ambulatory patients	Cost per case	In-patients	Cost per case	Total
cardiology	1000	50	100	5000	550 000
General surgery	1000	50	200	5000	1 050 000
Reserv (5-15 %)					100 000
Total	2000		300		1 700 000

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Estonian Health Insurance Fund

Waiting time (council decision)

Maximum waiting time 2006 (not emergency cases)

- Ambulatory up to 4 weeks
- Stationary and daysurgery up to 8 months
- Hip, knee replacement up to 3,5 years

Waiting list information is collected electronicli from hospitals once a mounth

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Estonian Health Insurance Fund budget

~94% of population is insured

There are four EHIF regions where centrally collected funds are allocated

- For primary care the allocation takes place according to capitation (age adjusted) and other GP payment methods related to practice characteristics
- For inpatient and outpatient acute care crude capitation is used
- For long-term care capitation is used taking into account over 65-year old population share
- For pharmaceutical costs there are no allocations to regions

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Administration - looking for a balance in decentralisation

1992 - 22 independent Sickness Funds

- co-ordination by Association of SF-s

1994 - Central Sickness Fund and 17 local Sickness Funds

- all under Ministry of Social Affairs

2001 - Estonian Health Insurance Fund - public independent legal body with 4 regional branches

Eesti Haigekassa
Estonian Health Insurance Fund

Administration: today

Estonian Health Insurance Fund Law

- Adopted June 2000, in effect January 2001

EHIF is a public independent legal body

- Governing board consisting of state, employer and insured people representatives 5:5:5
- Functions : catalogue of benefits, health services prices, budget of HI
- Management Board: 3 members

4 regional branches

- Largest branch 500,000 people

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Table 7. Main indicators for the years 2001-2006 (%)

Main indicators:	2001	2002	2003	2004	2005	2006*
Social tax as a percentage of total revenue	99.5	99.2	98.9	98.9	99.1	99.1
General medical care as a percentage of total expenditure	7.4	7.9	8.0	7.7	8.1	8.4
Specialized medical care as a percentage of total expenditure	47.6	45.3	49.9	51.0	51.6	52.6
Incapacity benefits as a percentage of total expenditure	16.5	16.1	16.2	17.4	17.4	18.9
Prescription drugs as a percentage of total expenditure	14.6	15.2	12.0	13.6	12.0	12.1
Operating expenses as a percentage of total expenditure	1.7	1.6	1.5	1.3	1.2	1.2
Reserves as a percentage of total expenditure	0.0	3.7	9.9	10.1	7.8	8.0
Health insurance benefits as a percentage of GDP	4.3	4.0	4.2	4.4	4.5	4.6

* - approved budget

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Chart 3. Proportion of the insured and the social tax paid 2005

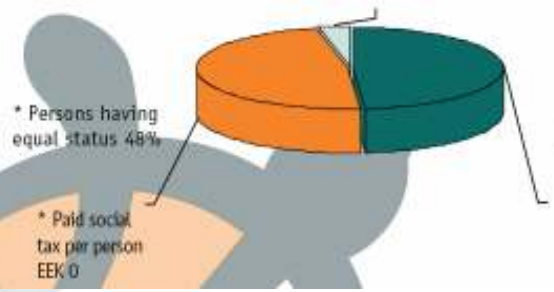

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Table 17. Disease prevention projects and other prevention activities

Prevention activities in EEK thousand	2006 budget	2006 actual	2006 actual/ 2006 budget %
Dental health	25 231	26 134	104%
Reproductive health of young people	6 961	6 528	94%
Early detection of cervical cancer	5 251	5 [illegible]	101%
Screening for phenylketonuria and hypothyroid	1 123	1 061	88%
Prevention of [illegible]	9 [illegible]	10 [illegible]	111%
Early detection of osteoporosis	1 137	850	72%
Prevention of heart disease	4 [illegible]	2 [illegible]	49%
Immunization against hepatitis B	9 041	9 365	103%
Early detection of cervical cancer	6 [illegible]	[illegible]	34%
Hearing screening for newborns	1 427	1 178	77%
Other prevention activities	163	0	0%
Total	77 [illegible]	74 [illegible]	97%

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Table 24. Major indicators for therapeutic services in outpatient (O) and inpatient (I) specialized medical care (excl. emergency response expenses) in 2004 and 2005

Indicator		2004 actual	2005 actual	2005 actual/ 2004 actual %
Treatment cost (in EEK thousand)	O	[illegible]	[illegible]	[illegible]
	I	[illegible]	[illegible]	[illegible]
Number of cases	O	[illegible]	[illegible]	[illegible]
	I	[illegible]	[illegible]	[illegible]
Average cost per case (EEK)	O	[illegible]	[illegible]	[illegible]
	I	[illegible]	[illegible]	[illegible]
Hospital patient days	I	[illegible]	[illegible]	[illegible]
Average duration of treatment (days)	I	[illegible]	[illegible]	[illegible]
Persons treated	O	[illegible]	[illegible]	[illegible]
	I	[illegible]	[illegible]	[illegible]
Specialists' appointments	O	[illegible]	[illegible]	[illegible]
Ratio of outpatient appointments to medical cases	O	[illegible]	[illegible]	[illegible]
Ratio of outpatient appointments to medical persons	O	[illegible]	[illegible]	[illegible]

Eesti Haigekassa
Estonian Health Insurance Fund

Table 35. Implementation of the 2005 budget for drug benefits by covered prescription drugs, compared to 2004.

Drugs reimbursed for the treatment (in EEK thousand)	2004	2005	2005 vs 2004 (%)	percentage of expenditure on covered prescription drugs in drug benefits 2004	2005
Drugs reimbursed at 100 %	301 219	380 540	126%	25%	29%
Drugs reimbursed at 85 %	320 379	299 282	93%	27%	24%
Drugs reimbursed at 75 %	81 870	89 232	109%	9%	9%
Drugs reimbursed at 50 %	158 322	185 454	118%	18%	19%
Drugs reimbursed under special conditions	1 540	7 664	498%	0,15%	0,58%
TOTAL	863 347	971 153	113%		

Eesti Haigekassa
Estonian Health Insurance Fund

Table 36. Number and average cost of covered prescriptions (CP) reimbursed by the EHIF in 2004 and 2005

	2004 prescriptions	2004 average cost in EEK	2005 prescriptions	2005 average cost in EEK	change in number of CP %	2005 vs. 2004 average cost of CP %
Reimbursed at 100 %	427 858	704	538 207	695	127%	98,7%
Reimbursed at 85 %	1 608 351	186	1 707 486	175	106%	94,2%
Reimbursed at 75 %	435 787	187	398 698	174	91%	93,0%
Reimbursed at 50 %	2 304 551	69	2 375 310	70	103%	101,4%
TOTAL	4 776 221	180	4 819 692	172	101%	95,1%

Eesti Haigekassa
Estonian Health Insurance Fund

Table 38. Spending on benefits for temporary incapacity for work in 2004 and 2005

Expenditure on benefits for temporary incapacity for work in EEK thousand	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %
Sickness benefits	925 [illegible]	776 190	917 [illegible]	118%
Nursing benefits	104 850	111 658	127 114	114%
Maternity benefits	[illegible]	[illegible]	[illegible]	[illegible]
Work injury benefits	20 618	21 317	22 [illegible]	107%
Total	1 101 [illegible]	1 [illegible]	1 [illegible]	[illegible]

Eesti Haigekassa
Estonian Health Insurance Fund

In conclusion -

- Earmarked HI tax has provided stable revenue growth to Estonian health care
- The changes/reforms undertaken have been planned by Ministry and EHIF together, with stakeholder support

Eesti Haigekassa
Estonian Health Insurance Fund

In conclusion -

Estonia looks for provider competition - strengthening EHIF purchaser role, limited open tendering in ambulatory care

Estonia never tried insurer-competition

Minutes from WG meeting #1

Date: March 3, 2006

Place: IMC office

Participants:

1. Saadet Mahmudova – National Coordinator on PHC, FM and Information programns
2. Rzayeva Gulnara – Head of WCC
3. Bayramova Elza – Family Doctor from Polic#4
4. Nasibova Saida - Family Doctor from Polic#4
5. Mustafayev Ilgar – head of department at Institute of Pulmonary Diseases, faculty member of Family Medicine at ASICME
6. Kerimov Malik – Doctor, private sector
7. Tagizade Tarana – National Coordinator on Maternal and Child health
8. Gasanova Jale – private clininc
9. Abbasova Zamina – doctor from Polic#4
10. Hasanova Nurlana – national coordinator on IMCI program
11. Jafarov Ibrahim - Salyan CH head doctor
12. Aliyev Sadatkhan- Jalilabad CH head doctor
13. Namazov Saribey- Guba CH head doctor
14. Chelik Khalida- City Polic # 8 (participant from AIHA partnership program)
15. Peter Houslohner – PHC project
16. Natalia Valeeva – PHC project
17. Kamalya Suleymanova – PHC project
18. Aybeniz Ibrahimova – PHC project

Meeting was chaired by Saadet Mahmudova
Short introduction of each meeting participant
Recent PHC launch event at MOH
Presentation of PHC project goals for meeting participants
Discussion about current problems in health sector
Previous Health Reforms project results and lessons learned were introduced by head doctors of pilot regions (Jalilabad, Guba, Salyan)
Discussion about purpose of working group

Minutes from WG meeting # 2

Date: March 16, 2006

Place: IMC office

Subject: Power Point presentations provided by PHC project consultants:
Dr. Georgiy Gotsadze "Profiles of General Practice in Europe"
Dr. Otar Vasadze "Licensing of medical personnel – international experience"
"Primary Health Care Financing"

Participants:

1. Saadet Mahmudova, MOH
National Coordinator on PHC,
Head of Family Medicine Department in Azerbaijan Post-graduate Institute

2. Tagizade Tarana, MOH
National Coordinator on Maternal and Child health

3.Tahir Hajiyev, MOH
Treatment and Prevention Department, inspector

4. Malik Abbasov, MOH
Licensing and accreditation

5. Elshad Abbasov WB WG
Pharm specialist PIU

6. Irada Akhundova WB WG
Institute of Pulmonary Diseases
Head of Departmnet

7. Zemfira Guliyeva,
Post-graduate Institute for physicians
Dean

8.Salikhov Mustafa
State Medical University
Head of department of Family Medicine

9. Nargiz Shamilova
USAID Mission

10. Ruziyya Ramazanova
USAID Mission

11. Policlinic #4
Nasibova Saida
Family Doctor

12. Ilgar Mustafayev
Institute of Pulmonary Diseases
Head of Departmnet

13. Fuad Ibrahimov – PHC project

14.Natalia Valeeva– PHC project

15. Aybeniz Ibrahimova– PHC project

16. Kamala Suleymanova– PHC project

17. Akaki Zoidze– PHC project

18. Nurlana Hasanova, MOH
National coordinator on IMCI program

19. Ulviyya Aliyeva - WB project WG member

Minutes from WG meeting # 3
Date: May 23 2006
Place: IMC office
Subject: IMCI strategy in Azerbaijan

Participants:

1. Saadet Mahmudova – FM coordinator
2. Ismaylova Shahla – IMCI trainer
3. Jafarova LAla – IMCI trainer
4. Salamova Sevda– IMCI trainer
5. Khaligova Aygun– IMCI trainer
6. Mammadova Nurlana – IMCI program Coordinator
7. Reshetnikova Olga– IMCI trainer
8. Ahmedova Mahabbat– IMCI trainer
9. Aliyeva Aygun– IMCI trainer
10. Mammdova Nargiz– IMCI trainer
11. Aliya Shahverdiyeva– IMCI trainer
12. Hasanov Alekber– IMCI trainer
13. Nagdaliyev Azim– IMCI trainer
14. Alyev Kamran- IMCI monitor
15. Isgandarova Lala- IMCI monitor
16. Ali-zade Tamilla- IMCI monitor
17. Hasanova Lala- IMCI monitor
18. Rustamova Arzu- IMCI monitor
19. Tarana Tagizade – National Coordinator on Maternal and Child health
20. Uma Kandalayeva – Project manager, "Child Survival", Mercy Corps
21. Jeyhoun Mamedov – AIHA, Country Director
22. Nargiz Shamilova – USAID
23. Akif Hasanov – Acquire Project
24. Nabat Mursagulova– Acquire Project
25. Natalia Valeeva – PHC project
26. Kamala Suleymanova – PHC project
27. Peter Houslohner – PHC project

Power Point presentation "Main principles of IMCI" - Kamala Suleymanova
Discussions on what was achieved and what were the main obstacles of IMCI implementation in Azerbaijan:

1. IMCI was accepted in 1997/8 by 30 experts and was presented to Ministry of Health
2. Group of trainers was created
3. Action plan was prepared
4. Additional group of facilitators was trained with support of INGOs in 2004 by WHO consultants
5. IMCI training packages was adopted to the local requrements
6. 314 medical providers were trained in 16 regions (20-25%)
7. 270 monitoring visits were implemented and reports were prepared

Suggestions:

1. IMCI training should be provided at both – under and postgraduate medical education level
2. Training course may vary depending on type of medical provider- trainees

3. Review of existing IMCI training package should be implemented every 5 year
4. specify selection criteria for training participants
5. Existing decrees of MOH create difficulties in IMCI program implementation
6. All four program components should be implemented simultaneously to achieve better results
7. IMCI drugs should be included to the essential drugs list
8. Identify /strengthen financial resources/support

Next steps

Evaluation of IMCI program implementation results by independent expert
Calculations of training expenses for one medical provider
Evaluation of survey results will be carried out by Mercy Corps in September
Creation of IMCI program regulation mechanism- Working Group in MOH (within 3 weeks)
Development of IMCI program strategy communication – IMCI website and IMCI newsletter

Meeting minutes from WG meeting # 4

Date: April 13 2006

Subject: **Education, Licensure, and Certification of Doctors and Nurses in the USA**
John R. Baird, M.D. and Darleen Bartz, Ph,D, APRN

Place: IMC office

Participants:

1. Saadet Mahmudova
   Head of Family Medicine Department at Postgraduate Medical Institute and National Coordinator for Family Medicine/Primary Health Care/ Information

2. Tarana Tagizade - National Coordinator for Maternal and Child Health, MOH

3. Sulhiyya Hasanova - Family Medicine Department at Postgraduate Medical Institute, faculty member,

4. Ilgar Mustafayev- Family Medicine Department at Postgraduate Medical Institute, faculty member

5. Irada Ahundova - WB project PIU member

6. Leyla Almaszade -, working on Licensure and Certification with the Ministry of Health

7. Huseynaga Huseynov - Chief of Education, Department of Post Graduate Institute

8. Nasimi Gasimov- Head of Education Department at Medical University

9. Mustafa Salekhov- Head of Family Medicine Department for Medical University and Policlinic faculty

10. Farkhad Mektiyev - Director of World Bank Health Reform Project, MOH

11. Dilara Mamedaliyeva– Director of Undergraduate Medical School for Nurses

12. Malik Abbasov - Responsible for Licensing and Accreditation, MOH

13. Ulviyya Aliyeva - WB project PIU member

14. Melinda Pavin, Senior Technical Advisor for Health,

15. Ruziya Ramazanova, USAID Azerbaijan, CTO

16. Natalia Valeeva – PHC project

17. Fuad Ibrahimov– PHC project

18. Aybeniz Ibrahimova– PHC project

19. Kamala Suleymanova– PHC project

DRAFT
09.09.2006

Order of the Minister of Health of the Republic of Azerbaijan

The Minister of Health of Azerbaijan, acting on instructions of the President of the Republic, has determined that strengthening Primary Health Care (PHC) throughout the country is one of the leading priorities of the Ministry and an essential means of achieving the country's Millenium Development Goals. International experience has shown that up to 90% of medical complaints and conditions can be successfully treated at the patient's first point of contact with the health care system, if the medical personnel who serve that patient are well-trained, well-equipped, well-motivated, and well-managed General Practitioners (family doctors). In fact, General Practice (family medicine) is widely recognized throughout the world as an essential component of effective PHC. Thus, the establishment and further development of General Practice (family medicine) in Azerbaijan can be viewed as a necessary requirement for the strengthening of PHC in the Republic.

With the aim of fundamentally strengthening the system of PHC in the Republic of Azerbaijan, and in order to establish General Practice (family medicine) as a recognized medical specialty on the territory of the Republic and to spur the further development of this specialty, I order:

1. The following is approved:

1.1 Terms of reference (*Polozheniye*) concerning the activity of a General Practitioner (family doctor) (*Polozheniye* No. 1).

2. The department of the organization and development of medical care to the population, the department of medical educational institutions, the department of personnel, the department of economics, and the department of statistics are instructed, on or before 01 December 2006:

2.1. To include in the official list of positions of medical and pharmaceutical personnel and specialists the positions of General Practitioner (family doctor) and general practice (family medicine) nurse.

2.2. To develop and approve according to established procedures the skill requirements for General Practitioner (family doctor) and General Practice (family medicine) nurse.

2.3. To prepare Terms of Reference (*polozheniye*) concerning the activities of a General Practice (family medicine) nurse.

3. The department of licensing of medical services, institutions, and personnel, the department of personnel, and the department of medical educational institutions, in cooperation with the Medical University of Azerbaijan and the State Institute for the Advancement of Doctors are instructed:

3.1. By 01 January 2007, to prepare Terms of Reference (*polozheniye*) governing the licensing of a General Practitioner (family doctor).

3.2. By 01 July 2007, to develop and approve according to established procedures a program of clinical residency in the specialty of General Practice (family medicine).

3.3. By 01 January 2008, to develop and approve according to established procedures a protocol by which to identify and approve clinical training sites for participants in a clinical residency in the specialty of General Practice (family medicine).

3.4. By 01 June 2007, to develop and approve according to established procedures a special “retraining” program in the specialty of General Practice (family medicine) at the State Institute for the Advancement of Doctors.

3.5. By 01 April 2007, to develop and approve according to established procedures a list of short-course training programs in specialties and competencies considered to be part of the normal preparation of a General Practitioner (family doctor).

3.6. By 01 June 2007, to develop and approve according to established procedures a protocol for the identification and approval of healthcare institutions where supervised internship in the specialty of General Practice (family medicine) can be implemented.

4. The department of the organization and development of medical care to the population and the department of statistics are instructed, by 01 January 2007, to develop and approve according to established procedures statistical reporting procedures, indicators and forms concerning General Practice (family medicine).

5. Responsibility for ensuring the fulfillment of this order is assigned to the Deputy Minister of Health, _____.

Minister O. Shiraliyev

Polozheniye No. 1
Terms of Reference (*Polozheniye*) concerning the activity of a General Practitioner (family doctor)

1. A General Practitioner (family doctor) is a doctor who has completed special post-graduate training in the provision of a comprehensive range of primary health care and preventive services to patients and members of their families, irrespective of gender and age.

2. The following persons may be appointed to the position of General Practitioner (family doctor) in healthcare organizations, irrespective of their organizational-legal form:

2.1. specialists who possess higher medical education (from a university in Azerbaijan or another country), who have completed a three-year clinical residency in the specialty of General Practice (family medicine) at approved healthcare facilities (in Azerbaijan or another country), and who possess a valid license to practice medicine in Azerbaijan as a General Practitioner (family doctor);

2.2. specialists who possess higher medical education with a concentration in either therapy or pediatrics, who possess a certificate confirming successful completion of a special "retraining program" in the specialty of General Practice (family medicine) at the State Institute for the Advancement of Doctors, and who possess a valid license to practice medicine in Azerbaijan as a General Practitioner (family doctor);

2.3. specialists who possess higher medical education with a concentration in either therapy or pediatrics, who possess certificates confirming successful completion of 400 hours of special short-course training programs in specialties and competencies recognized by the State Institute for the Advancement of Doctors as part of the normal preparation of a General Practitioner (family doctor), who have completed at least 800 hours of supervised internship in the specialty of General Practice (family medicine) at an approved healthcare facility, and who possess a valid license to practice medicine in Azerbaijan as a General Practitioner (family doctor).

3. In order to obtain a license to practice medicine in Azerbaijan as a General Practitioner (family doctor), which is normally valid for no more than five years, a specialist must:
(a) possess higher medical education;
(b) have completed the required amount of post-graduate medical training in the specialty of General Practice (family medicine) or in associated short-course training programs;
(c) possess a certificate confirming the successful completion of a special licensing examination in the specialty of General Practice (family medicine);
(d) submit the necessary application forms and pay the required fees; and
(e) fulfill other requirements as may be established by the department of licensing of medical services of the Ministry of Health.

4. A General Practitioner (family doctor) receives patients at a healthcare organization and visits patients at their home, provides emergency care to patients, provides comprehensive preventive, curative-diagnostic, and rehabilitative services to patients, irrespective of gender and age, and strives to resolve medical-social problems of families.

5. A General Practitioner (family doctor) performs the following functions:

5.1. Performs curative and rehabilitative measures within the range of his or her competency, including minor surgical procedures and normal gynecological procedures.

5.2. Performs preventive care, aimed at detecting early and hidden forms of illness, socially significant diseases, and factors that increase the risk of disease and illness.

5.3 Ensures complete and timely immunizations according to established procedures.

5.4. Performs regular medical checkups of patients, which includes ordering all necessary laboratory and other analyses, and prescribing necessary curative and restorative measures.

5.5. Performs regular pre-natal, post-natal, and post-abortion examinations of women who become pregnant, give birth, and undergo abortions, respectively, and prescribes or provides necessary curative and restorative care.

5.6. Provides necessary medical care to patients in their homes, according to established procedures.

5.7. Refers patients to other medical specialists in cases where a patient's complaint or illness is unusually complicated or falls outside the range of his or her competency.

5.8. Facilitates the hospitalization of patients when necessary, according to established procedures, and regularly consults with hospitalized patients and helps to coordinate the care provided by other specialists.

5.9. Conducts normal (uncomplicated) births, in the absence of a gynecologist and according to established procedures.

5.10. Provides information and education to patients and members of their families concerning the maintenance of good hygiene and sanitary conditions, various health problems, how to prevent illness, and the importance of leading a health lifestyle.

5.11. Determines patients' temporary disability and provides necessary documentation to the social protection organs.

5.12. Provides consultative services to patients and members of their families concerning:
(a) immunizations;
(b) infants' and children's nutrition, the promotion of children's physical, mental and psychological development, and the timely detection of deviations from normal development;
(c) the proper management of chronic diseases and the prevention of chronic disease crises;

(d) the maintenance of good reproductive health, including family planning, contraception, pre- and post-natal care, safe motherhood, and the prevention of sexually transmitted diseases.

5.13. Ensures that information obtained during each encounter with a patient is properly documented and entered into the patient's medical record, including the results of all tests ordered, irrespective of when the results of those tests are received.

5.14. Compiles and transmits to proper authorities all necessary data and documentation, according to established procedures.

5.15. Participates in meetings, scientific and practitioner conferences, and continuously improves his or her medical knowledge and skills, including attendance at special approved short-course training programs.

6. A General Practitioner (family doctor) is governed in his or her activity by existing legislation of the Republic of Azerbaijan, normative acts and regulations issued by the Ministry of Health and other governmental bodies, and these terms of reference (*polozheniye*).

7. A General Practitioner (family doctor) is responsible for ensuring that all of his or her actions and decisions are in accordance with existing legislation of the Republic of Azerbaijan.

HOUSEHOLD INTERVIEW
(Health Status And Utilization, Health Expenditure And Satisfaction)

Section A: Identification of a District/ community

A_1 NAME OF DISTRICT:

Absheron/Baku 1
Sheki.....2
Gakh 3
Ismayilli.....4
Agdash 5
Quba.....6
Yasamal/Baku 7

A_2 NAME OF VILLAGE/TOWN: _____

Section B: Documentation

B_1 VISIT RECORD

Visit Number	1	2	3
Date of Visit	__ __ / __ __ dd mm	__ __ / __ __ dd mm	__ __ / __ __ dd mm
Result (to be completed at the end of the interview)	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Interviewer Name			

Result Codes:
1 – Completed Interview
2 – Nobody Home
3 – Household Informant not home
4 – Refusal
5 – Unoccupied House
6 – Incomplete Interview (REASON: _____)
7 – Other (SPECIFY: _____)

B_2 DATE OF INTERVIEW: _____ / _____ / _____
dd mm yy

B_3 TIME INTERVIEW STARTED: __|__|:__|__|
Hour Min

B_4 NAME OF INTERVIEWER: _____ , _____
Last Name First Name

B_5 NAME OF CONTROLLER: _____ , _____
Last Name First Name__No Controller Present 99

B_6 **NAME OF SUPERVISOR:** _____ , _____
Last Name First Name

Section C: Data Entry

C_1 DATE OF DATA ENTRY _____ / _____ / _____

ID# _ / _ _ _ _

dd mm yy

CHECK AND MAKE SURE THAT DATES SEQUENCE ARE CORRECT IN AZERI

C_2 NAME OF DATA ENTRY OPERATOR (LAST, FIRST): _____ , _____
Last Name First Name

_____

Section D: Demographics of Household

D_1 FIRST NAME OF RESPONDENT .....NAME

D_2 ADDRESS OF HOUSEHOLD: _____No Address 99

D_2.1 Telephone number of the respondent: _____

D_3 NAME OF HOUSEHOLD (LAST NAME): _____

D_4 TYPE OF HOUSEHOLD DWELLING:

SINGLE FAMILY DWELLING/HOUSE..... 1
PREFABRICATED DWELLING/HOUSE..... 2
APARTMENT BUILDING 3
PUBLIC BUILDING (used for IDP) 4
TENT 5
OTHER (SPECIFY: _____) 6

D_5 APPROXIMATE DISTANCE FROM PLACE OF RESIDENCE TO NEAREST PRIMARY HEALTH CARE FACILITY WITH FELDSHER, NURSE OR MIDWIFE .....KM

D_6 APPROXIMATE DISTANCE FROM PLACE OF RESIDENCE TO NEAREST PRIMARY HEALTH CARE FACILITY WITH A DOCTOR .....KM

D_7 HOW WOULD YOU TRAVEL TO THE NEAREST PHC FACILITY (CIRCLE ONLY ONE IN EACH COLUMN)

IDEALLY		USUALLY		IN WINTER		IN SUMMER	
Walk	1	Walk	1	Walk	1	Walk	1
Private car	2	Private car	2	Private car	2	Private car	2
Public Transport	3	Public Transport	3	Public Transport	3	Public Transport	3
Other (SPECIFY) _____	4	Other (SPECIFY) _____	4	Other (SPECIFY) _____	4	Other (SPECIFY) _____	4

D_8

TIME NEEDED TO GET TO THE NEAREST PHC FACILITY	IN WINTER	IN SUMMER

Walk	_____min	_____min
Private car	_____min	_____min
Public Transport	_____min	_____min
Other	_____min	_____min

D_9 APPROXIMATE DISTANCE FROM PLACE OF RESIDENCE TO NEAREST DISTRICT HOSPITAL ..... _____KM

D_10 HOW WOULD YOU TRAVEL TO THE NEAREST DISTRICT HOSPITAL (CIRCLE ONLY ONE IN EACH COLUMN)

IDEALLY	USUALLY	IN WINTER	IN SUMMER
Walk 1	Walk 1	Walk 1	Walk 1
Private car 2	Private car 2	Private car 2	Private car 2
Public Transport 3	Public Transport 3	Public Transport 3	Public Transport 3
Other (SPECIFY) 4 _____	Other (SPECIFY) 4 _____	Other (SPECIFY) 4 _____	Other (SPECIFY) 4 _____

D_11

TIME NEEDED TO GET TO THE NEAREST DISTRICT HOSPITAL	IN WINTER	IN SUMMER
Walk	_____min	_____min
Private car	_____min	_____min
Public Transport	_____min	_____min
Other	_____min	_____min

D_12 For how long, did your family/household live in this community/area?

Less than 1 y 0

1 – 3 y 1

3 – 5 y.....2

More than 5 years.....3

D_13 Please tell me the number of all the people who have lived in your household (including yourself) in the past three months ..... _____#

D_14 Please give me the names of the members of your household (or people who live with you in your house), including those that have passed away during these months. Also, please give me their age on their last birthday (in years; for infants in months), martial status, education level, their main method of earning money (or primary occupation), and whether they have a regular primary health care doctor. Please start with yourself. Then, start with the oldest female household member to youngest female household member. After, please continue with the oldest male household member to youngest male household member.

ID# _ / _ _ _ _

#	A **First Name**	B **Relation to Respondent**	C **Gender**	D **Age**	E **Marital Status**	F **Education Level & Year**	G **Primary Occupation (If '1', '2', '3' or '10', SPECIFY)**	H Does person have regular primary health care doctor?
1.		Self	M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
2.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
3.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
4.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
5.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
6.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
7.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
8.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
9.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know
10.			M F 1 2	___ M ___ Y		___ (level) ___(year)		1. yes; 2. No 88. Don't know

B. Relation to respondent Code:
1. Self
2. Spouse
3. Son/daughter, son in law/daughter in law
4. Parents and/or grandparents
5. Brother or sister
6. Grandchild
7. Uncle, aunt or cousins
8. Other relatives
9. Non-relative

E. Marital Status Code:
1 Married
2 Not married/ living with partner
3 Separated
4 Divorced
5 Widowed
6 Never Married

F. Education Level and Year Code:
Level 0 - Child/ Does not attend school
Level 1 – never attended school
Level 2 - General School Year - 1 2 3 4 5 6 7 8 9 10 11
Level 3 - Professional (vocational) school Year - 1 2 3
Level 4 - Technical School Year - 1 2 3
Level 5 - University/Faculty Year - 1 2 3 4 5+
Level 6 - Post University/ Postgraduate Studies Year - 1 2 3 4 5+
Level 99 - Don't Know

G. Primary Occupation Code
1 Self-Employed (SPECIFY)
2 Contract Employee (SPECIFY)
3 State Employee (SPECIFY)
4 Pensioner
5 Housewife
6 Student (university and above)
7 Unemployed
8 Disabled
9 Military
10 Other (SPECIFY)
99 N/A – child and/or dependent

D_15 In the past one year, did anyone in your household die (including newborns and children).

Yes 1

No (**GO TO Q.E_1**).....0

D_16 If yes, please give me the age of the persons that died and the cause of death. (For those persons, who died during the last three months, please take the serial numbers from the Table D_14, write them in the first row in the table below and then ask the questions D_16A and D16_B. But for those, that died more than 3 months ago (during last year), indicate only age and reason of death, without indicating the serial numbers as we do not have it for these persons (as they are not included in the D_14).

Mortality	Individual (take individual serial numbers from table D14 and record them in the row below)						
	/___/	/___/	/___/	/___/	/____/	_/___/	/___/
D_16A. Age (on last birthday). Record in years. If less than one year, record in month.	_|_| Year _|_| Month	_|_| Year _|_| Month	_|_| Year _|_| Month	_|_| Year _|_| Month	_|_| Year _|_| Month	_|_| Year _|_| Month	_|_| Year _|_| Month
D_16B. Cause of death (RECORD ONE)	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
Birth related ..... 1 (SPECIFY: _____)							
Pregnancy related..... 2 (SPECIFY: _____)							
Acute Respiratory Illnesses (ARI)..... 3 (SPECIFY: _____)							
Infectious Diseases (non-respiratory)..... 4 (SPECIFY: _____)							
Immunization Related Diseases ..... 5 (SPECIFY: _____)							
Car Accident ..... 6 (SPECIFY: _____)							
Violence, homicide..... 7 (SPECIFY: _____)							
Suicide ..... 5 (SPECIFY: _____)							
Other Trauma..... 6 (SPECIFY: _____)							
Poisoning ..... 7 (SPECIFY: _____)							
Terminal illness/chronic condition..... 8 (SPECIFY: _____)							
Heart Attack 9							
Stroke..... 10							
OTHER (SPECIFY: _____) .. 11							
DOES NOT KNOW..... 88							

Section E: Health Status and Utilization – Chronic Conditions

E_1 Does anyone in your household (or persons that live with you) have a chronic illness, or an illness that they have had for a long time and is ongoing? This includes an illness that has been ongoing for 30 days or more.

Yes 1

No (**GO TO Q.F_1**) 0

E_2 Can you please tell me who in your household has a chronic condition, what type of chronic condition(s) they have, when that chronic condition(s) started, and whether they see a health provider regularly for the management of that condition? For each person who has a chronic illness, please give me up to two chronic illnesses that are the most problematic for that person. Please start with first person and first chronic illness that is problematic and then go to the next person.

Chronic Illness #	HHM # (see table under D_14)	Description of Chronic Illness	Chronic Illness Code (see codes below)	Date Symptoms Started	Is the person under regular care by a physician	Has member ever seen a provider for this condition?
1				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
2				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
3				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
4				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
5				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
6				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1
7				___ / ___ mm yy	Yes.....1 No.....0	Yes.....1 → Go to E3 No.....0 → Go to F1

1	Respiratory	Chronic pneumonia, chronic bronchitis, obstructive bronchitis, emphysema, chronic otitis, lung cancer, etc.
2	Asthma	
3	Ischemic Heart Disease	Myocardial ischemia disorders including angina pectoris, Chest pain
4	Hypertension	
5	Other Cardiovascular	Atherosclerosis, heart failure, Cardiac Arrhythmias, Valvular heart disease, etc.
6	Gastrointestinal	Gastritis, peptic ulcer, cancer of gastrointestinal organs, malabsorption syndrome, Chrone disease, ulcerative colitis, diverticulosis, hemorrhoid, etc.
7	Hepatic and biliary disorders	Cirrhosis, chronic hepatitis, liver cancer, stones in gall bladder, cholecystitis, choledocholithiasis
8	Infectious diseases	Brucellosis, TB
9	Diabetes Mellitus	
10	Other Endocrine	Thyroid, goiter, Thyroid cancer, etc
11	Musculoskeletal	Rheumatoid arthritis, lupus syndrome, polyarthritis, osteochondrosis, gouts, cancer of bones and joints, osteoporosis,
12	Stroke	Ischemic stroke, hemorrhagic stroke, subarachnoid hemorrhage
13	Other Neurological	Migraine, TIA, neoplasm, epilepsy, multiple sclerosis, Parkinson disease, myopathies, Infant palsy, etc.
14	Skin problems	Chronic dermatitis, cancer, vitiligo, ichtiosis, keratosis, hyperpigmentosis, etc.
15	Urogenital	Chronic cystitis, glomerulonephritis, chronic bacterial pyelonephritis, prostatitis, prostate adenoma, nephrolithiasis, cancer, hereditary chronic nephropathies, etc.
16	Gynecological	Infertility, salpingitis, endometriosis, genital organs cancer, chronic anovulatory disorders, breast cancer, chronic pelvic diseases, etc.
17	Psychological/ Mental	Chronic neurosis, depression, schizophrenia, psychopathic disorders and other mental health problems
18	Allergy	
19	Anemia	
20	Other illness (specify)	
99	Don’t know	

HEALTH CARE SEEKING BEHAVIOR CHRONIC ILLNESS	Chronic Illness Number (from table E_2, first column) 1	2	3	4	5	6	7
E_3 Where does ill person usually go for the management of this chronic illness? (RECORD ONLY ONE) Own Community/Area Clinic ..... 1 Other Community/Area Clinic ..... 2 Own District Clinic/Hospital ..... 3 Other District Clinic/Hospital ..... 4 Clinic/Hospital in Baku ..... 5 Home Visit (**Go To F_1**) ..... 6 Pharmacy (**Go To F_1**) ..... 7 Other (Specify: _____)..... 8	_|_| SPEC:	_|_| SPEC:	_|_| SPEC:	_|_| SPEC:	_|_| SPEC:	_|_| SPEC:	_|_| SPEC:
E_4 What type of facility is this? Feldsheral Midwife Point (FAP) ..... 1 Village Doctors Ambulatory (SVA)..... 2 Village Site Hospital (SUB)..... 3 Polyclinic in District managed by Central District Hospital (DPOLY)..... 4 Central District Hospital (CDHOSP) ..... 5 City Polyclinic (CPOLY)..... 6 City General Hospital (CGHOSP)..... 7 Dispensary (DISP)..... 8 Private Clinic/Hospital (PRV)..... 9 Other (SPECIFY: _____) ..... 10 DOES NOT KNOW..... 88	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
E_5 In the past one year**,** how many times has ill person visited this facility for the management of the chronic illness?	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
E_6 When was the last time that ill person visited this facility? (APPROXIMATE DATE)	_ /_ /_ m d y	_ /_ /_ m d y	_ /_ /_ m d y	_ /_ /_ m d y	_ /_ /_ m d y	_ /_ /_ m d y	_ /_ /_ m d y
E_7 Was ill person referred to this facility by a provider? Yes..... 1 No **(GO TO E_9)**..... 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|

E_8 Who referred ill person to this facility? (CIRCLE ONLY ONE) [n1] Provider from own Community/Area Clinic.. 2 Provider from other Community/Area Clinic .... 3 Provider from own District Clinic/Hospital..... 4 Provider Other District Clinic/Hospital ..... 5 Emergency/ambulance ..... 6 Family/community ..... 7 Pharmacist ..... 8 OTHER (SPECIFY: _____) 9	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
E_9 Was ill person hospitalized in a past one year for this chronic illness? Yes ..... 1 No **(GO TO F_1)** 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
E_10 Who referred ill person to this hospital? (CIRCLE ONLY ONE) Self referral ..... 1 Provider from own Community/Area Clinic ..... 2 Provider from other Community/Area Clinic .... 3 Provider from own District Clinic/Hospital..... 4 Provider Other District Clinic/Hospital ..... 5 Emergency/ambulance ..... 6 Family/community ..... 7 Pharmacist ..... 8 OTHER (SPECIFY: _____) 9	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|

Section F: Health Status and Utilization – Acute Conditions

Now, I am going to ask you some general questions about your family's health within the past three months.

F_1 In the past three months, was anyone in your household (including yourself) ill, sick, or injured? These include illnesses that lasted less than 30 days**. Please tell me the conditions other than the ones you mentioned before.**

Yes 1

No (**GO TO Q.G_1**) 0

F_2 In the past three months, how many people (including yourself) became ill, felt sick or were injured? ..... _____ # ILL PERSONS

F_3 Who was ill, feeling sick, or injured for the past three months? What type of illness(es)/injury did you/he/she have? When did this illness/injury start? How many days did this illness last? Please give me up to two different acute illnesses for each person (MAKE SURE IN DIFFERENT CATEGORIES). Please start with the most recent illness/injury.

Acute Illness#	# HHM (from table D_14)	Description of Illness/Injury	Acute Illness Episode Code (See Codes on Next Page)	Date Started	# Days lasted
1				___ / ___ mm yy	_____DAYS or Ongoing……..99
2				___ / ___ mm yy	_____DAYS or Ongoing……..99
3				___ / ___ mm yy	_____DAYS or Ongoing……..99
4				___ / ___ mm yy	_____DAYS or Ongoing……..99
5				___ / ___ mm yy	_____DAYS or Ongoing……..99
6				___ / ___ mm yy	_____DAYS or Ongoing……..99
7				___ / ___ mm yy	_____DAYS or Ongoing……..99

Acute Illness Episodes Code

1	Respiratory	Pneumonia, flu, bronchitis, pharyngitis, runny nose, fever, dyspnea etc.
2	Myocardial infarction	
3	Other Cardiovascular	Chest pain, hypertension attacks/crisis, arrythmia, etc.
4	Abdominal	Cramps, abdominal pain, nausea, vomiting, food poisoning diarrhea, cholecystitis, appendicitis, peritonitis, stones in gall bladder, etc.
5	Infectious diseases	Diphtheria, tetanus, hepatitis, measles, chickenpox, mumps, rubella, etc.
6	Stroke	Ischemic stroke, hemorrhagic stroke, SAH
7	Other Neurological	Attack of migraine, myositis, neuralgia, headache, concussion, etc.
8	Trauma/injury	Broken bone, electrocution, etc.
9	Road accident	
10	Poisoning	Snake bite, chemical ingestion, etc.
11	Burn	Fire, chemical, etc.
12	Skin problems	Rush, other skin diseases (dermatitis)
13	Urogenital	Cystitis, pyelonephritis, endometritis, prostatitis, attack of stones in urinary tract
14	Pregnancy related	Abortion, delivery complications
15	Psychological/ Mental	acute neurosis, depression, other mental health problems
16	Muskulo-Skeletal	Back pain, arthritis, rheumatism, etc.
17	Other illness (specify)	
88	Don't know	

F_4 TOTAL NUMBER OF ACUTE ILLNESSES/INJURIES IN HOUSEHOLD IN PAST 3 MONTHS:_____ #

COMPLETE EACH OF THE FOLLOWING SECTIONS, BASED ON ANSWER PROVIDED IN TABLE F3.

HEALTHCARE SEEKING BEHAVIOR ACUTE ILLNESS	ACUTE Illness Number (from table F_3, first column)						
	1	2	3	4	5	6	7
F_5 In your opinion, <u>at the time the illness/injury started (before medical care was obtained)</u>, how serious did you think the illness/injury was? Not at all serious ..... 1 Moderately serious ..... 2 Very serious ..... 3 Don't remember 77	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
F_6 In your opinion, did the ill person need to get health services? Yes ..... 1 No (**GO TO Q.F_9**) ..... 0 Maybe/Don't know 88	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
F_7 Was ill person able to get needed health care services? Yes **(GO TO Q.F_9)**..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
F_8 Why was ill person not able to get health care services? (RECORD ALL THAT APPLY) (start with the most important reason) LACK OF FINANCES ..... 1 LACK OF TRANSPORTATION ..... 2 NO DOCTOR IN COMMUNITY/AREA ..... 3 NO HEALTH FACILITY IN COMMUNITY/AREA . 4 NO TREATMENT AVAILABLE DUE TO LACK OF SUPPLIES/EQUIPMENT..... 5 DID NOT KNOW WHERE TO GO ……..6 Other (SPECIFY: _____) ..... 7 **GO TO Q.F_9**	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th	_|_| 1st _|_| 2nd _|_| 3rd _|_| 4th _|_| 5th
	1	2	3	4	5	6	7

F_9 What did the ill person do? Where did the ill person received care? (IF ADDITIONAL ANSWERS, PLEASE RECORD ON BACK OF PAGE) Own Community/Area Clinic ..... 1 Other Community/Area Clinic ..... 2 Own District Clinic/Hospital ..... 3 Other District Clinic/Hospital ..... 4 Clinic/Hospital in Baku ..... 5 Home Visit by Doctor ..... 6 Pharmacy ..... 7 Self-Treatment ..... 8 Did Not Do Anything Else ..... 9 Other (Specify:_____) ..... 10 **IF ANSWER IS "6" , "7", "8" or "9", GO TO F13**	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd
F_10 What type of facility is this? Feldsheral Midwife Point (FAP) ..... 1 Village Doctors Ambulatory (SVA) ..... 2 Village Site Hospital (SUB) ..... 3 Polyclinic in District Managed by Central District Hospital (DPOLY) ..... 4 Central District Hospital (CDHOSP) ..... 5 City Polyclinic (CPOLY) ..... 6 City General Hospital (CGHOSP) ..... 7 Dispensary (DISP) ..... 8 Private Clinic/Hospital (PRV) ..... 9 Other (SPECIFY: _____) ..... 10 DOES NOT KNOW 88	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd
F_11 How ill person received a care for this acute illness? As hospitalized inpatient ..... 1 As outpatient 2	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd
F_12 Who provided a care to ill person for this acute illness? Nurse ..... 1 Feldsher ..... 2 Doctor ..... 3 Other (SPECIFY: _____) 4	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd	1st 2nd 3rd
F_13 Was ill person referred to this facility by a provider? Yes ..... 1 No **(GO TO F_15)** 0							

F_14 Who referred ill person to this facility? (ONLY ONE ANSWER FOR EACH OF THE FACILITY INDICATED IN THE F_9)	___	___	___	___	___	___	___
Provider[n2] from own Community/Area Clinic. 2	___	___	___	___	___	___	___
Provider from other Community/Area Clinic 3							
Provider from own District Clinic/Hospital..... 4							
Provider Other District Clinic/Hospital 5	___	___	___	___	___	___	___
Emergency/ambulance 6							
Family/community 7							
Pharmacist 8	SPEC	SPEC	SPEC	SPEC	SPEC	SPEC	SPEC
OTHER (SPECIFY: _____) 9							

	1	2	3	4	5	6	7
F_15 Was this illness exacerbation of a chronic illness? Yes ..... 1 No (**GO TO Q.F_17**) ..... 0 Don't Know (**GO TO Q.F_17**) 88	___	___	___	___	___	___	___
F_16 What type(s) of chronic illness was this exacerbation/ illness related to? RESPIRATORY ..... 1 ISCHEMIC HEART DISEASE ..... 2 HYPERTENSION ..... 3 OTHER CARDIOVASCULAR ..... 4 ABDOMINAL ..... 5 HEPATIC AND BILIARY DISORDERS ..... 6 INFECTIOUS ..... 7 DIABETES MELLITUS ..... 8 OTHER ENDOCRINE ..... 9 MUSKULO-SKELETAL ..... 10 STROKE ..... 11 OTHER NEUROLOGICAL ..... 12 SKIN PROBLEMS ..... 13 UROLOGICAL ..... 14 GYNECOLOGICAL ..... 15 PSYCHOLOGICAL/MENTAL ..... 16 ALLERGY ..... 17 ANEMIA ..... 18 OTHER (SPECIFY:_____) ..... 19 DOES NOT KNOW 99	___	___	___	___	___	___	___
F_17 Did ill person or another family member buy or receive medicine for this illness/injury? Yes **(GO TO Q.F_19)** ..... 1 No 0	___	___	___	___	___	___	___

F_18 If "No", why did ill person or another family member not buy or receive medicine for this illness? (PUT 'YES' (1) AS RESPONDENT NAMES REASON; OTHERWISE PUT 'NO' (0))							
F_18A DOCTOR DID NOT PRESCRIBE	☐	☐	☐	☐	☐	☐	☐
F_18B LACK OF FINANCES	☐	☐	☐	☐	☐	☐	☐
F_18C LACK OF TRANSPORTATION	☐	☐	☐	☐	☐	☐	☐
F_18D MEDICINE DIFFICULT TO FIND	☐	☐	☐	☐	☐	☐	☐
F_18E ILL PERSON ALREADY HAD MEDICINE	☐	☐	☐	☐	☐	☐	☐
F_18F DOES NOT BELIEVE NEEDED MEDICINE	☐	☐	☐	☐	☐	☐	☐
F_18G DOES NOT LIKE TAKING MEDICINE	☐	☐	☐	☐	☐	☐	☐
F_18H OTHER (SPECIFY)	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:
GO TO Q.F_20							
F_19 How did ill person get this medicine? (CIRCLE ONLY ONE FOR EACH ILNESS EPISODE) Purchased ..... 1 Clinic gave for free ..... 2 Received from other source (SPECIFY) 3	☐ SPEC:	☐ SPEC:	☐ SPEC:	☐ SPEC:	☐ SPEC:	☐ SPEC:	☐ SPEC:
F_20 Did ill person complete the prescribed treatment (including completing the medicine) as recommended by the doctor? Yes **(GO TO Q.F_22)** ..... 1 No ..... 0 Doctor did not prescribe treatment 99	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

F_21 If "No", what is the reason(s) that the ill person did not complete the treatment? (PUT 'YES' (1) AS RESPONDENT NAMES REASON; OTHERWISE PUT 'NO' (0))							
F_21A STILL UNDER TREATMENT	☐	☐	☐	☐	☐	☐	☐
F_21B RAN OUT OF MONEY	☐	☐	☐	☐	☐	☐	☐
F_21C COULD NOT FIND PERSCRIBED DRUG	☐	☐	☐	☐	☐	☐	☐
F_21D CARE WAS NOT CONVENIENT	☐	☐	☐	☐	☐	☐	☐
F_21E PAINFULL, UNDESIRABLE, INTOLERABLE SIDE EFFECTS	☐	☐	☐	☐	☐	☐	☐
F_21 F TREATMENT NOT EFFECTIVE/SIDE-EFFECTS	☐	☐	☐	☐	☐	☐	☐
F_21G DID NOT TRUST PROVIDER	☐	☐	☐	☐	☐	☐	☐
F_21H FELT BETTER	☐	☐	☐	☐	☐	☐	☐
F_21I DIED	☐	☐	☐	☐	☐	☐	☐
F_21J OTHER (SPECIFY)	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:

F_22 How much money was spent in total on this illness/injury episode including cash, goods, services and gifts (in AZ MAN)? I will read you some expense categories, and you can tell me how much you spent on each. (If respondent did not spend money on item, enter '0'. If did not remember for particular category, enter "88")	AZM	AZM	AZM	AZM	AZM	AZM	AZM
F_22A Provider consultation	_____	_____	_____	_____	_____	_____	_____
F_22B Lab and Diagnostic services (blood test, x-rays, etc.)	_____	_____	_____	_____	_____	_____	_____
F_22C Medicine	_____	_____	_____	_____	_____	_____	_____
F_22D Transportation	_____	_____	_____	_____	_____	_____	_____
F_22E Other (SPECIFY)	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:
F_23 How did you pay for provider consultation? (THREE ANSWERS ARE POSSIBLE)							
Cash only as fee for service to facility (not including co-payment for insurance) 1	☐	☐	☐	☐	☐	☐	☐
Cash only as informal payment to provider directly) ..... 2 Exchange of goods/services ..... 3 Combination of cash and exchange of goods/services .. 4	☐	☐	☐	☐	☐	☐	☐
Family health insurance ..... 5 Individual health insurance ..... 6 Did not pay..... 7	☐	☐	☐	☐	☐	☐	☐
OTHER (SPECIFY:_____)..... 8	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:	SPEC:

Section G: Health Insurance

G_1. In the past one year, did anyone in your household (including yourself) have health insurance (pre-payment for medical services)?

Yes (**GO TO Q.G_3**)..... 1

No 0

G_2. Why do your household members not have health insurance? (CIRCLE 'YES' AS RESPONDENT NAMES REASON; OTHERWISE CIRCLE 'NO'.)

		Yes	No
G_2A	CANNOT AFFORD INSURANCE	1	0
G_2B	INSURANCE IS NOT PROVIDED IN COMMUNITY	1	0
G_2C	DOES NOT HAVE TRUST IN INSURANCE	1	0
G_2D	WOULD RATHER PAY FEE-FOR-SERVICE	1	0
G_2E	INSURANCE IS NOT NECESSARY	1	0
G_2F	INSURANCE MORE COSTLY THAN FEE-FOR-SERVICE	1	0
G_2G	OTHER (SPECIFY: _____)	1	0

GO TO Q.G_5

G_3. How many people in your household (including yourself) currently have health insurance?#_____

G_4. What type of health insurance do your family members have? How many household members have that type of insurance? How long have you had insurance (in months)? (CIRCLE ALL THAT APPLY)

	Yes	No	# HH members	How Long? (Indicate in months)
Community Health Fund - Individual	1	0	_____	_____
Community Health Fund – Family	1	0	_____	_____
Work Health Insurance	1	0	_____	_____
Other (SPECIFY: _____)	1	0	_____	_____

G_5. Are you willing to pay/continue to pay health insurance or premium for you and your family member for quality medical services?

Yes 1
No 0
Maybe 2

Section H: Household Wealth and Expenditure

H_1 JUDGING ONLY FROM THE APPEARANCE OF THE HOUSE, THE WAY PEOPLE ARE DRESSED, AND THE WAY THE HOUSE IS ARRANGED, IS THIS HOUSEHOLD EXTREMELY POOR, POOR, MIDDLE INCOME, RICH, OR EXTREMELY RICH? (THE FOLLOWING IS BASED ON YOUR OBSERVATION ONLY; DO NOT READ TO RESPONDENT)

EXTREMELY POOR 1
POOR 2
MIDDLE INCOME 3
RICH 4
EXTREMELY RICH 5
DON'T KNOW/UNABLE TO SAY 88

Now I would like to ask you a few questions about how much your family spends on certain items.

First, I would like to ask you some questions about how much your household spent on healthcare in the past three months.

H_2 In the past three months, how much money did your household spend on healthcare (in AZ MAN)? I will read you some expenditure categories, and you can tell me how much you spent on each. (IF DID NOT SPEND ANY ON PARTICULAR CATEGORY, ENTER "0". IF DID NOT REMEMBER FOR PARTICULAR CATEGORY, ENTER "88")

		CASH	CASH equivalent.
H_2A	Provider consultation (including dental care, antenatal care and immunizations)	___AZM	___AZM
H_2B	Lab and Diagnostic services (blood test, x-rays, etc.)	___AZM	___AZM
H_2C	In-patient care (hospital stay, surgery, etc.)	___AZM	___AZM
H_2D	Medicine	___AZM	___AZM
H_2E	Transportation	___AZM	___AZM
H_2F	Other (SPECIFY:_____)	___AZM	___AZM
H_2G	Total household health expenditure (needs to be calculated by the interviewer and after should be checked with respondent!)	___AZM	___AZM

Now, I would like to ask you some questions about how much you pay for some other types of household goods.

H_3 In the past one month, how much do you estimate was spent by your household on…

		Cash	Cash equivalent
H_3A	Food purchased for meals prepared at home (including value of food produced in your household)	_____AZM	_____AZM
H_3B	Meals eaten outside your household (for everyone in the household)	_____AZM	_____AZM
H_3C	Non-food products for the house such as candles, soap, razor blades, cleaning materials (e.g. Chlor)	_____AZM	_____AZM
H_3D	Rent including "kvart plata"	_____AZM	_____AZM
H_3E	One-time services e.g. repair man, laundry	_____AZM	_____AZM
H_3F	Ongoing services, including the salaries of those working for you in the home (someone with long term employment)	_____AZM	_____AZM
H_3G	Transportation using public vehicles (bus, taxi, etc.)	_____AZM	_____AZM
H_3H	Transportation using private vehicle (including gas)	_____AZM	_____AZM
H_3I	Phone bills (land and mobile) including internet.	_____AZM	_____AZM
H_3J	Electricity (including bribes for electricity)	_____AZM	_____AZM
H_3K	Central heating, gas or fuel for generator (including related bribes)	____AZM	_____AZM
H_3L	Water, canalization	____AZM	_____AZM
H_3M	Cigarettes	____AZM	_____AZM
H_3N	Alcohol purchased at the store	____AZM	_____AZM

H_4 In the past three months, how much did the household spent on…

		Cash	Cash equivalent
H_4A	Recreation, such as books, films, sports, holidays, cable TV etc.	____AZM	_____AZM
H_4B	Footwear and clothing	____AZM	_____AZM
H_4C	Taxes, police or court fees, bribes or other fines	____AZM	_____AZM
H_4D	Family celebrations (e.g. birthdays) or religious celebrations (e.g. weddings, funerals)	____AZM	_____AZM

H_5 Over the past one year, how much did the household spent on…

		Cash	Cash equivalent
H_5A	Long distance travel/transportation (including air travel, train, and maintenance and fuel of privately owned vehicle, and costs of public transport.)	____AZM	_____AZM
H_5B	Education of household children (including kindergarten, tuition fees, cost of educational materials and special lessons such as music, etc)	____AZM	_____AZM
H_5C	Durable items such as new furniture, carpets, heaters, air conditioner, satellite, cars, fridges, TVs, etc	____AZM	_____AZM
H_5D	Gifts, charity, and support to friends or family outside this household	____AZM	_____AZM

H_6 Are there other household expenses that have not been mentioned (including one time expenses)?

Yes 1

No (**GO TO Q.H_8**)..... 0

H_7 If 'Yes', please explain what these expenses were, what was the total amount and how frequently they occurred:

	TYPE OF EXPENSE	AMOUNT	FREQUENCY
H_7A		_____AZM	1- Daily, 2 -Weekly, 3 -Monthly, 4- Quarterly, 5- Annually
H_7B		_____AZM	1- Daily, 2 -Weekly, 3 -Monthly, 4- Quarterly, 5- Annually
H_7C		_____AZM	1- Daily, 2 -Weekly, 3 -Monthly, 4- Quarterly, 5- Annually

H_8 In the past three years, has any member of your household (including yourself) received a loan from a bank, a person, or an organization?

Yes 1

No (**GO TO Q.H_11**)..... 0

H_9 If yes, who gave you (or another household member) the loan(s)? (CIRCLE 'YES' AS RESPONDENT NAMES PERSON/INSTITUTION; OTHERWISE CIRCLE 'NO'.)

		Yes	No
H_9A	RELATIVE/FAMILY MEMBER	1	0
H_9B	NEIGHBOR	1	0
H_9C	FRIEND	1	0
H_9D	COLLEAGUE/CO-WORKER	1	0
H_9E	BANK (SPECIFY: _____)	1	0
H_9F	ORGANIZATION (SPECFY: _____)	1	0
H_9G	PROJECT (SPECIFY: _____)	1	0
H_9H	OTHER (SPECIFY: _____)	1	0

H_10 In the past three years, how much in total loans have you or other members of your household received? ....._____AZM

H_11 In the past one month, how much was your total household income? ....._____AZM

Section I: Women and Child Health

I_1 NUMBER OF FEMALES MORE THAN 15 YEARS OF AGE THAT LIVE IN THIS HOUSE (COUNT FROM Q D_14 AND VERIFY WITH RESPONDENT) ....._____#

IF ZERO, GO TO SECTION X: Diarrhea.

I_2 RECORD FOLLOWING INFORMATION FOR EACH FEMALE MORE THAN 15 YEARS OF AGE LIVING IN HOUSEHOLD (RECORD FROM QUESTION D_14 AND VERIFY WITH RESPONDENT; START WITH YOUNGEST WOMEN AND CONTINUE WITH OTHERS).

Women #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ M d y
2			___ / ___ / ___ M d y
3			___ / ___ / ___ M d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
I_3 Did this woman have a delivery in the past 12 months? Yes ..... 1 No (**GO TO Q.I_7**) 0	___	___	___	___	___	___	___
I_4 If yes, did this woman have a prenatal visit to healthcare provider? Yes ..... 1 No (**GO TO Q.I_7**) 0	___	___	___	___	___	___	___
I_5 If yes, when did the first prenatal visit occur? 1-4 weeks ..... 1 5-8 weeks ..... 2 9-12 weeks ..... 3 13-16 weeks ..... 4 17-20 weeks ..... 5 21-24 weeks ..... 6 25-28 weeks ..... 7 29-32 weeks ..... 8 33-36 weeks ..... 9 37-40 weeks ..... 8 DOES NOT REMEMBER 88	___	___	___	___	___	___	___
I_6 If yes, where did this women deliver? At home, no skilled health personnel [1] attendance ..... 1 At home attended by skilled health personnel ..... 2 SUB ..... 3 Own district maternity ..... 4 Other district maternity ..... 5 Baku maternity ..... 6 Other (specify_____) 7	___	___	___	___	___	___	___
I_7 Does this woman have children under 5 years of age? Yes ..... 1 No (**GO TO Q.I_9**) 0	___	___	___	___	___	___	___

[1] Nurse, midwife, feldsher, or doctor

I_8 If yes, is this woman knowledgeable about the date of the next vaccination for their children? Yes (check with imm calendar)..... 1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
I_9 Did this woman receive clinical breast exam in the past 3 years? Yes..... 1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
I_10 Did this woman receive cervical cancer screening in the past 5 years? Yes..... 1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_

Section x: Diarrhea

x_1 NUMBER OF CHILDREN UNDER 5 YEARS OF AGE THAT LIVE IN THIS HOUSE (COUNT FROM Q D_14 AND VERIFY WITH RESPONDENT)....._____#

IF ZERO, GO TO SECTION J: ARI.

x_2 RECORD FOLLOWING INFORMATION FOR EACH CHILD UNDER 5 YEARS OF AGE LIVING IN HOUSEHOLD (RECORD FROM QUESTION D_14 AND VERIFY WITH RESPONDENT; START WITH YOUNGEST WOMEN AND CONTINUE WITH OTHERS).

Children #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
x_3 Did this child have diarrhea in the past one month? Yes ..... 1 No (**GO TO Q.J_1**) 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
x_4 If yes, has this child been seen by healthcare provider? Yes ..... 1 No (**GO TO Q.J_1**) 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
x_5 If yes, has this child been prescribed antibiotic? Yes ..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
x_6 If yes, has this child been prescribed ORS? Yes ..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
x_7 If yes, has this child been prescribed Vit A? Yes ..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|

Section J: ARI

J_1 NUMBER OF HH MEMBERS WITH ACUTE COUGH IN THE PAST 3 MONTHS THAT LIVE IN THIS HOUSE (COUNT FROM Q F_3 AND VERIFY WITH RESPONDENT)....._____#

IF ZERO, GO TO SECTION K: Hypertension.

J_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO HAD ACUTE COUGH IN THE PAST 3 MONTHS (START WITH PERSON WITH MOST RECENT EPISODE AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ M d y
2			___ / ___ / ___ M d y
3			___ / ___ / ___ M d y
4			___ / ___ / ___ M d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
J_3 Has this person been seen by healthcare provider for this illness (acute cough)? Yes ..... 1 No (**GO TO Q.K_1**) 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
J_4 If yes, did this person receive a physical examination of the chest for evidence of pneumonia? Yes ..... 1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
J_5 Has this person get chest x-ray? Yes ..... 1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
J_6 If yes, was this person diagnosed with pneumonia? Yes ..... 1 No (**GO TO Q.K_1**) 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
J_7 If yes, was this person prescribed antibiotics? Yes ..... 1 No (**GO TO Q.K_1**) 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_

Section K: Hypertension

K_1 NUMBER OF HH MEMBERS WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE HYPERTENSION (COUNT FROM Q E_2 AND F_3 AND VERIFY WITH RESPONDENT)....._____#

IF ZERO, GO TO SECTION L: Ischemic heart disease.

K_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE HYPERTENSION (START WITH PERSON WITH EARLIEST DIAGNOSIS AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
K_3 Did this person have his/her blood pressure checked by a doctor, nurse or other health professional within past year? Yes ..... 1 No 0	___	___	___	___	___	___	___
K_4 If yes, what was the frequency of blood pressure measurement by health provider within past year? Every week ..... 1 Every month ..... 2 Every quarter ..... 3 Every 6 months ..... 4 Once in a year ..... 5 DOES NOT REMEMBER 88	___	___	___	___	___	___	___
K_5 Is this person prescribed continuous pharmaceutical treatment for blood pressure control? Yes ..... 1 No(**GO TO Q.L_1**) 0	___	___	___	___	___	___	___
K_5 Does this person comply with prescribed continuous pharmaceutical treatment for blood pressure control? Yes ..... 1 No 0	___	___	___	___	___	___	___

Section L: Ischemic heart Disease

L_1 NUMBER OF HH MEMBERS WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE ISCHEMIC HEART DISEASE (COUNT FROM Q E_2 AND F_3 AND VERIFY WITH RESPONDENT)....._____#

IF ZERO, GO TO SECTION M: Diabetes Mellitus.

L_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE CORONARY ARTERY DISEASE (START WITH PERSON WITH EARLIEST DIAGNOSIS AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
L_3 Has this person been advised at least once to take aspirin at a dose of 75-150 mg/day (continued indefinitely) unless they have a contraindication? Yes ..... 1 No 0	___	___	___	___	___	___	___
L_4 Has this person ever received counseling on cholesterol lowering diet? Yes ..... 1 No 0	___	___	___	___	___	___	___

Section M: Diabetes Mellitus

M_1 NUMBER OF HH MEMBERS WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE DIABETES (COUNT FROM Q E_2 AND F_3 AND VERIFY WITH RESPONDENT)....._____#

IF ZERO, GO TO SECTION N: Smoking.

M_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT THEY HAVE DIABETES (START WITH PERSON WITH EARLIEST DIAGNOSIS AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
M_3 What treatment is this person prescribed to control blood sugar? No treatment ..... 0 Diet..... 1 Per oral antidiabetic drugs ..... 2 Insulin..... 3 Combination of diet and medicines ..... 4 OTHER (SPECIFY:_____) 5	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
M_4 Does this person comply with prescribed treatment for blood sugar control? Yes..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
M_5 Has this person had retinal exam within past year? Yes..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
M_6 Has this person had his/her feet examined within past year? Yes..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|

Section N: Smoking

N_1 NUMBER OF HH MEMBERS WHO ARE CURRENT SMOKERS ....._____#

IF ZERO, GO TO SECTION O: Alcohol

N_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO CURRENTLY SMOKES (START WITH PERSON WITH EARLIEST DIAGNOSIS AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
N_3 How long has been this person smoking? Less than 1 y..... 1 1-5 y ..... 2 5-10 y ..... 3 10-20 y ..... 4 More than 20 5	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|
N_4 Has this person ever received counseling to stop smoking? Yes..... 1 No 0	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|	_|_|

Section O: Alcohol

O_1 NUMBER OF HH MEMBERS WHO CONSUME ALCOHOL....._____#

IF ZERO, GO TO SECTION P: Patient Satisfaction

O_2 RECORD FOLLOWING INFORMATION FOR EACH HH MEMBER WHO CONSUMES ALCOHOL (START WITH PERSON WITH EARLIEST DIAGNOSIS AND CONTINUE WITH OTHERS. CROSSCHECK WITH Q D_14).

HH member #	# HHM (from table D_14)	Name	Date of birth
1			___ / ___ / ___ m d y
2			___ / ___ / ___ m d y
3			___ / ___ / ___ m d y
4			___ / ___ / ___ m d y
5			___ / ___ / ___ m d y
6			___ / ___ / ___ m d y
7			___ / ___ / ___ m d y

	1	2	3	4	5	6	7
O_3 Does this person have alcohol dependency (alcoholism)? Yes.....1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_
O_4 If yes, has this person ever received counseling to stop drinking alcohol? Yes.....1 No 0	_|_	_|_	_|_	_|_	_|_	_|_	_|_

Section P: Satisfaction

P_1 In the past one year, has any member of your household visited your own community/area clinic (FAP, SVA, SUB, DPOLY, CPOLY) for any health service including for those not mentioned before (such as obtaining vaccinations or physical examinations)?

Yes (COMPLETE 'SATISFACTION QUESTIONNAIRE')..... 1

No (STOP) 0

IF HH MEMBER(S) HAVE VISITED THEIR CLINIC IN PAST ONE YEAR, ASK HH INFORMANT TO COMPLETE THE 'COMMUNITY CLINIC SATISFACTION QUESTIONNAIRE' (INVOLVE ALSO OTHER HH MEMBERS). MAKE SURE RESPONDENTS ARE THINKING ABOUT THEIR LOCAL COMMUNITY/AREA CLINIC AND NOT THE LOCAL HOSPITAL OR ANY OTHER CLNIC/HOSPITAL LOCATED OUTSIDE OF THE COMMUNITY/AREA. WRITE THE NAME OF THE COMMUNITY/AREA CLINIC AT THE TOP OF THE SATISFACTION QUESTIONNAIRE AND GIVE TO RESPONDENT TO COMPLETE. AFTER COMPLETION, FOLD IN HALF AND PUT IN DESIGNATED ENVELOPE TO ENSURE CONFIDENTIALITY OF RESPONDENT.

THANK YOU!!

COMPLETED BY SURVEYOR ONLY

TIME Time interview completed: __|__|:__|__|

RELY How reliable do you feel these responses are? This means, do you feel you have been provided with answers that are truthful and accurate? (CIRCLE ONLY ONE)

All reliable 1
Mostly reliable..... 2
Partially reliable 3
Unreliable..... 4

CO-OP Degree of co-operation (CIRCLE ONLY ONE)

Very good 1
Good 2
Not so good 3
Not good at all..... 4

UNDER Did the person interviewed understand the questions (CIRCLE ONLY ONE)

No difficulty 1
Little difficulty 2
Much difficulty 3
Great difficulty..... 4

Name of Clinic/Hospital: _____ ID: __ / ___ ___ ___

Date _____ / _____ / _____

Local Clinic Satisfaction Questionnaire

We would like to ask you to help us evaluate the health services at your community clinic. The following are some questions about your satisfaction with the services. Please answer as honestly as possible. This information will not be shared with your doctor or anyone else at the clinic. You do not need to put your name on the questionnaire.

We are interested in your feelings, good or bad, about the medical care you have received at your community clinic. Please think only about your community clinic when answering this question. Do not think about your district clinic/hospital or other clinics/hospitals that are located outside of your community.

P.1 When was the last time when you visited your community area clinic?

1. During last 6 month
2. More than 6 month ago

P.2 How often in general do you visit your community area clinic?

1. Always when needed
2. Only sometimes
3. Almost never

P.3. How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number for Each Line)

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	Doctors are good about explaining the reason for medical tests……	1	2	3	4	5
2.	Do you think your doctor's office has everything needed to provide complete medical care……	1	2	3	4	5
3.	The medical care you have been receiving is just about perfect…….	1	2	3	4	5
4.	Sometimes doctors make you wonder if their diagnosis is correct	1	2	3	4	5
5.	You feel comfortable that you can get the medical care I need without being set back financially……	1	2	3	4	5

Name of Clinic/Hospital: _____ ID: __ / ___ ___ ___

Date _____ / _____ / _____

6.	When you go for medical care they are careful to check everything when treating and examining me ..	1	2	3	4	5
7.	You have to pay for more of my medical care than I can afford……	1	2	3	4	5
8.	You have easy access to the medical specialists you need…….	1	2	3	4	5

Name of Clinic/Hospital: _____ ID: __ / ___ ___ ___

Date _____ / _____ / _____

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
9.	Where you get medical care, you have to wait too long for emergency treatment……..	1	2	3	4	5
10.	Doctors act too businesslike and impersonal towards you……...	1	2	3	4	5
11.	Doctors treat you in a very friendly and courteous manner…	1	2	3	4	5
12.	Those who provide medical care hurry too much when they treat you……...	1	2	3	4	5
13.	Doctors sometimes ignore what you tell them……..	1	2	3	4	5
14.	You have some doubts about the ability of the doctors who treat you	1	2	3	4	5
15.	Doctors usually spend plenty of time with you……...	1	2	3	4	5
16.	You find it hard to get an appointment for medical care right away……	1	2	3	4	5
17.	You are dissatisfied with some things about the medical care you receive….	1	2	3	4	5
18.	You are able to get medical care whenever you need it……	1	2	3	4	5

HOSPITAL ASSESSMENT QUESTIONNAIRE FOR ENGINEERS

Questionnaire No [ ]

Date: _____

Engineer (Name, Last name): _____

Respondent's name, last name:_____

Respondent's position _____

1. Rayon _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2 Telephone number

_____

3. Facility Type:

1. Village Site Hospital (SUB)
2. Central District Hospital (CDHOSP)
3. Maternity Hospital (MHOSP)
4. City General Hospital (CGHOSP)
5. Pediatric Hospital (PEDHOSP)
6. Infectious Hospital (IHOSP)
7. Psychiatric Hospital (PHOSP)
8. Other (Specify)_____

Section A: Facility general info

1. Facility Ownership Status:

1. State
2. Municipal
3. Private
4. Other (specify)_____

2. Please, indicate number of the buildings of your facility _____

2.1 Does your facility need some additional space or another building?

1. Yes (specify, how many, for what purposes etc.)_____
2. No

(IF MORE THAN ONE MAIN <u>(NOT SUPPORTING) BULDINGS EXISTS</u>, PLEASE COMPLETE THE SELECTED SECTIONS OF THE FORM (QUESTIONNAIRE) FOR EACH BULIDING SEPARATELY! THERE ARE SPECIAL NOTE NEXT TO EACH SUCH SECTION IN THE FORM)

SECTION 1: BUILDING
(THIS SECTION NEEDS TO BE FIILED IN FOR EACH BUILDING SEPARATELY!)

BULDING #_____ Department name: _____
(PLEASE INDICATE NUMBER OF THE BULDING, IF SEVERAL BULDING EXISTS)

3. **In which year the facility building was constructed?**
4. **Last time, when the building was repaired?**

_____ _____
Month Year

5. **What is your estimate of the current general condition of the building of your facility?**
   1. It does not need repair ***Go to Quest .7***
   2. It needs minor repair
   3. It needs major repair
   4. Is dilapidated, not possible to repair

6. **What are the repair needs in your facility for separate parts of the building?**

	No need in repair	Min or repair	Major repair	Dilapidated
	4	3	2	1
1) Foundation	4	3	2	1
2) Walls	4	3	2	1
3) Roof	4	3	2	1
4) Doors/windows	4	3	2	1
5) Floors	4	3	2	1
6) Interior	4	3	2	1
7) Plumbing	4	3	2	1
8) Sanitation	4	3	2	1
9) Electrical system	4	3	2	1
10) Other (specify) _____	4	3	2	1

7. **Please indicate number of floors of the bulding _____**

8. **Has your facility building entrance for the disabled? 1. yes 2. no**

9. **Is your facility building equipped properly in order disabled to access all floors and rooms? 1. yes 2. no**

Section 2: **Building condition by departments/ units (Please complete below table for the facility (not for each building separately!), regardless the number of the buildings in the facility)**

Department/ Unit	Constr Date	Date of last repair	Seism safe (yes/no)	# of rooms	Total space (M^2)	Toilet (yes/no)	Shower (yes/no)	Repair needs (use section 1, Q5 codes. Enter one answer for all 6 elements listed below by departments/buildings)					
								1. Doors/ windows	2.Floors	3.Interior	4.Plumbing	5.Sanitation	6.Electrical system
1. ICU													
2. Neonatal ICU													
3. Pediatric ICU													
4. Maternity													
5. Maternity OR (for c-section)													
6. Surgery													
7. Surgery OR													
8. Postsurgery													
9. Therapy													
10. Neonatal													
11. Paediatric													
12. Laboratory													
13. Diagnostic													
14. Training/conference													
15.													
16.													
17.													
18.													
19.													
20.													
21. Total				Tot # of rooms ---------	Total M^2 of the building ----------								

Section 3: **Utilities by department/ unit (Please fill in below table for the facility (not for each building separately!), regardless the number of the buildings in the facility)**

Department/ Unit	Heating		Air condition		Med Gas (O_2)		Electric wiring		Electricity Back up	Cold water		Hot water		Elevator		Fire security (Spreankler)	
	yes/ no	Q5codes	yes/ no	Q5 codes	yes/ no	Q5 codes	yes/ no	Q5 codes	Yes/no	yes/ no	Q5 codes	yes/ no	Q5 codes	yes/ no	Q5 codes	yes/ no	Q5 codes
1. ICU																	
2. Neonatal ICU																	
3. Pediatric ICU																	
4. Maternity																	
5. Maternity OR (for c-section)																	
6. Surgery department																	
7. Surgery (Operation Room)																	
8. Postsurgery unit																	
9. Therapy																	
10. Neonatal																	
11. Pediatric																	
12. Laboratory																	
13. Diagnostic																	
14. Training/conference																	
15. Administration																	
16.																	
17.																	
18.																	
19.																	
20.																	
21.																	

Section 4: (Whole section with its all parts (a, b, c, d, e) needs to be filled in for each buildings separately, if several buildings exists!)

BULDING #_____ Department name: _____
(PLEASE INDICATE NUMBER OF THE BULDING, IF SEVERAL BULDING EXISTS)

a) Building condition and materials

1. Condition of site, where the building is located.

1. Good
2. Satisfactory
3. Bad (Go to 1.1)

1.1. Is it possible to leave/build facility on this site?

1.Yes
2.No

2. Physical characteristics of the building: (encircle)

1. Tower-type
2. Single-sectional
3. Multi-sectional (Number of sections) _____
4. other (specify) _____

3. Materials used: (encircle all corresponding numbers)

1. Wood
2. Clay
3. Stone
4. Brick
5. Ferro-concrete
6. Panel

4. Building was constructed :

1. With anti-seismic strengthening
2. without strengthening

5. What material is used for connection of floors?

1. Concrete
2. Wood frame

6. What material is used for roof?

1. tar
2. asbestos-cement
3. tiles (ceramic)
4. metal sheets
5. other (specify) _____

7. Can you observe damages of the building?

1. Yes
2. No ***go to question 9***

8. What is the degree of the damages? (encircle)

1. minor damages
2. serious damages of non structural units
3. Important damages of main frames (structure, foundation, walls)
4. Parts of the building are ruined, connection among the parts of the building is ruined

5. Complete destruction of the building

9. Does the building contain materials prohibited according to anti-fire or sanitary norms (e. g. asbestos, some kinds of linoleum)

1. Yes
2. No

10. Please estimate whether the repair of the building is needed or not

1. The building has to be repaired
2. It is in good condition repair is not needed ***Go to question 15***
3. The repair does not make sense, new building required **(If several buildings exists, go to the same section (4th) and fill in for another building! If only one building exists, *go to section 5 road, question 36).***

11. What frames or elements of the facility building are damaged?

#	Frames or elements	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the frame or element need? *(Please describe in specific)*
1.	Roof			
2.	Exterior			
3.	Internal			
4.	Wet points			
5.	Doors and windows			
6.	Ceiling			
7.	Floors *(specify the type)*	1.		
		2.		
		3.		
		4.		
8.	Other (specify) _____			
9.	Other (specify) _____			
10.	Other (specify) _____			

12. Estimated value of materials and labour needed for the rehabilitation of the building:
_____ AzMan

13. What frames or elements of other (supporting) building(s) are damaged?

#	Frames or elements *(name)*	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this frame/element need? *(Please describe in specific)*
1.				
2.				
3.				
4.				
5.				
6.				

14. Estimated value of materials and labour needed for the rehabilitation of the other building:
_____ AzMan

b) Water supply and sewage systems

15. Do the water supply and sewage internal systems need repair?

1. Yes
2. No, water supply and sewage internal systems are in good condition ***go to question 18***
3. No, water supply and sewage internal systems should be changed entirely
4. No, water supply and sewage internal system is not installed

16. **What elements of water supply and sewage internal systems need to be repaired (changed)? In case the systems do not exist, describe activities for the installation**

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
Water supply system:				
1.	Pipes *(indicate diameter and length)*			
2.	Hand washing *(indicate quantity)*			
3.	Taps			
4.	Shower			
5.	Other (specify) _____			
In case the systems do not exist, describe activities for the installation here:				
Sewage system:				
6.	Pipes *(indicate diameter and length)*			
7.	Lavatory Pan *(indicate quantity)*			

8.	Sewage Collector *(indicate*			
9.	Other (specify) ____ _____			
In case the systems do not exist, describe activities for the installation here:				

17. Estimated value of materials and labour needed for the rehabilitation/installation of the water supply and sewage internal systems:
_____ AzMan

18. Does the external water supply system need repair or installation of a new system?

1. Yes, repair is needed
2. Yes, entire replacement or installation is needed
3. No, water supply external system is in a good condition ***go to question 21***
4. No, there is no main water supply pipe near the facility

19. What elements of the external water supply system have to be repaired? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
1.	Pipes *(indicate diameter and length)*			
2.	Closing Taps *(indicate quantity)*			
3.	Meter for water			
4.	Well for meter			
5.	Other (specify) ____ _____			

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
If installation is technically possible, describe needed activities here:				

20. Estimated value of materials and labour needed for the rehabilitation/installation of the external water supply system:
_____ AzMan

21. Does the external sewage system need repair?

1. Yes, repair is needed
2. Yes, entire replacement or installation is needed
3. No, external sewage system is in a good condition ***go to question 24***
4. No, *there are no central sewage system in a city/village*

22. What elements of the external sewage system have to be repaired? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Sewage well *(indicate quantity)*			
2.	Pipes *(indicate diameter and length)*			
3.	Whole in a ground			
4.	Other (specify) _____			
5.	Other (specify) _____			
If installation is technically possible, describe needed activities				

23. Estimated value of materials and labour needed for the rehabilitation/installation of the external sewage system:

_____ AzMan

c) Electricity

24. Does the internal electric system need repair?

1. Yes
2. No, entire replacement or installation of internal electric system is needed
3. No, it is in a good condition ***go to question 27***

25. What elements of the internal electric system are damaged? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Wires *(Indicate cut diameter and length)*			
2.	Switchers and rosettes			
3.	Lighters			
4.	El. Distributor			
5.	Meter			
6.	Automatic switchers			
7.	Earth connectors			
8.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				

26. Estimated value of materials and labour needed for the rehabilitation of the internal electric system:

_____ AzMan

27. Does the external electric system need repair?

1. Yes
2. No, it is in a good condition ***go to question 30***
3. No, external electric system should be changed entirely, entire replacement or installation is needed

28. What elements of the external electric system are damaged? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Cable *(Indicate cut diameter and length)*			
2.	Open tires			
3.	El. Pole			
4.	El. supply Distributor			
5.	El. Distributor (receiver)			
6.	Other (specify) ____ _____			
If installation is technically possible, describe needed activities here:				

29. Estimated value of materials and labour needed for the rehabilitation/installation of the external electric system:

_____ AzMan

d) Natural Gas

30. Does the internal or external natural gas system need repair?

1. Yes
2. No, it is in a good condition ***go to question 33***
3. No, external or internal natural gas system should be changed entirely (or newly installed)
4. No, the natural gas system does not exist near the facility ***go to question 33***
5. No, because it exists but is not functioning for years ***go to question 33***

31. What elements of the natural gas system have to be repaired (replaced)? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
Internal natural gas system				
1.	Pipes *(indicate diameter and length)*			
2.	Taps			
3.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				
external natural gas system				
4.	Pipes *(indicate diameter and length)*			
5.	Regulator point			
6.	Meter			
7.	Closing Taps			

8.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				

32. Estimated value of materials and labour needed for the rehabilitation/installation of natural gas internal system:
_____ AzMan

32.1. Estimated value of materials and labour needed for the rehabilitation/installation of natural gas external system:
_____ AzMan

e) Heating system

33. Does the heating system need repair?

1. Yes
2. No, it is in a good condition ***go to question 36***
3. No, the system should be changed entirely (or newly installed)
4. No, the Heating system does not exist in the facility ***go to question 36***
5. No, because it exists but is not functioning for years due to absence of a fuel ***go to question 36***

34. What elements of the heating system have to be repaired (replaced)? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
Internal system				
1.	Pipes for heating *(indicate diameter and length)*			
2.	Heater *(indicate quantity)*			
3.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				
External system				
4.	Heating Net			

	(indicate length)			
5.	Pipes for heating *(indicate diameter and length)*			
6.	Boiler (*indicate power)*			
7.	Chimney			
8.	El. Pump			
9.	Ventilator			
10.	Boiler's Internal Pipes' Net			
If installation is technically possible, describe needed activities here:				

35. Estimated value of materials and labour needed for the rehabilitation/installation of the internal heating system:
_____ AzMan

35.1. Estimated value of materials and labour needed for the rehabilitation/installation of the external heating system:
_____ AzMan

Section 5: Road (This section is to be filled in for the facility! Not for all buildings separately)

36. Does the road leading to the facility need repair?

1. Yes
2. No, it is in a good condition ***Go to section 6: equipment***

37. Please, describe the damage

#	Description	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Road cover (Holes)			
2.	Earth Road			

3.	Asphalt			
4.	Drainage			
5.	Other (specify) _____ _____			

38. Estimated value of materials and labour needed for the rehabilitation of the road leading to the facility:

_____ AzMan

Section 6: Equipment (This section is to be filled in for the facility! Not for all buildings separately!)

In the table below for each item please indicate their quantities and describe them using the criteria given below

Equipment item	**Quantity**	**Of which:** (Criteria for description)		
		1. Of good functioning condition	2. Cannot fulfil its function but is repairable	3. Cannot fulfil its function and impossible to repair
1. Diagnostic equipment				
1.1 X-ray				
1.2 Mammography				
1.3 Ultrasound				
1.4 Echocardiography				
1.5 Doppler ultrasound				
1.6 Cardio monitor				
1.7 Ventilator				
1.8 Autoclave				
1.9 Dry sterilization				
1.10Refrigerator				
1.11CT scan				
1.12MRI				
1.13Angiography				
2. Laboratory				
2.1 Automated chem analyzer				
2.2 Electrophoresis equipment				
2.3 ELISA system				
2.4 Hematology analyzer				
2.5 Immuno-analyzer				
2.6 Microscope (binocular, AC powered)				
2.7 ISE analyzer with blood pH and pO2				
2.8 Multi channel pipette				
4. Operating room				
4.1 For acute general surgery (**Instruction:** This means whether the general surgery room is equipped properely according to the standard. This should be checked with the standard list, that is available at the MOH! surveyor needs to assess this item against this standard list!)				
For normal deliveries (the same instruction as above, on item 4.1)				

Hospital Assessment Questionnaire

Questionnaire No _____

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon/ City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2. Telephone number

_____

3. Facility Type:

1. Village Site Hospital (SUB)
2. Central District Hospital (CDHOSP)
3. Maternity Hospital (MHOSP)
4. City General Hospital (CGHOSP)
5. Pediatric Hospital (PEDHOSP)
6. Infectious Hospital (IHOSP)
7. Psychiatric Hospital (PHOSP)
8. Other (Specify)_____

4. Please provide the size of population in your official catchment area

Adults	4.1_____
Children	4.2_____
Women of age 15-49	4.3_____

Section 1: **Please provide no of referrals by your facility according the below list of specializations** *(for the year 2005)*

		Total # of referrals
1.	General Surgery	
2.	Orthopaedics	
3.	Traumatology	
4.	Paediatrics	
5.	Neurology	
6.	Gynaecology	
7.	Obstetrics	
8.	Internal medicine	
9.	Cardiology	
10.	Pneumonology/TB	
11.	Oncology	
12.	Infectious Diseases	
13.	Psychiatry	
14.	Dermatology/STD	
15.	ENT	
16.	Ophthalmology	
17.		
18.		
19.		
20.		

Section 2: Transportation/communication/computer equipment/medical waste

1. What transportation means does your facility own?

	Total quantity	**From them**			**Main** purpose of use: **1=**administration **2=** Emergency service **3**=Mobile/outreach service **4=**material transportation	**If used for any service, is it properly equipped?** 1=Yes 2=No
		In working condition	Missing parts	Dilapidated		
1. 2 WD Car						
2. 4 WD Car						
3. Ambulance vehicle						
4. Other **(specify)** _____						

2. Now, please provide information about means of communication of this facility.

(*Please, circle existing one in a column 1)*

	How many means of communication listed below exist in this facility? (quantity)	From them (if having):		
		In working condition	Not functioning but repairable	Dilapidated
1. Telephone landline				
2. Radio				
3. Facility mobile telephone				
4. Private mobile telephone				
6. Internet/email				
7. Fax				
8. Other (specify)_____				

3. What computer equipment does your facility own?

	Total quantity	Production year				From them		
		No1	No2	No3	No4	In working condition	Not functioning but repairable	Dilapidated
1. Computer								
2. Printer								
3. UPS								
4. Copier								
5. Other (Specify)_____								

4. How is the medical waste of your facility treated? *(Encircle only one answer)*

1. By the garbage collector
2. By the incinerator
3. We burn it at designated place
4. We drop it to the designated place
5. We bury it
6. Other (Specify) _____

5. How frequently is your garbage treated? *(Encircle only one answer)*

1. Every day
2. Every other day
3. Twice per week
4. Once per week
5. Twice per month
6. Once per month
7. The same day when we have waste
8. Other (specify) _____

Section 3: Personnel

Please, give us information about personnel distribution by gender, age, specialization, years of experience in specialization, and workload

	Specialisation	Total number	Age groups					Gender		Years of experience in specialization				Received clinical training (How many years ago received)		
	Department/ Unit _____		35 and less	36-45	46-55	56-65	66 and more	Male	Female	less then 1 year	1-5	6-10	11 and more	less then 1 year ago	2-5 years age	6 and more years ago
1	Paediatrician															
2	Gynaecologist/ Obstetrician															
3	General Therapist															
4	Infectionist/ epidemiologist															
5	Cardiologist															
6	Endocrinologist															
7	Oncologist															
8	General Surgeon															
9	Traumatologist/ orthopaedist															
10	Neurologist															
11	Dermatologist/STD															
12	ENT															
13	Ophthalmologist															
14	Lab Physician															
15	Radiologist															
16	Ultra-sound specialist (separate person)															
17	Pharmacist															

	Specialisation	Total number	Age groups					Gender		Years of experience in specialization				Received clinical training (How many years ago received)		
	Department/ Unit _____		**35 and less**	**36-45**	**46-55**	**56-65**	**66 and more**	**Male**	**Female**	**less then 1 year**	**1-5**	**6-10**	**11 and more**	**less then 1 year ago**	**2-5 years age**	**6 and more years ago**
18	Dentist															
19	Midwife															
20	Nurse															
21	Equipment Technician															
22	Lab technician															
23	Administration															
24	Finance															
25	Person for building maintenance															
26	Cleaning staff															
27	Guard															
28	Driver															
29	Other (Specify)															
30	Other (Specify)															
31	Other (Specify)															
32	Other (Specify)															
33	Total															

34. How many physicians in your facility work in more than one specialisation?

_____

35. Please, indicate in the table below the numbers of persons working on management positions only, not as physicians/specialists

Position	**No**
Director	
Deputy Director(s)	
Head of division/department	
Deputy Heads	
Other (specify) _____	

36. How does your management structure look like? *(Draw a chart)*

Section 4: Utilization of services within the past year (2005)

Department/ unit	# of beds	# of patients in 2005	Total patient X days[1] (For calculation see instruction below, in the footnote!)	# of patients referred from other facilities	# of patients referred to other facilities
1. ICU					
2. Neonatal ICU					
3. Pediatric ICU					
4. Maternity					
5. Maternity OR (for c-section)					
6. Surgery					
7. Surgery OR					
8. Postsurgery					
9. Therapy					
10. Neonatal					
11. Pediatric					
		# of tests in 2005		**# of patients referred from other facilities**	**# of patients referred to other facilities**
12. Laboratory					
13. Diagnostic					

Section 5: Patient outcome indicators for 2005

	#	CIRCLE	CIRCLE
1. # of patients hospitalized with stroke		Not relevant	Data not available
2. # of stroke patients who died during hospital stay		Not relevant	Data not available
3. # of patients hospitalized with acute myocardial infarction		Not relevant	Data not available
4. # of AMI patients who died during hospital stay		Not relevant	Data not available
5. # of pregnant women with eclampsia		Not relevant	Data not available

[1] **Instruction: The "total patient X days" needs to be calculated in the following way: If e.g. during the year 2005 one patient was hospitalized for 20 days (hospital stay), another – for 45, other for 15 and etc. 20+45+15=80 days are the total patient X days)**

		relevant	available
6. # of pregnant women with eclampsia who gave still birth (dead infant)		Not relevant	Data not available

Section 6: Patient admission in 2005

	#
TOTAL NUMBER OF HOSPITALIZED PATIENTS	
PATEINTS REFFERED BY LOCAL HOSPITAL DOCTORS	
SELF-REFERRED	
REFERRAL FROM PHC FACILITIES (FAP, DAC, DPOLY)	
REFERRAL FROM OTHER INSTITUIONS	
EMERGENCY (AMBULANCE OR SELF-REFERRED)	

Hospital Provider Survey Questionnaire

Questionnaire No [ ]

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon/ City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

_____

3. Facility Type:

1. Village Site Hospital (SUB)
2. Central District Hospital (CDHOSP)
3. Maternity Hospital (MHOSP)
4. City General Hospital (CGHOSP)
5. Pediatric Hospital (PEDHOSP)
6. Infectious Hospital (IHOSP)
7. Psychiatric Hospital (PHOSP)
8. Other (Specify)_____

SECTION 1: Personal Characteristics

1 What is your age in years? _____ **years**

2 What is your Gender? ☐ **Male** ☐ **Female**

3 For How Long have you been working in this facility? _____ **years**

4 For How Long have you been practicing medicine? _____ **years**

SECTION 2: Practice Characteristics

1. Which of the following best describes your principal practice arrangement (Circle one):

1 Full-time salaried position:

2 Part-time salaried position:

↪ What amount of time you work at this facility .....

2.1 25-50%

2.2 51-75%

2.3 more then 75%

3. Other [1](specify):

2. Which of the following best describes your principal specialty area (Check one):

1 Pediatrician

2 Internist

3 Obstetrician/Gynecologist

4 Surgery

5 ENT

6 Urology

7 Cardiology

8 Neurology

9 Ophthalmology

10 Other specialist (specify)

_____

_____

_____

3. In your practice, do you focus or concentrate on any of the following areas? Is the focus a result of formal training, such as a fellowship, or a result of your practice experience? *(Please put mark X in the box were applicable. If there are several areas that are applicable check all of them. The boxes that are not applicable leave BLANK)*

	PRACTICE FOCUS	Formal Training (Fellowship)	Practice Experience
1	Internist (therapevt) only for adults		
2	General Pediatrician taking care of only children		
3	Obstetrician and Gynecologist taking care of women problems		

[1] e.g. works on more than one full-time salaried position

4	Cardiology		
5	Neurology		
6	Surgery		
7	Allergology		
8	Traumatologist-Ortho		
9	Urologist		
10	Ear Nose Throat		
11	Ophthalmologist		
12	Endocrinologist		
13	Infectious Disease		
14	Other, **please specify** _____		

4. In the last year, what percentage of your patients were referred to you by:

1. *PHC providers (FAP, DAC)* ..... [ ] %
2. PHC providers (DPOLY) ..... [ ] %
3. Emergency (ambulance) ..... [ ] %
4. other physicians ..... [ ] %
5. Self-referred ..... [ ] %

SECTION 3: Practice Activity

1. During a typical <u>WEEK</u>, estimate the number of: (Enter one number per line)

1 Hours that you spend on patient care including physical examination and diagnostic and treatment procedures..... _____ hrs/week

2 hours that you spend on filling out documentation not related to patient care (e.g. stat reports) .... _____ hrs/week

3 hours that you teach residents or fellows .... _____ hrs/week

4 hours that you teach other medical personnel ..... _____ hrs/week

2. During a typical <u>MONTH</u>, estimate the number of: (Enter one number per line)

1 New patients you see in <u>your clinic/ward</u>..... .... _____ /month

2 patients you see/treat outside hospital..... .... _____ /month

3. For what percentage of your new patient visits in 2005, YOU were the first or initial contact physician? (Circle one)

1 1-10 percent
2 11-25 percent
3 greater than 25 percent
4 I accept patients only upon referral

4. During the calendar year 2005, how many: (Enter one number per line, if not applicable leave empty or put 0)

1	days per week did you practice?	days/week
2	hours/week did you practice?	hours/week
3	months did you practice during a year?	months
4	weeks vacation did you take?	weeks
5	Average hours/month you spent on your professional development	hours/month
6	days did you spend away from your practice attending training activities or professional meetings?	Days/year
7	Number of medically or non-medically justified absence for seven days or less in a row (short-term absentism)	
8	Number of medically or non-medically justified absence 8-29 days in a row	
9	Number of medically or non-medically justified absence for 30 days or more in a row (long-term absentism)	
10	Number of weeks worked over 150% regular working time according to national legislation	Weeks

SECTION 4. Provider Satisfation

To what extent do you agree or disagree with the following statements? (Circle one number on each line)

		Strongly Agree	Some-what Agree	Neither Agree nor Disagree	Some-what Disagree	Strongly Disagree
1	I am satisfied with organization of work at my facility	1	2	3	4	5
2	I feel, some components of my work do not have any sense	1	2	3	4	5
3	My job is still interesting for me as was before	1	2	3	4	5
4	My work is overwhelmed with extra administrative tasks	1	2	3	4	5
5	For the same salary/income I would prefer to have nonmedical job	1	2	3	4	5
6	I do really get satisfaction from my work	1	2	3	4	5
7	My work is chracterized with good balance between my efforts and rewards I get	1	2	3	4	5
8	My work is related to many unnecessary efforts from my sides	1	2	3	4	5

Hospital Guidelines/ Record Review Questionnaire

Questionnaire No [ ]

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon/ City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2. Telephone number:

_____

3. Facility Type:

1. Village Site Hospital (SUB)
2. Central District Hospital (CDHOSP)
3. Maternity Hospital (MHOSP)
4. City General Hospital (CGHOSP)
5. Pediatric Hospital (PEDHOSP)
6. Infectious Hospital (IHOSP)
7. Psychiatric Hospital (PHOSP)
8. Other (Specify)_____

SECTION 1: Availability of services

Does your facility offer the following services to the population?

	RESPONSE		
	yes	**no**	**Evidence for responses (describe in specific)**
BASIC LAB SERVICES			
1. Hematology			
2. Hemostasis			
3. Immuno-hematology			
4. Enzymes			
5. Proteins			
6. Biochemistry			
7. Gazometry			
8. Bacteriology			
9. Serology			
OTHER SERVICES			
10. Blood transfusion			
11. Emergency obstetric care (hemorrhage and obstructed labour)			
12. Laparoscopic surgery			
13. TUR			
14. Coronary stenting			
15. Intracranial hematoma evacuation			
16. Intracranial aneurysma surgery			

SECTION 2: Quality of Services/ Clinical Practice Guidelines

Are the following guidelines available and used in your facility?

	Availablity *(to be verified by observation)*		**Use**	
GUIDELINES	**yes**	**No**	**yes**	**No**
1. Antibiotic use				
2. Case management of Acute Myocardial Infarction				
3. Case management of Stroke				
4. Patient referral to other facilities/ upper level				
STANDARD PROTOCOLS				
5. Antibiotic use				
6. Acute Myocardial Infarction				
7. Stroke				
8. Patient referral to other facilities/ upper level				

SECTION 3: Patient care characteristics

DELIVERY	**#**
1. Total number of deliveries in 2005	
2. Total number of uncomplicated deliveries in 2005	
3. Total number of patient x days[1] for uncomplicated deliveries in 2005	
4. Total number of c-sections in 2005	

[1] **Instruction: The "total patient X days" needs to be calculated in the following way: If e.g. during the year 2005 one patient was hospitalized for 20 days (uncomplicated delivery cases), another – for 45, other for 15 and etc. 20+45+15=80 days are the total patient X days**

5. Number of randomly selected case records (UNCOMPLICATED) **(select all if item 2. is =< 15, if >15 select 15 randomly)**	
6. Number of mothers breasyfeeding at discharge (from those case records that you selected randomly!)	
ACUTE MYOCARDIAL INFARCTION (AMI)	
7. Total number of patients admitted with AMI in 2005	
8. Total number of AMI patient x days in 2005	
9. Number of AMI patients who died during their hospital stay in 2005	
10. Number of randomly selected case records **(select all if item 7. is =< 10, if >10 select 10 randomly)**	
11. Number of AMI patients discharged on aspirin (from those cases that you have selected randomly!)	
STROKE	
12. Total number of patients admitted with stroke in 2005	
13. Total number of stroke patient x days[2] in 2005	
14. Number of stroke patients who died during their hospital stay in 2005	
15. Number of randomly selected case records **(select all if item 12. is =< 10, if >10 select 10 randomly)**	
16. Number of patients with CT scan after stroke (from those case records that you have selected randomly!)	
17. Number of patients with CT scan 3 hours after stroke (from those case records that you have selected randomly!)	

SECTION 4: Management function

Are the following management practices put in place in your facility?

	RESPONSE		
	yes	**no**	**Evidence for responses (describe in specific)**
PHYSICAL ASSET MANAGMENT			
1. A policy and procedures manual for stock management, inventory, and fixed assets			
2. Equipment inventory/ register (paper based)			

[2] For the instruction see footnote for Sections 3, item 3

3. Equipment inventory/ register (computer data base)			
4. Non-expendable equipment inspection checklist for planned preventive maintenance			
5. Pharmaceutical stock inventory			
6. Pharmaceutical stock cards			
7. The software that comprises a stock management system which provides information reports on minimum and maximum stock levels, prompts for re-order levels, notes expired items, reports on receipts and issues by stock item and stock balances			
FINANCIAL Management			
8. Policies and procedures manual for budgeting			
9. A written chart of accounts that accurately reflects categories of income, expenditures, assets and liabilities			
10. Policies and procedures manual for purchasing and procurement			
11. Policies and procedures manual for payroll			
12. A policy and procedures manual for cash control, banking, and cash flow			
13. An internal audit function			
HUMAN RESOURCE MANAGEMENT (HRM)			
14. HRM Budget			
15. HRM staff			
16. HR planning			
17. HR data (paper based)			
18. HR data (computerized)			
19. Personnel files			

20. Job classification system			
21. Compensation and benefits system			
22. Recruitment, hiring, transfer, and promotion procedures			
23. Policy manual			
24. Job descriptions			
25. A formal performance evaluation system			
26. Staff training as formal component of the organization			

PHC FACILITY ASSESSMENT QUESTIONNAIRE FOR ENGINEERS

Questionnaire No [ ]

Date: _____

Engineer (Name, last name): _____

Respondent's name, last name: _____

Respondent's position _____

1. Rayon _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2 Telephone number

_____

3. Facility Type:

1. Feldcher-Midvife Point (FAP)
2. Village Doctor Ambulatory (SVA)
3. Polyclinic in District Managed by Central District Hospital (DPOLY)
4. City (Children and Adults) Polyclinic (CPOLY)
5. Dispensary (DISP)
6. Women Consultation (WCONS)
7. Other (Specify)_____

Section 1: Building

1. Facility Ownership Status:

1. State
2. Municipal
3. Private
4. Other (specify)_____

2. In which year the facility building was constructed? _____

3. Last time, when the building was repaired?

_____ _____
Month Year

4. What is your estimate of the current general condition of the building of your facility?

1. It does not need repair ***Go to Quest. 7***
2. It needs minor repair
3. It needs major repair
4. Is dilapidated, not possible to repair

5. **Does your facility need some additional space or another building?**
    1. Yes (specify)_____
    2. No

6. **What are the repair needs in your facility for separate parts of the building?**

	No need in repair	Min or repair	Major repair	Dilapidated
	4	3	2	1
1) Foundation	4	3	2	1
2) Walls	4	3	2	1
3) Roof	4	3	2	1
4) Doors/windows	4	3	2	1
5) Floors	4	3	2	1
6) Interior	4	3	2	1
7) Plumbing	4	3	2	1
8) Sanitation	4	3	2	1
9) Electrical system	4	3	2	1
10) Other (specify) _____	4	3	2	1

7. **Please indicate number of buildings of the facility _____**

8. **Please indicate number of floors of the facility _____**

9. **Has your facility entrance for the disabled? _____**
    1. Yes
    2. No

10. **Is your facility equipped properly in order disabled to access all floors and rooms?**
    1. Yes
    2. No

Section 2: Utilities

Please indicate total number of rooms in your facility and provide spaces utilities for each

Name	# of rooms	Total space (M^2)	Date of last repair	Heating		Electric wiring		Water pipes	
				(yes/no)	(Q4 codes)	(yes/no)	(Q4 codes)	(yes/no)	(Q4 codes)
1. Consultation									
2. Examination									
3. Consultation/ Examination									
4. Minor surgery									
5. Dentistry									
6. Laboratory									
7. Management (Directors)									
8. Administration (reception, finance, registration, statistics)									
9. Drug store									
10. Kitchen									
11. Staff rooms									
12. Toilet M/F									
13. Toilet (M)									
14. Toilet (F)									
15. Toilet for patients									
16. Not used rooms									
17. Other (specify) _____									
18. Total	Total number of rooms ----------	Total **M^2** of the building ----------							

Electricity

19. How electric power is supplied to your facility in summer? 1=Uninterruptedly during 24 hours 2=According to a schedule 3=Haphazardly 4=Not supplied at all	**20. During how many hours per working day, on average, was electric power supplied in last summer?** *(Write down)*	**21. How electric power is supplied to your facility in winter?** 1=Uninterruptedly during 24 hours 2=According to a schedule 3=Haphazardly 4=Not supplied at all	**22. During how many hours per working day, on average, was electric power supplied in last winter?** *(Write down)*

Water Supply

23. From which sources is water supplied to your facility? *(Encircle all items relevant to your facility)*	**24. Which is the quality of the water supplied?** 1=Good for drinking 2=The quality is not so good 3=Not good for drinking	**25. What was the periodicity of water supply in the last summer?** 1=Uninterrupted supply 2=Supply only during appointed hours of day or appointed days of month 3=Supply difficulties in summer	**26. During how many hours per working day, on average, was the water supplied in the last summer?** *(Write down)*	**27. What was the periodicity of water supply in the last winter?** 1=Uninterrupted supply 2=Supply only during appointed hours of day or appointed days of month 3=Seasonal supply, supply difficulties in winter	**28. During how many hours per working day, on average, was the water supplied in the last winter?** *(Write down)*
1. Central water supply system tap in facility					
2. Central water supply system tap but not in facility					
3. Well (including artesian)					
4. Well (including artesian) but not in the					
5. Pumping station					
6. Natural spring					

7. River, brook, lake					
8. Other (specify) _____					

29. What is the source of energy_ for heating?

Source	code
1) Electric power	
2) Natural Gas	
3) Liquid gas	
4) Kerosene or diesel fuel	
5) Wood	
6) Coal	
7) Other (specify)_____	

Answers

1= Do not use at all
2= Use occasionally
3= Use often
4= Mainly use this source
5= This is the only source

30. What are the means for heating?

	Code
1. Shared system of hot water	
2. Autonomous system of hot water	
3. Electric heater	
4. Natural gas heater	
5. Coal heater	
6. Wood heater	
7. Kerosene heater	
8. Other (specify) _____	

Answers

1= Do not use at all
2= Use occasionally
3= Use often
4= Mainly use this mean
5= This is the only mean

31. What kind of sewage system do you have?

1. Metal pipes
2. Ceramic pipes
3. Plastic pipes
4. Other (specify)_____
5. Not needed

32. Where does the water used by your facility go (outside the facility)?

1. Flows through central drainage system
2. Flows into a special canal
3. Flows into a reservoir (lake, basin etc.), a river
4. Pours out into environment
5. Other (specify) _____

33. Which type of WC does your facility use?

1. WC with running water
2. WC in another building
3. Hole in the ground/ latrine
4. Other (specify) _____

34. Does the entire building belong to your facility?

9. Yes
10. No, only the part of it owns our facility
11. No, it is wholly owned by other

Section 4:
a) Building condition and materials

1. Condition of site, where the building is located.

1. Good
2. Satisfactory
3. Bad (Go to 1.1)

1.1. Is it possible to leave/build facility on this site?

1.Yes
2.No

2. Physical characteristics of the building: (encircle)

1. Tower-type
2. Single-sectional
3. Multi-sectional (Number of sections) _____
4. other (specify) _____

3. Materials used: (encircle all corresponding numbers)

1. Wood
2. Clay
3. Stone
4. Brick
5. Ferro-concrete
6. Panel

4. Building was constructed :

1. With anti-seismic strengthening
2. without strengthening

5. What material is used for connection of floors?

1. Concrete
2. Wood frame

6. What material is used for roof?

1. tar
2. asbestos-cement
3. tiles (ceramic)
4. metal sheets
5. other (specify) _____

7. Can you observe damages of the building?

1. Yes
2. No ***go to question 9***

8. What is the degree of the damages? (encircle)

1. minor damages
2. serious damages of non structural units
3. Important damages of main frames (structure, foundation, walls)
4. Parts of the building are ruined, connection among the parts of the building is ruined
5. Complete destruction of the building

9. Does the building contain materials prohibited according to anti-fire or sanitary norms (e. g. asbestos, some kinds of linoleum)

1. Yes
2. No

10. Please estimate whether the repair of the building is needed or not

1. The building has to be repaired
2. It is in good condition repair is not needed ***Go to question 15***

3. The repair does not make sense, new building required ***go to section 4 road, question 36).***

11. What frames or elements of the facility building are damaged?

#	Frames or elements	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the frame or element need? *(Please describe in specific)*
1.	Roof			
2.	Exterior			
3.	Internal			
4.	Wet points			
5.	Doors and windows			
6.	Ceiling			
7.	Floors *(specify the type)*	1.		
		2.		
		3.		
		4.		
8.	Other (specify) _____			
9.	Other (specify) _____			
10.	Other (specify) _____			

12. Estimated value of materials and labour needed for the rehabilitation of the building:
_____ AzMan

13. What frames or elements of other (supporting) building(s) are damaged?

#	Frames or elements *(name)*	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this frame/element need? *(Please describe in specific)*
1.				
2.				
3.				
4.				
5.				
6.				

14. Estimated value of materials and labour needed for the rehabilitation of the other building:
_____ AzMan

b) Water supply and sewage systems

15. Do the water supply and sewage internal systems need repair?

1. Yes
2. No, water supply and sewage internal systems are in good condition ***go to question 18***
3. No, water supply and sewage internal systems should be changed entirely
4. No, water supply and sewage internal system is not installed

16. **What elements of water supply and sewage internal systems need to be repaired (changed)? In case the systems do not exist, describe activities for the installation**

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
Water supply system:				
1.	Pipes *(indicate diameter and length)*			
2.	Hand washing *(indicate quantity)*			
3.	Taps			
4.	Shower			
5.	Other (specify) _____			
In case the systems do not exist, describe activities for the installation here:				
Sewage system:				
6.	Pipes *(indicate diameter and length)*			
7.	Lavatory Pan *(indicate quantity)*			

8.	Sewage Collector *(indicate*			
9.	Other (specify) ____ _____			
In case the systems do not exist, describe activities for the installation here:				

17. Estimated value of materials and labour needed for the rehabilitation/installation of the water supply and sewage internal systems:
_____ AzMan

18. Does the external water supply system need repair or installation of a new system?

1. Yes, repair is needed
2. Yes, entire replacement or installation is needed
3. No, water supply external system is in a good condition ***go to question 21***
4. No, there is no main water supply pipe near the facility

19. What elements of the external water supply system have to be repaired? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
1.	Pipes *(indicate diameter and length)*			
2.	Closing Taps *(indicate quantity)*			
3.	Meter for water			
4.	Well for meter			
5.	Other (specify) ____ _____			

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does this element need? *(Please describe in specific)*
If installation is technically possible, describe needed activities here:				

20. Estimated value of materials and labour needed for the rehabilitation/installation of the external water supply system:
_____ AzMan

21. Does the external sewage system need repair?

1. Yes, repair is needed
2. Yes, entire replacement or installation is needed
3. No, external sewage system is in a good condition ***go to question 24***
4. No, *there are no central sewage system in a city/village*

22. What elements of the external sewage system have to be repaired? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Sewage well *(indicate quantity)*			
2.	Pipes *(indicate diameter and length)*			
3.	Whole in a ground			
4.	Other (specify) _____			
5.	Other (specify) _____			
If installation is technically possible, describe needed activities				

23. Estimated value of materials and labour needed for the rehabilitation/installation of the external sewage system:

_____ AzMan

c) Electricity

24. Does the internal electric system need repair?

1. Yes
2. No, entire replacement or installation is needed
3. No, it is in a good condition ***go to question 27***

25. What elements of the internal electric system are damaged? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Wires *(Indicate cut diameter and length)*			
2.	Switchers and rosettes			
3.	Lighters			
4.	El. Distributor			
5.	Meter			
6.	Automatic switchers			
7.	Earth connectors			
8.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				

26. Estimated value of materials and labour needed for the rehabilitation of the internal electric system:

_____ AzMan

27. Does the external electric system need repair?

1. Yes
2. No, it is in a good condition ***go to question 30***
3. No, external electric system should be changed entirely, entire replacement or installation is needed

28. What elements of the external electric system are damaged? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Cable *(Indicate cut diameter and length)*			
2.	Open tires			
3.	El. Pole			
4.	El. supply Distributor			
5.	El. Distributor (receiver)			
6.	Other (specify) ____ _____			
If installation is technically possible, describe needed activities here:				

29. Estimated value of materials and labour needed for the rehabilitation/installation of the external electric system:

_____ AzMan

d) Natural Gas

30. Does the internal or external natural gas system need repair?

1. Yes
2. No, it is in a good condition ***go to question 33***
3. No, external or internal natural gas system should be changed entirely (or newly installed)
4. No, the natural gas system does not exist near the facility ***go to question 33***
5. No, because it exists but is not functioning for years ***go to question 33***

31. What elements of the natural gas system have to be repaired (replaced)? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
Internal natural gas system				
1.	Pipes *(indicate diameter and length)*			
2.	Taps			
3.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				
external natural gas system				
4.	Pipes *(indicate diameter and length)*			
5.	Regulator point			
6.	Meter			
7.	Closing Taps			

8.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				

32. Estimated value of materials and labour needed for the rehabilitation/installation of natural gas internal system[MD1]**:**
_____ AzMan

32.1. Estimated value of materials and labour needed for the rehabilitation/installation of natural gas external system:
_____ AzMan

e) Heating system

33. Does the heating system need repair?

1. Yes
2. No, it is in a good condition ***go to question 36***
3. No, the system should be changed entirely (or newly installed)
4. No, the Heating system does not exist in the facility ***go to question 36***
5. No, because it exists but is not functioning for years due to absence of a fuel ***go to question 36***

34. What elements of the heating system have to be repaired (replaced)? If installation is technically possible, describe needed activities

#	Element	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
Internal system				
1.	Pipes for heating *(indicate diameter and length)*			
2.	Heater *(indicate quantity)*			
3.	Other (specify) _____			
If installation is technically possible, describe needed activities here:				
External system				
4.	Heating Net			

	(indicate length)			
5.	Pipes for heating *(indicate diameter and length)*			
6.	Boiler (*indicate power)*			
7.	Chimney			
8.	El. Pump			
9.	Ventilator			
10.	Boiler's Internal Pipes' Net			
If installation is technically possible, describe needed activities here:				

35. Estimated value of materials and labour needed for the rehabilitation/installation of the internal heating system[MD2]**:**

_____ AzMan

35.1. Estimated value of materials and labour needed for the rehabilitation/installation of the external heating system:

_____ AzMan

Section 4: Road

36. Does the road leading to the facility need repair?

1. Yes
2. No, it is in a good condition ***Go to section 5: equipment***

37. Please, describe the damage

#	Description	What kind of damage(s) can you observe? *(describe in specific)*	What is the reason for the damage?	What kind of repair does the element need? *(Please describe in specific)*
1.	Road cover (Holes)			
2.	Earth Road			
3.	Asphalt			

4.	Drainage			
5.	Other (specify) _____ _____			

38. Estimated value of materials and labour needed for the rehabilitation of the road leading to the facility:

_____ AzMan

Section 5: Equipment

In the table below for each item please indicate their quantities and describe them using the criteria given below

Equipment item	Quantity	Of which: (Criteria for description)		
		1. Of good functioning condition	2. Cannot fulfil its function but is repairable	3. Cannot fulfil its function and impossible to repair
1. Basic set				
1.1 Stethoscope				
1.2 Sphygmomanometer				
1.3 Fetal Stethoscope				
1.4 Reflex hammer				
1.5 Otoscope				
1.6 Ophthalmoscope				
1.7 Adult Weighing Scale				
1.8 Height measurer				
1.9 Infant Weighing Scale				
1.10 Examination lights				
1.11 Light flexible stand-type, mobile				
1.12 Vaginal Specula				
1.13 Midwife kit				
1.14 Vaccine carrier				
1.15 External Meatus syringe				
1.16 Nebulizer Adult				
1.17 Nebulizer Paediatric				
1.18 Peakflow meter				
1.19 Tongue depressor				
1.20 Bactericid lamp				
1.21 Wound dressing kit				
1.22 Suture kit				
1.23 Instrument (sterilisation) box				
1.24 Glucometer				
1.25 Haemoglobinemeter				
1.26 ECG				
1.27 Autoclave				
1.28 Dry sterilization				
1.29 Refrigerator				
1.30 Water distillation apparatus				
2. Complementary set				
2.1 Gastroscope				
2.2 Funnel				
2.3 Stomach suction pump				
2.4 Clysma instrument				
2.5 Metal Catheter				
2.6 Elastic Catheter				
2.7 Splint				
2.8 Eye Pipette				

Equipment item	Quantity	Of which: (Criteria for description)		
		1. Of good functioning condition	2. Cannot fulfil its function but is repairable	3. Cannot fulfil its function and impossible to repair
2.9 Trans/ Perfusion standard				
2.10 Warm water bottle				
2.11 Physician's bag				
2.12 Obstetrician's bag				
2.13 Foetal Ultrasound				
2.14 Portable X Ray				
2.15 Other (specify) _____				
2.16 Other (specify) _____				
3. Laboratory				
3.1 Microscope				
3.2 Centrifuge				
3.3 Laboratory cupboard				
3.4 Lab Kit				
3.5 Rack, Blood Sedimentation				
3.6 Pipette (serological)				
3.7 Strap				
4. Other Material				
4.1 Emergency drugs[1]				
4.2 Vaccines[2]				
4.3 Cold box (vaccines)				
4.4 Refrigerator (vaccines)				
4.5 General waste container				
4.6 Clinical waste container				
4.7 Sharp clinical waste container				
4.8 Waste (non clinical) bin				
4.9 Bucket				
4.10 Cleaning equipment[3]				
4.11 Emergency light				
4.12 Safe				
4.13 Other (specify) _____				
4.14 Other (specify) _____				

[1] Write digit 1 in the empty cell if existed, or 0 if it does not exist there or of a poor condition
[2] Write digit 1 in the empty cell if existed, or 0 if it does not exist there or of a poor condition
[3] Write digit 1 in the empty cell if existed, or 0 if it does not exist there or of a poor condition

Primary Healthcare Facility Assessment Questionnaire

Questionnaire No _____

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon / City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2 Telephone number

_____

3. Facility Type:

1. Feldcher-Midvife Point (FAP)
2. Village Doctor Ambulatory (SVA)
3. Polyclinic in District Managed by Central District Hospital (DPOLY)
4. City (Children and Adults) Polyclinic (CPOLY)
5. Dispensary (DISP)
6. Women Consultation (WCONS)
7. Other (Specify)_____

4. Please provide the size of population in your official catchment area

Adults 4.1_____

Children 4.2_____

Women of age 15-49 4.3_____

Section 1: Health Care Network/ Referral

1. What are the distances from your facility to the nearest facilities listed below in km?
Write "0" if in the same settlement

	Facility	km
1.	Village Site Hospital (SUB)	
2.	Central District Hospital	
3.	Polyclinic in District Managed by Central District Hospital	
4.	Maternity Hospital	
5.	Women's Consultation	
6.	City Hospital	
7.	Pediatric Hospital	
8.	Operating drugstore	
9.	Emergency service (ambulance)	
10.	Baku	

2. Please provide no of referrals by your facility according the below list of conditions and procedures *(for the year 2005)*

	Conditions	Total # of referrals
1.	Respiratory	
2.	Myocardial infarction	
3.	Other Cardiovascular	
4.	Abdominal	
5.	Infectious diseases	
6.	Stroke	
7.	Other Neurological	
8.	Trauma/ injury	
9.	Road accident	
10.	Poisoning	
11.	Burn	
12.	Diabetes Mellitus	
13.	Urogenital	
14.	Pregnancy related	
15.	Psychological/ Mental	
16.	Muskulo-Skeletal	
	Procedures	**Total # of referrals**
17.	Surgery	
18.	CT scanning	
19.	EKG	
20.	X-ray	
21.	Biochemistry	
22.	Bacteriology	
23.	Serology	
24.	HIV testing	

Section 2: Transportation/communication/computer equipment/medical waste

1. Does your facility provide mobile/outreach or emergency services? (two answers can be *circled)*

1. Mobile/outreach services
2. Emergency service
3. None of them is available

2. What transportation means does your facility own?

	Total quantity	**From them**			Main purpose of use: **1**=administration **2**= Emergency service **3**=Mobile/outreach service **4**=material transportation	**If used for any service, is it properly equipped?** 1=Yes 2=No
		In working condition	Missing parts	Dilapidated		
1. 2 WD Car						
2. 4 WD Car						
3. Ambulance vehicle						
4. Other (specify) _____						

3. Now, please provide information about means of communication of this facility.

(*Please, circle existing one in a column 1)*

	How many means of communication listed below exist in this facility? (quantity)	From them (if having):		
		In working condition	Not functioning but repairable	Dilapidated
1. Telephone landline				
2. Radio				
3. Facility mobile telephone				
4. Private mobile telephone				
6. Internet/email				
7. Fax				
8. Other (specify)_____				

4. What computer equipment does your facility own?

	Total quantity	Production year				From them		
		No1	No2	No3	No4	In working condition	Not functioning but repairable	Dilapidated
1. Computer								
2. Printer								
3. UPS								
4. Copier								
5. Other (Specify)_____								

5. How is the medical waste of your facility treated? *(Encircle only one answer)*

1. By the garbage collector
2. By the incinerator
3. We burn it at designated place
4. We drop it to the designated place
5. We bury it
6. Other (Specify) _____

6. How frequently is your medical waste treated? *(Encircle only one answer)*

1. Every day
2. Every other day
3. Twice per week
4. Once per week
5. Twice per month
6. Once per month
7. The same day when we have waste
8. Other (specify) _____

Section 3: Personnel

Please, give us information about personnel distribution by gender, age, specialization, years of experience in specialization, workload, and license presence.

	Specialisation	Staffing norm as approved by MOH	Total actual number	Age groups					Gender		Years of experience in specialization				Received clinical training (How many years ago received)		
				35 and less	36-45	46-55	56-65	66 and more	Male	Female	less then 1 year	1-5	6-10	11 and more	less then 1 year	2-5 years	6 and more years
1	GP																
2	Paediatrician																
3	Gynaecologist/ Obstetrician																
4	General Therapist																
5	Infectionist/ epidemiologist																
6	Cardiologist																
7	Endocrinologist																
8	Oncologist																
9	General Surgeon																
10	Traumatologist/ orthopaedist																
11	Neurologist																
12	Dermatologist/STD																
13	ENT																
14	Ophthalmologist																
15	Lab Physician																
16	Radiologist																
17	Ultra-sound specialist (separate person)																
18	Pharmacist																

	Specialisation	Staffing norm as approved by MOH	Total actual number	Age groups					Gender		Years of experience in specialization				Received clinical training (How many years ago received)		
				35 and less	36-45	46-55	56-65	66 and more	Male	Female	less then 1 year	1-5	6-10	11 and more	less then 1 year	2-5 years	6 and more years
19	Dentist																
20	Midwife																
21	Nurse																
22	Equipment Technician																
23	Lab technician																
24	Administration																
25	Finance																
26	Person for building maintenance																
27	Cleaning staff																
28	Guard																
29	Driver																
30	Other (Specify)																
31	Other (Specify)																
32	Other (Specify)																
33	Other (Specify)																
34	Total																

35. How many physicians in your facility work in more than one specialisation?

NO _____

36. Please, indicate in the table below the numbers of persons working on management positions only, not as physicians/specialists.

Position	**No**
Director	
Head of division/department	
Deputies	
Other (specify) _____	

37. How does your management structure look like? *(Draw a chart)*

Section 4: Utilization of services within the past year (2005)

	#	CIRCLE	CIRCLE
1. Total number of patient visits		Not relevant	Data not available
2. Total number of home visits		Not relevant	Data not available
3. Total number of referrals from your facility to any other facility		Not relevant	Data not available
3. Total number of referrals from your facility to Baku facilities		Not relevant	Data not available
4. Total number of referrals from other facilities to your facility		Not relevant	Data not available
6. Total number of laboratory tests		Not relevant	Data not available
7. Total number of radiological examinations		Not relevant	Data not available
8. Total number of minor surgical/orthopaedic interventions		Not relevant	Data not available

Section 5: Service provision indicators for 2005

	#	CIRCLE	CIRCLE
1. # of children vaccinated against measles from 1to 2 years		Not relevant	Data not available
2. # of childrens under 1 given DPT 3 vaccine		Not relevant	Data not available
3. # of children under 1 given Hep B3 vaccine		Not relevant	Data not available
4. Total # of children under 1 in the facility catchment area (according to annual immunization plan)		Not relevant	Data not available
5. . Total # of children under 2 in the facility catchment area (according to annual immunization plan)		Not relevant	Data not available

Section 6: Patient outcome indicators for 2005

	#	CIRCLE	CIRCLE
1. # of patients with asthma in the catchment area		Not relevant	Data not available
2. # patients who developed status asthmaticus in 2005		Not relevant	Data not available

Primary Healthcare Facility Provider Survey Questionnaire

Questionnaire No [ ]

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon/ City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2 Telephone Number:

_____

3. Facility Type:

1. Feldcher-Midvife Point (FAP)
2. Village Doctor Ambulatory (SVA)
3. Polyclinic in District Managed by Central District Hospital (DPOLY)
4. City (Children and Adults) Polyclinic (CPOLY)
5. Dispensary (DISP)
6. Women Consultation (WCONS)
7. Other (Specify)_____

SECTION 1: Personal Characteristics

1	What is your age in years?	_____ **years**
2	What is your Gender?	☐ **Male** ☐ **Female**
3	For How Long have you been working in this facility?	_____ **years**
4	For How Long have you been practicing medicine?	_____ **years**

SECTION 2: Practice Characteristics

1. Which of the following best describes your principal practice arrangement (Circle one):

1 Full-time salaried position:

2 Part-time salaried position:

↪ What amount of time you work at this facility .....

2.1 25-50%

2.2 51-75%

2.3 more then 75%

3. Other[1] (specify)

2. Which of the following best describes your principal specialty area (Check one):

1 Pediatrician

2 Internist

3 Obstetrician/Gynecologist

4 Dentist

5 Other specialist (specify)_____
_____
_____
__

3. In your practice, do you focus or concentrate on any of the following areas? Is the focus a result of formal training, such as a fellowship, or a result of your practice experience? *(Please put mark X in the box were applicable. If there are several areas that are applicable check all of them. The boxes that are not applicable leave BLANK)*

	PRACTICE FOCUS	Formal Training (Fellowship)	Practice Experience
1	General Practice (treating children as well as adults)		
2	Internist (therapevt) only for adults		
3	General Pediatrician taking care of only children		
4	Obstetrician and Gynecologist taking care of women problems		
5	Dental care		
6	Cardiology		
7	Neurology		
8	Surgery		
9	Allergology		
10	Traumatologist-Ortho		
11	Urologist		
12	Ear Nose Throat		

[1] e.g. works on more than one full-time salaried position)

13	Ophthalmologist		
14	Endocrinologist		
15	Infectious Disease		
16	Other, **please specify** _____		

4. Practice Distribution of Cases by Patient Age during the last year (Enter 0 if none, If exact figures for the last year are not available, ask only for what is the distribution in general)

PATIENT AGE DISTRIBUTION	PERCENT CASES (last year)	PERCENT CASES (In general)
Pediatric - (<=12 yrs)	%	%
Pediatric (Teen) - (13-18 yrs)	%	%
Adult - (19-64)	%	%
Geriatric - >=65 yrs	%	%
Total	100%	100%

5. In the last year, what percentage of your patients were referred to you by:

a. other *Primary Health Care Providers* (FORMAL AND INFORMAL REFERRAL)..... [ ] %

b. other physicians ..... [ ] %

c. Self-referred patients …….. [ ] %

6. In the last year, what percentage of your patients were coming to your clinic from:

Your catchment area [ ] %

Beyond your catchment area [ ] %

7. In the last year, what percentage of patients you visited at home were living in:

Your catchment area [ ] %

Beyond your catchment area [ ] %

8. Please provide no of referrals by you according the below list of conditions and procedures *(for the year 2005)*

	Conditions	Total # of referrals
1.	Respiratory	
2.	Myocardial infarction	
3.	Other Cardiovascular	
4.	Abdominal	
5.	Infectious diseases	
6.	Stroke	
7.	Other Neurological	
8.	Trauma/ injury	
9.	Road accident	
10.	Poisoning	

11.	Burn	
12.	Diabetes Mellitus	
13.	Urogenital	
14.	Pregnancy related	
15.	Psychological/ Mental	
16.	Muskulo-Skeletal	
	Procedures	**Total # of referrals**
17.	Surgery	
18.	CT scanning	
19.	Angiography	
20.	EKG	
21.	X-ray	
22.	Biochemistry	
23.	Bacteriology	
24.	Serology	
25.	HIV testing	

9. In the last year, what was the number of patients

You have refered for hospitalization [ ]

Out of these, proportion of patients with discharge letter from the hospital inserted into medical record [ ] %

SECTION 3: Practice Activity

1. During a typical WEEK, estimate the number of: (Enter one number per line)

1 new patient visits to your office ..... /week
2 continuing patients with new problems coming to your office ..... /week
3 follow-up patient visits to your office ..... /week
4 new patient visits at their home ..... /week
5 continuing patients with new problems visiting at their home ..... /week
6 follow-up patient visits at their home..... /week
7 emergency patient visits in the office..... /week

2. During a typical WEEK, estimate the number of: (Enter one number per line)

1 hours that you spent on filling out documentation not related to patient visits (e.g. monthly statistical reports)..... hrs/week
2 hours that you teach residents or fellows .... hrs/week
3 hours that you teach other medical personnel ..... hrs/week

3. During a typical WEEK, estimate the weekly workload of: (Enter one number per line)

1 hours that you spent on home visits ..... hrs/week
2 hours that you spent in facility .... hrs/week

4. During a typical MONTH, estimate the number of: (Enter one number per line)

1 patients you see in your office..... .... _____ /month

2 patients you see in at their home..... .... _____ /month

5. For what percentage of your new patient visits in 2005, YOU were the first or initial contact physician? (Circle one)

1 1-10 percent
2 11-25 percent
3 greater than 25 percent
4 I accept patients only upon referral

6. During the calendar year 2005, how many: (Enter one number per line, if not applicable leave empty or put 0)

1	days per week did you practice?	days/week
2	Hours/week did you practice?	hours/weeks
3	months did you practice during a year?	months
4	Weeks vacation did you take?	weeks
5	Average hours/month you spent on your professional development	hours/month
6	days did you spend away from your practice attending training activities or professional meetings?	Days/year
7	Hours per week on average did you spent visiting supervisor (if you work in ambulatory then going to Rayonal center to collect vaccines, submit reports, collect drugs etc. If you work in policlinic going to Rayonal/city health department etc.)	hrs/week
8	Number of medically or non-medically justified absence for seven days or less in a row (short-term absentism)	
9	Number of medically or non-medically justified absence 8-29 days in a row	
10	Number of medically or non-medically justified absence for 30 days or more in a row (long-term absentism)	
11	Number of weeks worked over 150% regular working time according to national legislation	weeks

7. How long does a new patient usually have to wait for a routine initial office appointment?

1 _____ Minutes

2 _____ Hours

SECTION 4: PHC TASK PROFILE – CORE CLINICAL ACTIVITIES

Do you perform the following core clinical activities for your catchment population yourself (or your facility personnel including specialists)? (put one number on each line)

	(almost) always	usually	ocasiuonally	seldom/ never
	1	2	3	4
4. 1. Excision of warts				
4. 2. Myringotomy of eardrum				
4. 3. Removal of sebaceous cyst from scalp				
4. 4. Fundoscopy				
4. 5. Maxillary sinus puncture				
4. 6. Resection of ingrowing toenail				
4. 7. Joint injection				
4. 8. Removal of rusty spot from cornea				
4. 9. Strapping an ankle				
4. 10. Setting up intravenous infusion				
4. 11. Wound suturing				

SECTION 5: PHC TASK PROFILE – FIRST CONTACT

To what extent do patients refer to you as first contact for the following health problems? (put one number on each line)

	(almost) always	usually	occasionally	seldom/ never
	1	2	3	4
CHILDREN'S PROBLEMS				
5. 1. child with severe cough				
5. 2. child with rash				

	(almost) always	usually	occasionally	seldom/ never
	1	2	3	4
5. 3. child (7) with enuresis				
5. 4. child (8) with hearing problem				
WOMEN'S PROBLEMS				
5. 5. women (50), lump in breast				
5. 6. women (20), confirming pregnancy				
5. 7. women (35), irregular menstruation				
5. 8. women (18), oral contraception				
ACUTE PROBLEMS				
5. 9. man (45), chest pain				
5. 10. man (24), stomach pain				
5. 11. man (29), lower back pain				
5. 12. women (60), paralysis/paresis				
5. 13. man (29), first convulsion				
5. 14. man (50), burnt hand				
5. 15. man (35), sprained ankle				
5. 16. man (50) with toothache				
PROBLEMS OF THE ELDERLY				
5. 17. man (70), joint pain				
5. 18. women (75), memory problems				
5. 19. women (60), polyuria				
5. 20. women (60), deteriorating vision				
PSYCHOSOCIAL PROBLEMS				

	(almost) always	usually	occasionally	seldom/ never
	1	2	3	4
5. 21. man (45), anxiety				
5. 22. women (50), work problems				
5. 23. abused child (13)				
5. 24. man (52), alcohol problems				
5. 25. man, suicidal inclinations				
5. 26. couple relationship problems				
5. 27. man (32), sexual problems				

SECTION 6: PHC TASK PROFILE – PREVENTIVE MEDICINE

6.1 When do you or your personnel measure blood pressure (select only one answer)

In accordance with clinical symptoms 1

Upon patient request 2

In all patients regardless the purpose of the visit 3

In adults invited for this specific purpose 4

6.2 When do you or your personnel measure blood cholesterol? (you can select more than one answer)

In accordance with clinical symptoms 1

Upon patient request 2

In all patients regardless the purpose of the visit 3

In adults invited for this specific purpose 4

6.3 When do you or your personnel take pap smear for cervical cancer screening? (you can select more than one answer)

In accordance with clinical symptoms 1

Upon patient request 2

In women from high risk group or invited for this specific purpose 3

6.4 When do you or your personnel conduct manual examination to detect breast cancer? (you can select more than one answer)

In accordance with clinical symptoms 1

Upon patient request 2

In women from high risk group or invited for this specific purpose 3

6.5 To what extent are you involved in health education in regard with smoking, health diet and alcohol consumption ? (select only one answer)

Only in case of patient regular contacts 1

Only within special groups or programs 2

6.6 To what extent are in involved in the following activities? (put one number on each line)

	(almost) always	**usually**	**ocasiuonally**	**seldom/ never**
	1	**2**	**3**	**4**
6.6.1 Birth attendance				
6.6.2 Antenatal care				
6.6.3 Child immunization program				
6.6.4 Children health till 4 years				
6.6.5 Family planning/ contraception				
6.6.6 Homeopathy				

SECTION 7: PHC TASK PROFILE – MANAGEMENT AND FOLLOW UP OF DISEASES

To what extent are you involved in the management and follow up of the following diseases and conditions? (put one number on each line)

	(almost) always	**usually**	**ocasiuonally**	**seldom/ never**
	1	**2**	**3**	**4**
7. 1. Hyperthyroidism				
7. 2. Chronic bronchitis				
7. 3. Hordeolum				
7. 4. Peptic ulcer				
7. 5. Vertebral disk prolapsus				
7. 6. Hemorrhagic stroke				
7. 7. Chronic heart failure				

7. 8. Pneumonia				
7. 9. Peritonsillar abscess				
7. 10. Ulcerative colitis				
7. 11. Salpingitis				
7. 12. Concussion				
7. 13. Parkinson disease				
7. 14. Diabetes mellitus, type II (without complications)				
7. 15. Rheumatoid artritis				
7. 16. Depression				
7. 17. Myocardial infarction				
7. 18. Hypertension				

SECTION 8. Provider Satisfaction

To what extent do you agree or disagree with the following statements?
(Circle one number on each line)

		Strongly Agree	Some-what Agree	Neither Agree nor Disagree	Some-what Disagree	Strongly Disagree
1	I am satisfied with organization of work at my facility	1	2	3	4	5
2	I feel,some of the tasks I am involved in my daily work do not make any sense	1	2	3	4	5
3	My job is still interesting for me as was before	1	2	3	4	5
4	My work is overwhelmed with extra administrative tasks	1	2	3	4	5
5	For the same salary/income I would prefer to have nonmedical job	1	2	3	4	5
6	I do really get satisfaction from my work	1	2	3	4	5
7	My work is characterized with good balance between my efforts and rewards I get	1	2	3	4	5
8	My work is related to many unnecessary efforts from my sides	1	2	3	4	5

Primary Healthcare Facility Guidelines/ Record Review Questionnaire

Questionnaire No [ ]

Date: _____

Interviewer: _____

Respondent's name: _____

Respondent's position _____

1. Rayon/ City _____ **1.a. Village** _____

2. Facility Name

_____

2.1. Facility Address:

_____

2.2 Telephone Number:

_____

3. Facility Type:

1. Feldcher-Midvife Point (FAP)
2. Village Doctor Ambulatory (SVA)
3. Polyclinic in District Managed by Central District Hospital (DPOLY)
4. City (Children and Adults) Polyclinic (CPOLY)
5. Dispensary (DISP)
6. Women Consultation (WCONS)
7. Other (Specify)_____

SECTION 1: Immunization

1. Does your facility offer immunization service to the population?

Yes.....1

No .....2 **(go to sec 2)**

2. Is there adequate vaccine stock in your facility?

Yes.....1

No 2

Other (specify_____).....3

SECTION 2: Clinical Practice Guidelines

Are the following guidelines available and used in your facility?

	Availability *(to be verified by observation)*		**Use**	
GUIDELINES	**yes**	**no**	**yes**	**No**
1. Ischemic Heart Disease prevention and treatment				
2. Hypertension prevention and treatment				
3. Diabetes mellitus case management				
4. Patient referral to other facilities/ upper level				
STANDARD PROTOCOLS				
5. Ischemic Heart Disease prevention and treatment				
6. Hypertension prevention and treatment				
7. Diabetes mellitus case management				
8. Patient referral to other facilities/ upper level				

SECTION 3: Patient care characteristics

Total number of case records in a facility _____

Conditions		#	encircle
DIABETES MELLITUS (DM)			Not relevant
1.	Total number of patients with DM registered at the facility (who have case records)		
2.	Of which, number of patients with DM who visited facility within the past year		
3.	Please select randomly case records from the past year cases (item 3.2) and indicate number of randomly selected case records in the next cell **(select all if item 3.2 =< 10, if >10 select 10 randomly)**[1]		
4.	Of which, number of patients with fundal examination at least once in the past year (from those case records, that you have randomly selected!)		
5.	Number of patients with their feet examined at least once in the past year (from those case records that you have randomly selected!)		
ISCHEMIC HEART DISEASE (IHD)			Not relevant
6.	Total number of patients with IHD registered at the facility (who have case records)		
7.	Of which, number of randomly selected case records **(select all if item 3.6 =< 10, if >10 select 10 randomly)** [1]		
8.	Number of patients with their smoking status recorded since their disease has been diagnosed (from those case records that you have selected randomly!)		
ACUTE MYOCARDIAL INFARCTION (AMI)			Not relevant
9.	Number of patients who ever had AMI registered at the facility (who have case records)		
10.	Of which, number of randomly selected case records **(select all if item 3.9 =< 10, if >10 select 10 randomly)** [1]		
11.	Number of patients with lifestyle counseling documented in patient record (from those case records that you have selected randomly!)		
PNEUMONIA			Not relevant
12.	Number of children under five who ever had pneumonia registered at the facility (who have case records)		
13.	Of which, number of randomly selected case records **(select all if item 3.12=< 10, if >10 select 10**		

[1] For FAP and SVA number of randomly selected case records is 5

randomly) [1]		
14. Number of patients prescribed antibiotics (from those case records that you have selected randomly)		
DIARRHEA		Not relevant
15. Number of children under five who ever had diarrhea registered at the facility (who have case records)		
16. Of which, number of randomly selected case records **(select all if item 3.15 =< 10, if >10 select 10 randomly)** [1]		
17. Number of patients prescribed Vitamin A (from those case records that you have selected randomly)		
18. Number of patients prescribed oral rehidration therapy (from those case records that you have selected randomly)		

SECTION 4: Management function

Are the following management practices put in place in your facility?

	RESPONSE [2]		
	Yes	**No**	**Comment (describe in specific)**
PHYSICAL ASSET MANAGMENT			
1. A policy and procedures manual for stock management, inventory, and fixed assets			
2. Equipment inventory/ register (paper based)			
3. Pharmaceutical stock inventory			
FINANCIAL Management			
4. Policies and procedures manual for budgeting			
5. A written chart of accounts that accurately reflects categories of income, expenditures, assets and liabilities			
6. A policy and procedures manual for cash control, banking, and cash flow			
HUMAN RESOURCE MANAGEMENT (HRM)			
7. HR data (paper based)			

[2] "Yes" should be based on the actual evidence

8.	Personnel files			
9.	Policy manual			
10.	Individual job descriptions			
11.	A formal performance evaluation system			

Primary Health Care Strengthening Project

Azerbaijan

John R. Baird, M.D.

Darleen Bartz, Ph.D., APRN

April 2006

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EXECTUTIVE SUMMARY

Family Medicine (FM) is the basis for the reform of primary health care in Azerbaijan. The International Medical Corps (IMC) is working with the government of Azerbaijan in the development of critical reforms in health policy and health financing at the national level, while simultaneously testing key intervention at the level of the individual facilities and communities in selected districts that will serve as pilot demonstrations sites. The major goal of this project was to support further development of Family Medicine is Azerbaijan. Urgent tasks were identified to include: 1) development of an agreed-upon "profile" or standard scope of service for the "family physician" that is appropriate to the existing conditions in Azerbaijan; 2) development of agreed-upon scopes of service for essential allied personnel; in particular, nurses; 3) strengthening of the existing post-Medical graduate (in-service) education at the Institute for Continuing Medical Education; this program retrains already practicing physicians, chiefly pediatricians and internists (terapevty), to become "family physicians;" and 4) development of a formal certification process for determining that the "family physicians" have requisite skills to deliver the standard scope of service. The purpose of this consultancy is to assist the Ministry of Health to fulfill these tasks.

Family medicine in Azerbaijan is in the early stages of development. Minimal activity has taken place in the area of nursing reform. There is strong support in the Post-Graduate Medical Institute to offer a Family Medicine re-training program. The Family Medicine Department at Post-Graduate Medical Institute has been officially recognized. The head of the Family Medicine Department and her two faculty members are enthusiastic about expanding Family Medicine training.

General recommendations for the scope of services for Family Medicine Doctors and Nurses are made in this report allowing for flexibility in a variety of settings and allowing for gradual expansion of the scope based on needs identified in the setting and the knowledge and skills of the doctors and nurses. A draft topical outline of recommended re-training curriculum modules is also included in this report. This draft is intended as a starting point for discussion. Some key points of knowledge to be learned and skills to be gained have been outlined under a series of modules. There is a need for trainers who are adequately trained in the areas of the curriculum and adult learning techniques. It is recommended that retraining of Family Medicine doctors and nurses be completed in a doctor nurse partnership approach. Trainers need to be adequately trained in the area of the curriculum and adult learning techniques. Pediatricians, Internists, Obstetricians and Gynecologist as well as their nurses should be given first consideration for participation in the retraining program. Initial training of rural doctors and nurses would be of benefit Azerbaijan. Potential trainers need exposure to training in well established Family Medicine programs in other countries. It is important that doctors and nurses completing the Family Medicine retraining program receive certification demonstrating their successful completion of the program.

All of the recommendation in this report are preliminary and require refinement from a local working group. Outside consultation may be of assistance for the assisting this working group.

INTRODUCTION

Recent reports identify poor health outcomes in Azerbaijan which are in part due to a healthcare system that is ineffective in delivering affordable quality care to all. Demographic information indicates that there is a steady decline in the population growth rate and declining fertility and that the life expectancy shortened by six years between 1990 and 2002. The primary reasons identified for this is the increase in infant, child, and maternal mortality and premature adult mortality. While there appears to be sufficient health care providers in the country (3.6 physicians and 7.5 nurses per 1,000 population), the health care needs are currently not being met. The report of the World Bank identifies the following causes for the high mortality rates in Azerbaijan:

- Adults – Circulatory diseases, accidents, injuries, and poisoning, infectious diseases such as TB and HIV.
- Women – High maternal mortality rate due to post partum hemorrhage, post-abortion complications, and anemia.
- Infant and children – Main causes include respiratory diseases and dehydration due to diarrhea (Document of the World Bank, Report No. 31469-AZ, 2005).

Family Medicine has been identified as an approach which can be implemented to begin to address these health care concerns in Azerbaijan. The Ministry of Health has recognized the need for Family Medicine and has created a Department of Family Medicine within the University of Medicine. There is a need to move forward with development of Family Medicine to address the health concerns that have been identified and to improve the delivery of affordable quality care to by family medicine doctors and nurses.

The purpose of this consultancy was to provide information that would help promote Family Medicine in Azerbaijan by providing:

1. Draft scopes of service for a family medicine doctor and nurse.
2. Detailed outlines of post-graduate (in-service) retraining programs for family medicine doctor and nurses.
3. Preliminary recommendations for developing a retraining program for doctors and nurses.
4. Preliminary recommendations on strengthening the Department of Family Medicine in the Institute of Continuing Medical Education in the next 3-5 years
5. Preliminary recommendations regarding licensure and certification.

INFORMATION COLLECTION

Preparation

Preparation work completed by the consultants to accomplish the above identified purposes included review of all background materials sent by IMC prior to the onsite consultation including additional follow-up information requested by the consultants; a literature search related to primary health care and family medicine in similar countries (see Resources List); a review of Primary Health Care curriculums from other projects including American Family Medicine Residency curriculums, American Family Nursing curriculums, Tajikistan and

Kyrgyzstan curriculum outlines, Turkmenistan Retraining curriculum, and the Armenian Unified Family Medicine Curriculum; the consultants meeting prior to the onsite visit to discuss strategies, gathering information related to education, licensure, certification and accreditation requirements in the United States; and communicating and meeting with family medicine and nurse education staff members from the University of North Dakota School of Medicine, the University of North Dakota College of Nursing, Jamestown College Nursing Department, United Tribes Technical Institute of Nursing, the American Academy of Family Physicians, former partners of the AIHA Project from Portland Oregon, and other International Family Medicine experts.

Onsite Assessment

Onsite visits were completed by the Family Medicine consultant and Family Nurse consultant to Azerbaijan (see Appendix I for Curriculum Vitaes). The Family Medicine consultant, John R. Baird, M.D. made an onsite visit to Azerbaijan from April 4 to April 16, 2006. The Family Nurse Consultant made an onsite visit to Azerbaijan from April 10 to April 16, 2006. During these timeframes, the consultants had an opportunity to complete an assessment of the current status of Family Medicine and Family Nursing in Azerbaijan through meeting with several key stakeholders (see Appendix II) and observation in polyclinics and a private clinic. The assessment included obtaining information from key stakeholders regarding what they perceived as issues as well as possible solutions related to implementation of Family Medicine and Family Nursing in Azerbaijan.

Themes that emerged from the meetings with the key stakeholders included the following:

- There are currently more doctors and nurses available then necessary to meet the health care needs of the country's population.
- Doctors and nurse work limited hours and do not receive adequate payment.
- Most doctors are narrow specialists and most are located in urban areas.
- There is a shortage of physicians in the rural areas and much of the health care is provided by nurses and feldschers without physician supervision.
- Doctors and nurses make home visits as well as see patients in the clinic.
- Many nurses have limited knowledge and clinical skills, resulting in a limited scope of nursing practice. This may be due, in part, to the large number of doctors in the workforce and the limited amount of work available.
- Minimal skills are learned by doctors and nurses during their education.
- There is limited equipment is available in the medical school for doctor and nurse students to use during their education to learn to perform clinical skills.
- Doctors and nurses are currently taught by doctors. There is a need for nurses to teach nurses.
- Every five years, doctors and nurses are required to undergo a retraining program that last for a month and a half to two months.
- A new specialty may be selected when attending a retraining program.
- There a need for family medicine doctors and nurses who have received adequate training to meet the health care needs of individuals and families.

- Family Medicine retraining is needed which is patient and family centered, evidence-based, has a strong focus on learning clinical skills, and the majority of the time is spent performing clinical skills in a practice setting under the direction of a trained family medicine doctor or nurse.
- Retraining of nurses should begin with basic nursing skills and physical assessment
- Family medicine clinics should provide services to both adult and pediatric patients.
- Family medicine doctors and nurses should work as partners to provide and coordinate the care of patients and families regardless of age or illness.

While onsite, the consultants also provided a presentation to all who attended related to medical and nursing education, licensure, and practice in the United States (see Appendix III for outline of presentation). The onsite visit concluded with the submission of the Preliminary Report on April 16, 2006.

FINDINGS

The consultation included analysis of the information collected through the review of literature, the onsite visit to Azerbaijan including the discussions with stakeholders, multiple discussions between the consultants, and additional research. The following findings were identified and used in developing recommendations.

1. Scope of services for a Family Medicine Doctor and Nurse.

Family medicine in Azerbaijan is in the early stages of development. Minimal activity has taken place in the area of nursing reform. Nurses' scope of practice should be expanded in many areas with an emphasis on clinical skill development. There is a keen interest on the part of the stakeholders in the development of Family Medicine Reform in Azerbaijan. Outside support to assist in and support the development of Family Medicine is available at this time. There are many models for comparison from other countries, including the Newly Independent States (NIS).

2. Post Graduate re-training curriculum for currently practicing physician internists and pediatricians and nurses.

A re-training program currently exists for Doctors and Nurses at the Post-Graduate Institute. This re-training is not adequate in length and could benefit from a more systematic approach, including more clinical exposure. There is strong support in the Post-Graduate Medical Institute to introduce a Family Medicine re-training program.

3. Family Medicine retraining program.

There is currently a retraining program in the Post-Graduate Medical Institute that is based on the AIHA partnership. AIHA is currently funding participants from Ganja for this retraining program. The National Coordinator for Family Medicine/Primary Health Care has support to develop and implement retraining in family Medicine at the Postgraduate Institute.

There is a shortage of well trained and equipped general practice physicians and nurses in the rural areas.

4. Department of Family Medicine in the Institute of Continuing Medical Education.

Family Medicine Department at Post-Graduate Medical Institute has been officially recognized. The head of the Family Medicine Department and her two faculty members are enthusiastic about expanding Family Medicine training. Currently, there is limited knowledge of curriculum directed towards Family Medicine principles and topics and adult learning methods. There are no adequately trained Family Medicine trainers. Specialist who currently support the Family Medicine Department and teach in the retraining program are unsure of a curriculum and are unfamiliar with Family Medicine principals.

5. Doctor and Nurse Certification.

The Minister of Health had appointed individuals to actively pursue licensure and certification.

RECOMMENDATIONS

The recommendations from the consultation were provided consistent with the findings and conclusions and requested deliverables identified in the scope of work. The recommendations focused on (1) development of draft scopes of service for Family Medicine Doctors and Family Nurses; (2) development of initial outlines of post-graduate (in-service) re-training curriculum for currently practicing physician internists and pediatricians, and nursing to perform the draft scopes of services for Family Medicine Doctor and Nurse; (3) preliminary recommendations for developing and implementing retraining improvements for physicians (that would permit an initial cycle of the new program to begin in September 2006) and developing a Nurse re-training program; (4) Preliminary recommendations on strengthening the department of family medicine in the Institute of Continuing Medical Education, with an eye toward alternative scenarios of family medicine development in the next 3-5 years; and (5) preliminary recommendations for Family Medicine Doctor and Nurse Certification.

1. Draft Scope of Services for Family Medicine (General Practice/Primary Care) Doctors and Family Nurses

Primary Health Care (PHC) as discussed in the Declaration of Alma-Ata (1978) is the first level of contact individuals, the family, and communities have with the country's health system bringing health care as close as possible to where people live and work. PHC addresses the main health problems in the community, providing promotive, preventive, and curative and rehabilitative services accordingly. PHC should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all. PHC can be provided by general pediatricians, general internist, and obstetrician/gynecologists, as well as family physicians and nurses. The terms Family Medicine

and General Practice are used interchangeably with one term or the other being used more predominantly in certain countries.

Family Medicine is the specialty practice area, devoted to PHC, which provides accessible, comprehensive, and continuing health maintenance and coordinated medical care to the family and the individual, irrespective of age, sex or type of health problem. Family Medicine doctors and nurses act as the patient's first contact within the health care system and the patient's or family's advocate in all health related issues when needed (Unified Family Medicine Curriculum, 2003). Patients can encounter challenges in a health care system including "fragmentation of services, lack of a personal relationship with a physician, escalating costs, insufficient coordination of care, difficulty knowing which physician to contact, having to consult many physicians for common problems, and inadequate access to care especially in rural areas" (Boelen, Haq, Hunt, Rivo, and Shahady, 2002, p. 58). Well trained Family Medicine Doctors and Nurses greatly minimize these challenges and respond to the community and patient's needs by focusing their practice in different ways. Family Medicine Doctors and Nurses "must possess the skills, knowledge and clinical judgment to deal with a wide range of problems in the family practice setting…This requires special expertise in managing problems that are frequently encountered in the community, acknowledgement of skill limitations, and a willingness to refer patients when indicated" (Boelen, Haq, Hunt, Rivo, and Shahady, 2002, p. 53). Family Medicine Nurses provide holistic nursing care to patients, help them to understand and carry out the doctor's prescribed treatment, as well as assist the physician in taking their initial assessment of the patient, and teaching preventive health care (Family Medicine in Kyrgyzstan, p. 10).

Of note, the World Health Organization (1996) presented a specific functional description of nursing. This description is consistent with the concept of Family Medicine and should also be considered related to the scope of practice for a Family Medicine nurse. The functional definition for nursing is as follows:

> Nursing helps individuals, families and groups to determine and achieve their physical, metal and social potential, and to do so within the challenging context of the environment in which they live and work. The nurse requires competence to develop and perform functions that promote and maintain health as well as prevent ill-health. Nursing also includes the planning and giving of care during illness and rehabilitation, and encompasses the physical, mental, and social aspects of live as they affect health, illness, disability and dying.
>
> Nursing promotes the active involvement of the individual and his or her family, friends, social group and community, as appropriate, in all aspects of health care, thus encouraging self-reliance and self-determination while promoting a healthy environment.
>
> Nursing is both an art and science. It requires the understanding and application of specific knowledge and skills, and it draws on knowledge and techniques derived from the humanities and the physical, social, medical, and biological science. (p. 4)

Family Medicine Characteristics. The characteristics of Family Medicine are that it:

a) Is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.
b) Makes efficient use of health care resources through coordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialties taking an advocacy role for the patient when needed.
c) Develops a person-centered approach, orientated to the individual, his/her family, and their community.
d) Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
e) Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
f) Has a specific decision making process determined by the prevalence and incidence of illness in the community.
g) Manages simultaneously both acute and chronic health problems of individual patients.
h) Manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
i) Promotes health and well being both by appropriate and effective intervention.
j) Has a specific responsibility for the health of the community.
k) Deals with health problems in their physical, psychological, social, cultural and existential dimensions. (The European Definition of General Practice/Family Medicine, 2002)

Family Medicine Scope of Services. A scope of practice statement describes the who, what, where, why, when, why, and how of medical and of medical and nursing practice. The total scope of practice is dependent upon education, experience, role and the population served. The scope of Family Medicine services can vary significantly between areas of a country. The services provided by Family Medicine doctors and nurses "depend on the local prevalence of diseases and health problems, the availability of resources, the extent of their training and experience, the organization and funding of health care services, and the roles, responsibilities, and availability of other health care professionals" (Boelen, Haq, Hunt, Rivo, & Shahady, 2002, p. 51). The scope of practice for Family Medicine doctors and nurses must be dynamic to respond to the changing health needs and demands of the health care system. The scope of practice of doctors and nurses is influenced by advances in technology, transfer of tasks from doctors to nurses, implementation of Family Medicine (PHC), and shortage of doctors in rural areas.

The scope of practice of the Family Medicine nurse will be determined dependent upon the scope of practice of the Family Medicine doctor they are partnered with and their clinical skill level. Currently, many of the tasks that could be completed by nursing or nursing could assist the doctor with are completed by the doctor. There needs to be a willingness on the part of the Family Medicine doctor to work as a partner with the nurse and allow the nurse to function in a more expanded scope of practice. The partnership between the Family Medicine doctor and

nurse will result in quality care for their patient that is provided in an efficient, effective, and cost-effective manner.

While the focuses of these recommendations are on the nurse in a global sense, recognition needs to be given to the possibility of various levels of nursing that exist. There are many nurses that are trained in specialty areas. There may be a benefit to continue the training of nurses in specialty areas beyond their basic nursing education to work with the Narrow Specialists. Their scope of practice would be different from the Family Medicine nurse – which would is a specific, broader specialty area. In addition, feldschers provide services to patients in many rural areas and are often the only provider available. The scope of practice of the feldscher is greater than that of the nurse and should be recognized as such. There may be a benefit in feldschers also participating in a Family Medicine training program.

The scope of services that Family Medicine doctors and nurses should provide includes:

1. Provision of services as first point of medical care for any family or individual regardless of age or gender;
2. Health promotion and disease prevention interventions such as health screenings, immunizations, and behavior change counseling;
3. Diagnosis and management of the most common acute and chronic health problems, both physical and mental, utilizing a biopsychosocial model;
4. Recognition and stabilization of emergency conditions;
5. Recognition of conditions that should be referred to narrow specialists when the patient is more appropriately and better served by the specialist while maintaining the overall coordination of care;
6. Effective and compassionate communication with patients and families that will build trusting relationships to facilitate management and delivery of care;
7. Understanding and intervention during predictable points in the life-cycle of individuals and families including pregnancy, childbirth, newborn child, childhood, adolescence, life-threatening illnesses, loss and grief, and end-of-life care;
8. Performance of specific procedures related to primary care; and
9. Taking personal responsibility for developing and maintaining knowledge and skills, as a basis for effective, safe, and evidence-based patient care.

These general recommendations for the scope of services for Family Medicine Doctors and Nurses allows for flexibility in a variety of settings and allows for gradual expansion of the scope based on needs identified in the setting and the knowledge and skills of the doctors and nurses. In the rural areas it may be necessary for Family Medicine doctors and nurses to provide a wider variety of services. As the knowledge and skill level of the Family Medicine doctors and nurses' increase, their scope of services may also expand.

It is recommended that a working group be established to review the proposed scope of services for Family Medicine Doctors and Nurses. The working group should be lead by Family Medicine Doctors and Nurses with involvement from Narrow Specialists with an interest in and understanding of Family Medicine. Members from the Ministry of Health and the World Bank working group also must be involved in the review and decision making process. It may be

helpful for outside consultants to participate in the facilitation of this working group and finalization of the Scope of Practice for Family Medicine Doctors and Nurses.

2. Initial Outline of Post-graduate (in-service) Re-training Curriculum for Currently Practicing Physician Internists and Pediatricians, and Nurses to Perform the Standard Scope of Services for Family Medicine Doctors and Nurses

Retraining practicing Physician Internists, Pediatricians, and possibly Obstetricians and Gynecologists, as well as Nurses will speed the implementation of Family Medicine. It is important that the retraining be completed from the perspective of Family Medicine. Family Medicine doctors and nurses will need to be involved with the development and teaching of the curriculum. Narrow Specialist will also be needed for the training, however must have a general concept of the philosophy of Family Medicine and incorporate the concept in their instruction. Their instruction should be modified to train Family Medicine doctors and nurses to handle common conditions themselves rather than immediately refer. The training should focus on initial presentation or disease screening, early detection, and outpatient management. Trainers involved in this curriculum must be trained in the philosophy of Family Medicine as well as Adult Learning techniques. These recommendations are consistent with the 1996 report from the WHO that discussed the need for innovative approaches to curriculum planning for PHC and teaching and learning methods should be supported at the highest levels, so that Family Medicine doctor and nursing education programs are:

- Based on the most recent assessment and forecasts of a country's health needs and of the services required to meet them;
- Problem-based so as to promote the skills of critical thinking and problem-solving;
- Rooted in the philosophy of primary health care;
- Founded on current research in doctor and nurse practice;
- Culturally appropriate; and
- Multidisciplinary, where appropriate, to encourage shared learning and greater understanding of professions.

The current curriculum in the Post-Graduate Institute should be expanded upon, be evidence-based, take advantage of modules which have already been developed, and include more clinical, hands-on training. For the retraining to be effective, the majority of the course should be focused on development and improvement of clinical skills and take place in a clinical site with minimal time spent in lectures. Retraining should be flexible and take into consideration the current skills of the doctors and nurses. It is important that the re-training be completed as a doctor and nurse partnership to the extent possible, to emphasize the importance of medical teams; with recognition that the knowledge and skill level of the Doctor will be more extensive than the Nurse in many cases.

Family Medicine Curriculum Purpose, Educational Methods and Philosophy, Flexibility and Core Competencies. A curriculum must define the purpose, methods, educational philosophy, and competencies of the graduates.

Purpose. The purpose of a family medicine training program is to train doctors and nurses who take responsibility for the comprehensive care of patients and their families with

undifferentiated problems over time, regardless of age, gender, illness, or organ system. Family doctors and nurses must acquire and maintain a broad array of competencies reflecting the needs of the populations they serve, the communities in which they practice, and the environments in which they and their patients work and live.

Educational Methods and Philosophy. The family medicine training program should identify educational methods that are sufficiently flexible to meet the needs of the trainees and the community. Family medicine training needs to take place in patient care environments. The clinical part of the training must comprise a majority of the training course. Anatomic models, Mannequins (phantoms), which closely simulate the human body are helpful adjuncts for specific procedural training. They are not sufficient, however, for in-depth skill development which requires contact with patients.

Flexibility. The curriculum needs to be flexible. Flexibility of training will produce family medicine doctors and nurses with varying sets of competencies to meet personal and community needs. However, a core set of knowledge, skills, and attitudes must be developed by training program graduates. These core competencies can be enumerated.

Core Competencies. The training program should ensure the development of the following core competencies, with respect to all age groups and both genders:

1. Diagnose and manage the most common acute and chronic complaints, both physical and mental, utilizing a biopsychosocial model with emphasis on health promotion and disease prevention.
2. Recognize rare but significant and treatable diseases, hidden conditions, and other uncommon conditions requiring treatment. Refer patients appropriately and communicate effectively with narrow specialists.
3. Communicate with and establish compassionate, effective relationships with patients that will help to facilitate change in patient behaviors to improve their general health.
4. Understand and intervene during predictable points in the life cycle of individuals and families as they experience health and illness. These nodal points include pregnancy and childbirth, the newborn child, childhood, adolescence, life-threatening and life-altering illnesses, loss and grief, and end-of-life care.
5. Demonstrate respect for and responsiveness to the needs of patients and society by:
    - Accepting responsibility for patient care, including continuity of care or return to continuity of care;
    - Demonstrating integrity, honesty, compassion, and empathy in one’s roles as a doctor or nurse;
    - Respecting the patient’s privacy and autonomy; and
    - Demonstrating dependability and commitment.
6. Continuously acquire and refine the knowledge, skills, and attitudes targeted to community practice, current science, and ongoing quality improvement.
7. Engage in activities that will foster personal and professional growth as a doctor or nurse.

Structure of Re-training Curriculum Modules. While the content of the modules will vary to some extent dependent upon the topic covered, it is recommended that the modules be structured in the following manner:

RETRAINING CURRICULUM MODULE

I. Introduction
II. Attitudes
III. Objectives
- a. Knowledge
- b. Skills

IV. Implementation
- a. Lectures
- b. Case Presentations
- c. Skill Labs, including procedures
- d. Supervised clinical experiences
- e. Special assignments or projects

V. Evaluation
- a. Written tests
- b. Skills tests
- c. Documentation Reviews
- **d.** Other

VI. Logistics
- a. Faculty
- b. Equipment
- c. Clinical Sites
- d. Timelines

VII. Supporting Literature

An example of a teaching module for Family Medicine entitled Health Promotion and Disease Prevention is attached (see Appendix IV).

Draft Outline of Re-training Curriculum Modules

A draft topical outline of recommended re-training curriculum modules has been developed. This draft is intended as a starting point for discussion. Some key points of knowledge to be learned and skills to be gained have been outlined under a series of modules. Time allotted to each module and depth of coverage of the key points will need to be modified according to the abilities of the trainees. This same outline could be used as a basis for a family medicine residency program in the Medical University or for the re-training program in the Postgraduate Medical Institute. As part of the program evaluation process a pre-test could be administered to better assist in providing maximal instruction for the needs of the trainees. The modules should be discussed by the working group previously described in this report to determine if topics need to be added or removed based the health needs of the country, the current knowledge of doctors and nurses, and the amount of time that should be spent on each module. It is critical that the re-training include adequate clinical and hands-on training. It is recommended that at least 2/3 of the re-training time should focus on clinical skill development and improvement in a clinical site, while approximately 1/3 of the retraining time should be used for theoretical or didactic training

in the classrooms and auditoriums. It is recommended that outside consultants could be used to facilitate the working group discussion and finalization of the re-training curriculum modules for Family Medicine doctors and nurses, as well as further developing the content of the re-training modules once the working group has finalized the topical outline. It is also important to plan for an ongoing process of updating the modules in the future to include new knowledge and skills.

A draft topical outline of recommended re-training curriculum modules for currently practicing Physician Internists and Pediatricians, and Nurses to Perform the Standard Scope of Services for Family Medicine Doctors and Nurses is as follows:

MODULE 1: Orientation to Family Medicine/Primary Health Care

Knowledge

- Family Medicine/Primary Care Principles
- Team Work and System Thinking
- Communication
- Continuity of Care
- Nutrition
- Patient and Family Education
- Infection Control Principles
- Immunizations
- Assessment in the Home
- The Family System

MODULE 2: Physical Assessment/Patient Evaluation

Skills

- History Taking/Patient Recording
- Physical Assessment by Body System and evaluation in specific groups
  - Infant
  - Child
  - Adolescent
  - Adult
  - Women
  - Pregnant Women
  - Men
  - Older Adults

MODULE 3: Health Promotion and Disease Prevention

Knowledge

- Categories of prevention
  - Primary - prevention
  - Secondary – early diagnosis and treatment
  - Tertiary - rehabilitation
- Nutrition and nutritional counseling

- Exercise
- Psychosocial well-being
- Injury prevention
- Prevention of sexually transmitted diseases and unintended pregnancy
- Pharmacological prevention
- Environmental
- Determination of risks
- Criteria for use of screening tests
- Periodic health examinations

Skills

Information gathering

- History
- Physical Examination

MODULE 4: Infant and Child

Knowledge

- Fetal and neonatal period
- Well newborn and child care
- Physical growth
- Prevention and screening
- Sudden infant death syndrome
- Psychological disorders
- Social and ethical issues
- Genetics
- Developmental disabilities
- Medical problems of infants and children: recognition, management and appropriate referrals
- Integrated management of childhood illnesses (IMCI)
  - Diarrhea
  - Upper respiratory infection
  - Pain in ear
  - Nutrition disorders
  - Anemia
  - Breast feeding
  - Malaria

Skills

- APGAR scores
- Age appropriate history and physical examination
- Developmental screening tests
- History and physical for sexual abuse
- Administration and interpretation of behavioral questionnaires
- Hearing and vision screenings tests and assessments
- Bladder catheterization

- Vascular access
- Lumbar puncture
- Fluid and electrolyte replacement
- Coordinate patient care with narrow specialists as needed
- Management of IMCI
    - Emergency care in life-threatening conditions
    - Emergency care in diphtheritic and false croup
    - Methods of physical cooling
    - Detection of a child's illness
    - Oral re-hydration

MODULE 5: Adolescent Health

Knowledge

- Normal growth and development including physical, mental, emotional, and relationships
- Health risks and behaviors
- Prevention services, including immunizations, health promotion, and guidance
- Challenges facing sexual identity and responsible sexual behaviors
- Core conditions that may effect health of adolescent

Skills

- History and physical examination
- Services in the clinic setting
- Services in the community

MODULE 6: Women's Health

Knowledge

- Normal growth and development and variants
- Menstruation
- Reproductive tract infections/diseases
- Reproduction
- Adoption – Options and counseling
- Abortion – Issues and counseling
- Sexuality
- Prevention, screening and immunization guidelines
- Menopause
- Psychosocial issues
- Mental health and behavioral medicine
- Depressive illnesses, including postpartum depression
- Community issues
- Family centered maternity care
- Medical diseases in women

Skills

- Control of fertility
- Surgical/diagnostic
- Counseling

MODULE 7: Obstetrical Care

Knowledge

Pre-pregnancy planning and counseling
Prenatal care, including risk assessment
Labor and delivery
Postpartum care
Indications for a cesarean delivery
Obstetric complications and emergencies
Lactation

Skills

- Pre-pregnancy evaluation
- Initial pregnancy visit
- Risk assessment
- History, physical assessment, laboratory monitoring, and counseling throughout pregnancy
- Management of labor
- Fetal assessment
- Delivery
- Management of common intra-partum problems
- Post-partum care

MODULE 8: Gynecological Care

Knowledge

- Normal female growth and development and variants
- History and physical examination for all age groups
- Disease prevention/health promotion and periodic health evaluation
- Breast health and diseases of the breast
- Abnormal uterine bleeding
- Cervical lesions and abnormal cytology
- Ectopic pregnancy
- Sexual assault
- Menopause and geriatric gynecology

Skills

- Appropriate screening examination, including breast examination
- Obtaining vaginal and cervical cytology
- Colposcopy

- Cervical biopsy
- Endometrial biopsy
- Culdocentesis
- Cryosurgery/cautery for benign disease
- Microscopic diagnosis of urine and vaginal smears
- Bartholin Duct cyst drainage or marsupialization
- Dilatation and curettage for incomplete abortion

MODULE 9: Men's Health

Knowledge

- Normal growth and development and variants of each
- Normal differences between men and women
- Urologic examination
- Health promotion and disease prevention
- Mental health
- Psychosocial/community issues
- General medical problems
- Reproductive tract infections
- Benign diseases of the male ano-genital tract and breast
- Neoplastic disease of the male genital tract and breast
- Reproduction
- Sexuality

Skills

- Vasectomy
- Neonatal circumcision
- Penile nerve block for circumcision
- Various treatment modalities for penile condylomata
- Male reproductive system examination
- Counseling skills
- Urethral swab for sexually transmitted diseases
- Foley catheter placement
- Microscopic diagnosis of urine

MODULE 10: Older Adults

Knowledge

- Physiology of normal aging in various body systems
- Normal psychologic, social, and environmental changes of aging
- Alterations is disease presentation with aging
- Risks and adverse outcomes in geriatric care
- Health promotion and risk prevention
- Rehabilitation or maintenance of independent lifestyle
- Home care for the elderly
- Exercise, nutrition, and psychosocial counseling

- Evaluation of functional status
- Health problems in the elderly

Skills

- Comprehensive history and mental status examination
- Comprehensive physical examination
- Performance and interpretation of diagnostic tests
- House calls and coordination of home care
- Communication
- Counseling
- Communicating
- Coordinating care
- Referrals to narrow specialists
- Dealing with death and dying

MODULE 11: Critically Ill Adult

Knowledge

- Renal failure
- Metabolic disorders
- Cardiovascular conditions
- Endocrine conditions
- Hematologic conditions
- Gastrointestinal conditions
- Pulmonary conditions
- Neurological conditions
- Multi-system conditions
- Enteral and parenteral nutrition
- Prophylaxis
- End of life

Skills

- Cardiac resuscitation
- Intervenous therapy
- Diagnostic and therapeutic procedures
- Management and patient monitoring
- Glascow Coma scale
- Communication with patient and family

MODULE 12: Urgent and Emergent Care

Knowledge

- Principles of care
- Assessment and management of:
    - Trauma

- By site of injury
- Neurologic emergencies
- Psychiatric emergencies
- Environmental disorders
- Toxicologic emergencies
- Obstetric and gynecological emergencies
- Victims of violence
- Recognition and management of life threatening conditions
- Indications and interpretations of diagnostic tests
- Disease prevention

Skills

- Airway management
- Anesthetic techniques
- Homodynamic techniques
- Diagnostic/therapeutic procedures
- Skeletal procedures
- Other

MODULE 13: Surgical Patient

Knowledge

- Basic principles of surgical diagnosis
- Anesthesia
- Recognition of surgical emergencies
- Ethical, legal, and socioeconomic considerations
- Preoperative assessment
- Intraoperative care
- Postoperative care
- Outpatient surgery
- Office care of common conditions

Skills

- Preoperative assessment
- Recognition of need for emergent surgical techniques
- Intraoperataive care
- Postoperative care
- Minor surgical techniques
- Counseling regarding advanced directives and end-of-life issues

MODULE 14: End of Life Care

Knowledge

- Philosophy of palliative care
- Hospice care

- Prognosis of terminal illness
- Major pain syndromes
- Pain control
- Causes and treatment of non-pain symptoms
- Nutrition and hydration in the terminally ill
- Care locations
- Bereavement process
- Legal issues

Skills

- Physical assessment
- Pharmacologic pain management, including administration routes
- Use of pain scale
- Effective referral for patient and family
- Counseling for family and others
- Self-care and support when patient dies

MODULE 15: Allergy and Immunology

Knowledge

- Immune response and hypersensitivity reactions
- Immunodeficiency – primary and secondary
- Asthma
- Rhinitis
- Adverse reactions to foods, drugs, and biologicals
- Dermatitis
- Anaphylaxis
- Uticaria/angioedema

Skills

- Skin testing
- In vitro testing
- Pulmonary function testing

MODULE 16: Skin Conditions

Knowledge

- Classification and description of skin disorders
- Diagnosis and management of common dermatologic disorders
- Prevention of skin diseases
- Management of skin injuries
- Skin manifestations of systemic diseases
- Prevention, recognition, and management of skin cancers
- Dermatologic medication

Skills

- History and physical examination of dermatologic conditions
- Preventive skin examination
- Biopsy of skin lesions
- Scraping and microscopic examination
- Injection
- Incision and drainage
- Destruction of lesions
- Counseling of dermatologic disorders

MODULE 17: Cardiovascular Medicine

Knowledge

- Normal cardiovascular anatomy and physiology
- Changes in cardiovascular physiology with age and pregnancy
- Risk factors
- Cardiovascular history
- Cardiovascular physical examination
- Noninvasive examinations
- Invasive examinations
- Relevant laboratory interpretation
- Specific diseases/conditions
- Cardiovascular pharmacology

Skills

- Diagnostic skills
  - Blood pressure
  - Auscultation
  - Performing and interpreting ECG
  - Performing and interpreting chest X-ray
  - Laboratory tests
- Therapeutic interventions

MODULE 18: Musculoskeletal Conditions

Knowledge

- Normal anatomy and physiology
- Normal growth and development
- Musculoskeletal history taking
- Principles of musculoskeletal physical examination
- Laboratory data
- Testing
- Recognition and diagnosis of common conditions
- Recognition and diagnosis of common pediatric conditions
- Management and therapy
- Prevention

Skills

- Basic care
  - Fractures
  - Sprains and strains
  - Other problems
- Procedures
  - Joint aspiration
  - Joint and musculoskeletal injection
  - Splints
  - Casts
  - Dislocation reduction
  - Traction application
- Recognition, stabilization, and referral of orthopedic emergencies

MODULE 19: Rheumatic Conditions

Knowledge

- Normal musculoskeletal system anatomy and physiology
- Role of immunologic mechanisms on the pathogenesis of rheumatic disease
- Effect of aging on rheumatic conditions
- Evaluation of the patient
- Etiology, pathophysiology, epidemiology, clinical presentation, prevention, and criteria for diagnosis or rheumatic conditions
- Pharmacology
- Rehabilitation
- Indications for surgical treatment
- Awareness of commonly used complementary and alternative therapies

Skills

- Diagnosis
- Management and therapeutics
- Referral to narrow specialists

MODULE 20: Nervous System Conditions

Knowledge

- Normal anatomy, physiology, and anatomic principles related to neurological diseases
- Normal growth, development and aging of the nervous system
- Pathologic neurologic disorders
  - Motor function
  - Sensation
  - Vision
  - Cerebro-vascular disease

- Head and spinal cord trauma
- Multiple sclerosis
- Dizziness and disorders of hearing
- Disorders of cognitive function and communication
- Disorders of consciousness
- Headache
- Brain tumors
- Infections
- Spinal cord disorders
- Sleep disorders
- Peripheral nerve disorders
- Congenital disorders
- Chromosomal abnormalities
- Abnormal head growth
- Other

- Principles of pain management
- Psychologic and rehabilitation aspects of patient management
- Genetic basis for neurologic disorders
- Neurologic disorders in the elderly
- Neurologic complication of systemic illness

Skills

- Recognizing and diagnosing neurologic problems
- History and examination, including Glascow Coma scale and pediatric developmental examination
- Differential diagnosis
- Management of care including need for referral to narrow specialist
- Ancillary tests
- Management of neurologic conditions, chronic and acute
- Patient and family education and counseling
- Pharmacologic management

MODULE 21: Eye Conditions

Knowledge

- Normal anatomy, physiology, development of aging of the eye and ocular function
- Psychological and adaptive needs of patients with chronic ocular deterioration
- Effects of drugs and toxins on ocular function and disease
- Effects of ocular drugs on systematic function
- Understanding of the ocular disability of elderly patients and the importance of regular assessment and maintenance of functional capacity
- Ocular complications of systemic illness

- Guidelines for appropriate intervals for vision evaluation from birth to senescence
- Initial diagnosis, management, and appropriate referral criteria for common eye problems
- Appropriate indications for special procedures in ophthalmology

Skills

- Performance of specific procedures and interpretation of results
- Physical examination for all ages
- Diagnosis of problems
- Management of problems

MODULE 22: Human Behavior and Mental Health

Knowledge

- Basic knowledge of normal and abnormal psychosocial growth and development across the life cycles, and variants
- Mental health disorders
- Delirium, dementia, amnesic, and other cognitive disorders
- Substance related disorders – commonly abused drugs
  - Alcohol
  - Amphetamines
  - Cannabis
  - Sedative/hypnotics
  - Cocaine
  - Hallucinogens
  - Inhalants
  - Nicotine
  - Opioids
  - Sedatives
  - Polysubstance-related disorders
- Psychiatric disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Dissociative disorders
- Eating disorders
- Sleep disorders
- Personality disorders
- Disorders associated with abuse and neglect
- Others

Skills

- Evaluation skills
- Therapeutic skills
  - Management of emotional aspects

    - Management of psychiatric emergencies
    - Use of psychopharmacologic agents
    - Family support
    - Behavioral modification
    - Community resources
    - Crisis-counseling skills
    - Modification of environment
  - Appropriate referral to narrow specialists

MODULE 23: Infectious Diseases

Knowledge

- HIV virology and pathophysiology
- Immunodeficiency manifestations and complications
- Tuberculosis
- Other infectious diseases
- Epidemiology
- Laboratory testing
- Clinical manifestations
- Treatment and patient-care issues
- Psychosocial and ethical issues
- Special considerations for health care providers

Skills

- Evaluation
- Preventions
- Management
- Community involvement

MODULE 24: Office Laboratory Management

Knowledge

- Testing and interpretation of results
- Equipment
- Personnel training
- Quality assurance and quality control
- Record keeping
- Laboratory safety and management
- Blood borne pathogens – precautions
- Occupational exposure

Skills

- Use and care of the microscope
- Urinalysis
- Complete blood count
- Chlamydia testing

- Gram stain test
- Vaginal smears
- Skin scrapings
- Fecal occult blood
- Cultures
- Basic blood chemistries

MODULE 25: Medical Genetics

Knowledge

- Principles of human and medical genetics
- Ethical considerations
- Laboratory studies
- Limitations of genetic testing
- Genetic implications of common disorders and conditions
- Approaches to care

Skills

- Family history
- Assessment
- Testing
- Education
- Privacy and confidentiality

MODULE 26: Medical Ethics

Knowledge

- Belief system
- Analysis and decision making
- Principles of ethics
- Business and professional ethics
- Family doctor's role in counseling
- Ethics related to specific patient care scenarios

Skills

- Identify ethical issues
- Obtain informed consent
- Act appropriately
- Decide when ethically appropriate to withhold information from patient
- Care for patients with poor prognosis
- Appropriate consultation with family and other health care providers

MODULE 27: Disaster Medicine

Knowledge

- Types of disasters

    - Natural
    - Accidents
    - Physical attack
    - Acts of terrorism
  - Biological disasters
  - Chemical disasters
  - Medical therapies and supplies
  - Decontamination
  - Personal protective equipment
  - Communication and care coordination

Skills

  - Medical and surgical skills
  - Use of appropriate protective equipment
  - Infection control
  - Decontamination
  - Education

MODULE 28: Family Medicine Practice Management

Knowledge

  - Practice configurations – Family Group Practice
  - Practice facilities
  - Office organization
  - Practice operations
  - Office and business management
  - Medical records
  - Family Medicine Doctor and Nurse teams
  - Resources and equipment

Skills

  - Working in health care teams
  - Adapting to changes in the health care environment
  - Medical record management
  - Computer and internet skills

3. Preliminary recommendations for developing and implementing retraining improvements for physicians (that would permit an initial cycle of the new program to begin in September 2006) and developing a Nurse re-training program

There is currently a retraining program in the Post-Graduate Medical Institute that is based on the AIHA partnership. In addition, the National Coordinator for Family Medicine/Primary Health Care has support to develop and implement retraining in family Medicine at the Postgraduate Institute. It is recommended that once the working group has finalized the topical outline for the retraining program, the outline should be evaluated for similarities and differences to the existing re-training program. It is important to build upon the

work that has already been completed to the extent possible, as well as to utilize the expertise of the Narrow Specialists in addressing some of the topic areas. It is recommended that Narrow Specialists be trained in the philosophy of Family Medicine, undergo training on adult education, and update their training materials so that they are current and evidence based prior to teaching in the Family Medicine retraining program. It is also important that adequate resources and equipment are available for hands on clinical experience both in laboratory and clinical settings.

As there is a recognized shortage of physicians and nurses in rural areas, consideration should be given to the initial location of the Family Medicine retraining clinical sites. For example, AIHA is funding participants from Ganja for the retraining program. Developing and implementing a retraining program in a more rural location such as Ganja maybe initially more accepted than in the urban areas, as well as respond to the recognized need for well trained Family Medicine doctors and nurses in the rural areas. As discussed previously, Family Medicine should be able to respond to the changing health care needs, be evidence based, socially accepted, and accessible to all while focusing on those in need, be affordable and of high quality.

It is recommended that retraining of Family Medicine doctors and nurse be completed using a doctor-nurse partnership/team approach. This will speed the implementation of Family Medicine in the clinic setting as well as promote the use of the nurse in Family Medicine. Currently, the scope of practice for the nurse is very limited. In many cases, this limitation is a result of the large number of Narrow Specialists, the doctor's personal scope of practice, the limited number of patients available, and training. Working as partners, as a Family Medicine team, will provide an opportunity for both the doctor and nurse to expand their scope of practices and skills, while learning to work together to more effectively meet the needs of their patients.

The initial training program should follow a train-the-trainer format to prepare Narrow Specialists and others to teach in the retraining program. It is important that Narrow Specialists receive training related to the philosophy of Family Medicine and Adult Learning strategies, and support the concept of Family Medicine. If possible, some nurses with a strong knowledge based and strong clinical skills should be identified to assist with the Family Medicine training, particularly the training of the nurses. Subsequent retraining programs should focus on practicing internists and pediatricians and their nurses, gradually expanding to others as appropriate. Consistent with the need identified for Family Medicine doctors and nurses in rural areas, consideration should also be given to the planned location of practice in the selection process of physicians and nurses for retraining in Family Medicine.

Prior to a new retraining program, several issues need to be considered including identification of a clinical training site that would provide adequate clinical exposure and hands on experience. Options to be considered for training sites include increasing the patients seen at the current Family Medical Center – Poly Clinic #4; using the Mos-Mono Clinic as a clinical teaching site; and starting a training center in Ganja. Both Ploy Clinic # 4 and the Mos-Mono Clinic need to have a larger space to be able accommodate teaching. There is a need for adequate equipment for trainees to use to enhance their learning experience in any location that is used for clinical training.

There is a need for trainers who are adequately trained in the areas of the curriculum and adult learning techniques. In addition, Family Medicine and Narrow Specialist trainers need to have a clear understanding of the principles of Family Medicine and Scope of Practice.

Several options should be considered for the length of the retraining program. A three month program would be a bare minimum but would be inadequate. A 6 month to one year retraining program would be more ideal. The background and experience of the doctor or nurse entering the program should be considered and may impact the length of retraining needed. Curriculum which is flexible needs to be developed to respond to the varying needs of the trainees. Consideration also should be given regarding if the training should be continuous or if trainees have short breaks between modules/sessions. It may be difficult for doctors and nurses to be away from their practice and their families for extended periods of time if training occurs in another community. Some module could be planned so that independent study could continue from their home locations.

The criteria for eligibility for entry into the Family Medicine doctor and nurse retraining program should be identified. As discussed previously, pediatricians, internists, and obstetricians/gynecologist, as well as their nurses, should be given first consideration for acceptance in the retraining program. As the program develops, this could be expanded to include other backgrounds. Consideration should also be given to the location where the doctors and nurses practice, and also their availability to participate in the training as a doctor and nurse team. For retraining to be successful and attract good physicians and nurses adequate financial incentives must be provided.

A working group should be formed to discuss the above issues related to retraining. It is recommended that the initial Family Medicine doctor and nurse retraining program focus on retraining doctors and nurses who will serve as trainers and clinical preceptors in future programs. While the curriculum will need to be finalized and prior to the retraining program, the individual who will be the future trainers in this program will further expand the content of the training. If a retraining program is not able be implemented in Azerbaijan by the September 2006, consideration should be given to sending potential trainers to other countries that already have such a training program to gain the initial experience needed to train within the country. Arrangements may be able to be made for Family Medicine doctors and nurses to go to other countries for three to six months of clinical experience. It is recommended that outside consultants assist with the facilitation process of the working group as they work towards resolution of these issues.

4. Preliminary recommendations on strengthening the department of family medicine in the Institute of Continuing Medical Education, with an eye toward alternative scenarios of family medicine development in the next 3-5 years.

While Family Medicine has officially been recognized at the Post Graduate Medical Institute, this is a new area of practice and faculty members have had minimal opportunity for clinical practice. In addition, there is a general lack of knowledge and understanding of Family Medicine. There is a need for more Family Medicine trainers who are knowledgeable and have

strong clinical skills to train others in Family Medicine. Narrow Specialist who currently support the Family Medicine Department and teach in the retraining program need additional training regarding Family Medicine principles and need to adjust their curriculum to incorporate the philosophy and knowledge that are needed by Family Medicine doctors and nurses. Consideration should also be given to identifying Family Medicine nurses to conduct part of the training program.

A research base for a specialty such as Family Medicine and having good researchers in the future will expand the knowledge of Family Medicine. At this time, however, it is most important to have doctors and nurses with excellent teaching and clinical skills to implement the Family Medicine training program.

Family Medicine trainers need exposure to experienced Family Medicine doctors and nurses. This can be accomplished by sending trainers to Azerbaijan to train the trainer. A more efficient method may be to send potential trainers to other countries to participate in well established Family Medicine programs and be certified as trainers. Potential countries where this may be done include the United Kingdom, the United States, Israel, Kyrgyzstan, Turkey, or other European countries. It may be worthwhile to hire experienced Family Medicine Doctor and Family Medicine Nurse to live and work in the country to oversee the initial work of the trainers.

The initial trainers should come from the same location so they can practice together in a Family Practice group configuration. Family Group Practice allows newly trained Family Medicine doctors and nurses to learn from each other and to support one another. A group consisting of a combination of pediatricians, internists, and obstetricians/gynecologists would be a good initial configuration to allow for ongoing education among the group to allow the doctors to learn form each others' area of expertise.

5. Preliminary recommendations for Family Medicine Doctor and Nurse Certification

Licensure and certification are good methods to track doctors and nurses in the country ant to ensure that a minimum standard of care is provided. Licensure should be mandatory for all doctors and nurses completing a basic doctor or nurse education program prior to practice. Upon successful completion of the education program which is evidenced through competency testing of the doctor or nurse's knowledge of theory and ability to perform clinical skills portion, the doctor or nurse should be listed on a registry that is maintained by the Ministry of Health. All practicing doctors and nurses should be listed on the licensure registry. The licensure status of the doctor or nurse should be renewed approximately every two years based on evidence on continuing education in the area of practice and evidence of working during the period of licensure.

As doctors and nurses complete additional training in specialty areas, such as Family Medicine, they should be certified in the specialty area indicating that they are now able to practice in this additional area. Certification is a voluntary process that allows doctors and nurses to expand the areas in which they work. The certification maybe obtained through professional organizations. Evidence of the certification should then be provided to the Ministry of Health for addition to their registry listing indicating that the doctor or nurse is now eligible to practice in

this additional area. It is important that continuing education occur in the areas the doctor or nurse is currently practicing.

Consideration should be given to the process which would be used to license currently practicing doctors and nurses. Requiring the currently practicing doctors and nurses to submit an attestation of their successful completion of a medical or nursing education program and any specialty areas they have completed since that time may be an option to consider. After the initial licensure, all doctors and nurses would be expected to comply with the continuing education requirements established to maintain their licensure and certifications.

In addition to licensing the doctors and nurses, the government agency responsible for licensure would also be responsible to ensure that complaints against the doctor or nurse were investigated and disciplinary action was taken as needed. This is an important part of licensure as it is a mechanism by which safe care of the patient is provided by the doctors and nurses.

The combination of licensure including a disciplinary process, certification in specialty areas, and continuing education to maintain licensure and certification would greatly enhance the Ministry of Health's ability to ensure that quality care is provided to the people of Azerbaijan. Only doctors and nurses who remain current in their area of practice as well as provide safe patient care would be licensed to practice. The need for licensure and continuing education to maintain licensure and certification would provide an incentive to doctors and nurses to provide safe, evidenced-based quality care to their patients.

In addition, having one location for licensure of doctors and nurses such as a Department within the Ministry of Health would provide the data needed to determine where there were shortages in doctors and nurses, including in specific specialty areas. This information would greatly improve the Ministry of Health's ability to develop and implement plans to meet the health care needs within the country.

As with any new program, the development of a licensure program within the Ministry of Health to license doctors and nurses will require a significant amount of staff resources to implement, office space, and equipment to develop the requirements, develop forms, and gather and maintain the information obtained. Re-licensure and verifying of credentials, as well as the disciplinary process, are also staff time intensive. In addition, during the beginning stages of licensure, new doctors and nurses graduating from a medical or nursing education program as well as the existing doctors and nurses would need to be identified, required to submit an application for licensure, and be placed on a registry. The content of the registry listing would also need to be decided upon so that the necessary information was obtained.

As licensure and certification of doctors and nurses is in the beginning stages in Azerbaijan, there may be a benefit in having a working group formed to discuss the concept and how it can be implemented most efficiently and effectively in the country. There may be a benefit to have an individual experienced in licensure and certification from outside the country to facilitate the work group. The work group should include representatives from with Ministry of Health as well as doctors, nurses, and representatives from other stakeholder groups.

NEXT STEPS

Azerbaijan has an interest in developing General Practice/Family Medicine Doctors and Nurses and has made some initial steps. To continue strengthening Primary Health Care and to move towards a specialty of General Practice/Family Medicine several steps are needed.

1. Family Medicine must be officially recognized as a separate discipline for doctors and nurses.
2. Family Medicine needs a distinct curriculum for training and retraining.
3. Family Medicine must have a recognized position within the Post-Graduate Institute so that retraining of doctors and nurses can proceed for the short term development of this specialty.
4. Family Medicine must have a recognized position within the Medical University for long term success.
5. Family Medicine should be marketed to the people so that there is an awareness of the holistic services available to all ages through Family Medicine.
6. Financing must be in place to provide an incentive for doctors and nurses to practice Family Medicine.
7. A capitated financing system allows for better outcomes.
8. Family Medicine doctors and nurses must have adequate facilities in which to practice with equipment available.
9. Licensure and Certification of doctors and nurses will be important to assure standards are met and quality care is provided to patients.
10. Ultimately, a professional association should be formed to advocate for the specialty.

APPENDIX I

Curriculum Vitae
John R. Baird, M.D.
Darleen Bartz, Ph.D., APRN

Curriculum Vitae

John R. Baird, M.D.

Summary

Dr. Baird has 27 years experience as a family physician in private practice, academic medicine, a community health center, and public health. He has had international experience in Turkmenistan, Tajikistan, Uzbekistan, Armenia, and Guatemala. His expertise includes the practice of medicine, training of physicians and other allied health personnel, administration, accreditation of residencies, assessment of public health systems, design of health care delivery, regulation and promotion of health.

Education

Doctor of Medicine, Washington University School of Medicine, St. Louis, MO 1978
(in progress) **Master of Public Health,** University of Minnesota School of Public Health, Executive Program with a focus on public health management.
Bachelor of Science in Medicine, University of North Dakota School of Medicine, Grand Forks 1976
Bachelor of Science, Electrical Engineering, North Dakota State University, Fargo 1974

Diplomate, American Board of Family Medicine 1981-88, 1988-95, 1995-02, 2002-09
Family Practice Residency Program - Fargo, University of North Dakota School of Medicine 1981
National Public Health Leadership Institute Scholar, University of North Carolina, 2003-04, 12-month leadership development program funded by CDC.
Program Director Fellowship, National Institute for Program Director Development, 1997-98, intensive fellowship sponsored by the Association of Family Practice Residency Directors dealing with design, implementation and finance of family practice residencies.

Relevant Professional Experience

State Medical Officer. North Dakota Department of Health (2002 – present)
Project director for a HRSA State Planning Grant examining the demographics of those without health insurance and developing policy options to improve coverage. Involved with Healthy North Dakota, a statewide initiative focusing on improving health behaviors of all citizens. Working with health disparities, community health assessment and collaboration with the Native American tribes. Consult on disease control issues.

Health Officer. Fargo Cass Public Health (2002 – present)
Supervise and consult on all local public health activities including disease control, tuberculosis treatment, health promotion, community health assessment, strategic planning, immunizations, and family planning clinic.

Medical Director, Family Physician. Family HealthCare Center, Fargo, ND (1994-01)
As medical director (1997-01) supervised the medical care and participated in management team of this federally qualified community health center, recognized by HRSA in January 2000 as a Culturally Competent Center of Excellence. Busy primary care office practice with hospital obstetrics, treating low income people, including many refugees.

Program Director and Faculty Member. Family Practice Residency – Fargo, University of North Dakota (1989 – 2002)
As program director (1997-02) administered all aspects of a 15 resident family medicine program including educational program, finances, accreditation, teaching and practice.
Partner. West Fargo Medical Center, West Fargo, ND (1981 – 1991)
Practiced a full range of family medicine office and hospital care including obstetrics and other procedures with a very busy, five-person group of family physicians.
County Coroner. Cass County, North Dakota (1983 – present)
Investigate unusual, unexpected deaths, especially those with possible criminal causes.

International Experience

Partner. North Dakota – Turkmenistan Partnership (2000-03)
Assisted in the establishment of a model family medicine training and practice center in Ashgabat, Turkmenistan to retrain physicians and nurses. This included development of a 4-week curriculum, training of Turkmen trainers onsite and in North Dakota, and negotiation with the Turkmen government. This was a collaboration between a ND consortium (UND College of Nursing, UND School of Medicine, ND State Department of Health, and several ND healthcare facilities) and the Turkmenistan Ministry of Health, funded by USAID through AIHA.
Partner. Dushanbe, Tajikistan Partnership (2002-03)
Participated in a consultation and training of trainers and clinicians at the Republican Training Center for Family Medicine in Dushanbe, Tajikistan, funded by USAID through AIHA.
Consultant. ALSO Provider Course, Tashkent, Uzbekistan (2003)
Facilitator and advisor for an American Academy of Family Practice training course in emergency obstetrics, Advanced Life Support in Obstetrics (ALSO). Taught with obstetricians at the Second Tashkent State Medical Institute. Funded by USAID through AIHA.
Consultant. Functional Analysis, Redesign of Polyclinic 17, Yerevan, Armenia (2001)
Evaluated and recommended functional and structural changes needed for a three-story, multi-specialty clinic to be redesigned as the first clinical training site for family medicine in Armenia. Funded by USAID through Apt Associates.
Team Leader. Guatemala Medical Mission (2003-04)
Provided hands-on medical care and leadership of a mission team working for one week each summer with people in and around Quetzaltenango, Guatemala organized through the Episcopal Church.

Leadership & Teaching

Dr. Baird holds an appointment as a Clinical Professor of Family Medicine at the University of North Dakota School of Medicine. He has participated in and led a number of committees for the medical school and in the community. Over the past 27 years he has taught many residents and students in medicine and allied health fields by lecture, small group discussions and one-on-one teaching. He is a fellow of the American Academy of Family Practice and a direct member of the World Organization of Family Doctors, WONCA. He has written several articles and given a number of lectures in North Dakota, at national meetings and at an international conference, on a variety of primary care topics. He has an interest in models of health care delivery, issues around health disparities and access to healthcare, the health of special populations, and the use of computers.

Language

English – fluent, German – moderate fluency.

Health Care Policy and Nursing Regulatory Specialist

Darleen Bartz, Ph.D., MSN, MMGT, FNP-C, RNC

Summary	Dr. Bartz has 29 years of experience as a family nurse and is a health care policy and nursing regulatory specialist with extensive expertise and experience in the area of health care and nursing policy development and regulation. For the past 15 years, she has advocated, coordinated, and facilitated regulatory change through networking and collaborating with representatives from the local, state, and federal government as well as non-government stakeholders including patients/consumers, nurses, physicians, other health care providers, and advocates. In addition to her experience as a regulatory specialist, Darleen has several years of experience as a leader and a direct provider of nursing care.
International Experience	She has had international experience in Turkmenistan that includes provision of training to physicians and nurses related to primary health care and quality assurance.
Education	**Doctorate in Nursing,** University of North Dakota, Grand Forks, ND, 2006 **Post Graduate Family Nurse Practitioner Certificate Program**, Clarkson College, Omaha, NE, 1997 **Masters in Management**, University of Mary, Bismarck, ND, 1989 **Masters in Nursing**, University of Mary, Bismarck, ND, 1987 **Bachelors in Nursing**, Jamestown College, Jamestown, ND, 1977
Relevant Professional Work Experience	**Chief, Health Resources Section, North Dakota Department of Health (1999 – present)** Administrator of the health care regulatory programs for the state of North Dakota including hospitals, nursing homes, basic care facilities, home health care facilities, and intermediate care facilities for the mentally retarded. These programs monitor the quality of nursing and other care provided to residents and patients throughout North Dakota. Other regulatory responsibilities include regulation and registry of nursing assistants, paramedics, emergency medical technicians and quick responders. Responsibilities include overall management and administration of the regulatory activities of the Health Resources Section including the Divisions of Health Facilities, Emergency Health Services and Food and Lodging and the Department of Health - Health Insurance Portability Act Coordinator, Lead Privacy Officer, and Incident Command lead. **Interim Chief, Preventive Health Section, North Dakota Department of Health (July 1999 – May 2002)** Added responsibilities included the administration and management of the Preventive Health Section including the Divisions of Disease Control, Health Promotion, Maternal and Child Health, and Microbiology. This section is responsible for health promotion and illness prevention programs, epidemiology investigations and follow-up, injury prevention, and public health laboratory services. **Director, Division of Health Facilities, North Dakota Department of Health (March 1998 – July 1999)** This division is responsible for the regulation of health care facilities in North Dakota. As director for this division, responsibilities include personnel staffing and related issues, work load assignments, budget, networking and collaboration with partners on the local, state and federal levels. **Manager of Standards Development, North Dakota Department of Health (1992-February 1998)** Responsibilities included research and drafting of health care facility licensure regulations including hospitals, nursing facilities, home health agencies, basic care facilities; and nurse aide training, competency evaluation and registry; establishing and implementing a quality assurance program for the division; managing the nurse aide training and competency evaluation program survey process; provided state wide training to nursing staff and other professional staff on patient assessment and care planning in nursing facilities. **Manager of Licensure and Certification**, **North Dakota Department of Health (1990-1992)** Managed the State Licensure and Federal Certification of Health Care Facilities, including programs and staff. **Utilization Review Manager, North Dakota Department of Health (1989-1990)** Managed the Utilization Review Program and Inspection of Care program including associated staff. **Adjunct Nursing Professor, University of Mary, Bismarck (2004 to present)** Developed the course syllabus and taught the Masters' in nursing course entitled *Community as Partner.*

Health Care Policy and Nursing Regulatory Specialist

Darleen Bartz, Ph.D., MSN, MMGT, FNP-C, RNC

Relevant Professional Work Experience	**Clinical Instructor, University of North Dakota School of Medicine, Grand Forks (1999 – Present)** Functions as a consultant to the community health department of the school of medicine related to regulatory and nursing issues. **Family Nurse Practitioner and Staff Nurse, Medcenter One Health Care System, Bismarck (1990 – Present)** Available on an as needed basis as a primary health care provider in rural and ambulatory care clinics; a staff nurse in the normal and intensive care nurseries. **Assistant Director, Gynecological Operating Rooms, Inpatient Unit, and Outpatient Unit, St. Alexius Medical Center, Bismarck (1988 – 1989)** Supervisor, nurse, quality assurance coordinator. **Assistant Unit Supervisor, Medcenter One Health Systems, Inc., Bismarck (1982 - 1988)** Supervisor of Intensive and Normal Newborn Nurseries. **Charge and Staff Nurse, St. Luke's Hospital, Fargo, ND (1981 – 1982)** Charge nurse and caring for high risk and normal newborns. **Public Health and Home Health Nurse, Multi-County Nursing Service, Ada, MN (1979 – 1981)** Supervision of the care of home health and public health clients, supervised home health aids and homemakers in the home care setting, school nursing including screening for hearing, vision, lice, scoliosis and preschool screening, immunization clinics, foot-care clinics, blood pressure and glucose screening clinics, birth control counseling, and provided public health education including prenatal classes. **Charge and Staff Nurse, Ada Municipal Hospital, Ada, MN (1978-1979**) Charge and staff nurse for all areas of general acute patient care including obstetrics and intensive care. Provided oversight for the adjacent long term care facility. **Charge and Staff Nurse, Mercy Hospital, Valley City, ND (1977-1978)** Charge and staff nurse on a general surgery floor and pediatric unit.
Leadership, Regulatory, Nursing & Health Care Policy Develop-ment	Dr. Bartz's leadership in the area of regulatory and nursing/health care policy development and reform includes chair or participant position on the following workgroups: • Healthy North Dakota Diverse Population Workgroup (Participant) • Research and drafting of licensure rules for health care facilities and providers in North Dakota including Licensure Rules for Hospitals; Licensure Rules for Nursing Facilities; Nurse Aid Training, Competency, and Registry Regulations; Licensure Rules for Home Health Agencies; Licensure Rules for Basic Care Facilities • Member of the Long Term Care Advisory Committee • Member of the Emergency Medical Service Advisory Committee • Member of the Food Security Committee • North Dakota Board of Nursing Multi-State Registry Task Force • Centers for Medicare and Medicaid Services Training Work Group • Medication Aide Pilot Project Task Force (Participant) NDNA (Nursing) Quality of Care Advisory Group • Bismarck State College Certified Nurse Aide Consortium (Participant) • North Dakota Board of Nursing Nurse Practice Committee (Participant) • Division of Health Facilities Quality Assurance Committee • Board of Nursing Rules Development Work Group (Participant) • Resident Assessment Steering Committee (Co-chair) • NDNA Nursing Systems and Administration Council (Participant) • Board of Nursing Multi-state Licensure Advisory Committee (Member) • Long Term Care Task Force (Governor Appointed Member, 1999-2000) ASTHO Management Committee (Member, 2000-2002)
Language	English – fluent.

APPENDIX II

List of Meetings, Tours and Observations
During Consultation Visit
April 5, 2006 to April 16, 2006

All of these meetings were facilitated and translated by the IMC staff including Natalia Valeeva, Aybeniz Ibrahimova, and Kamalya Suleymanova.

PHC program senior staff

- Saadet Mahmudova, Head of Family Medicine Department at Postgraduate Medical Institute and National Coordinator for Family Medicine/Primary Health Care/ Information
- Observation of Postgraduate education process for ENT at Republican Hospital – theoretical lecture and practical teaching
- Sanan Kerimov, Deputy Minister, MOH
- Samir Abdullayev, Head of International Relations Affairs, MOH
- Tarana Tagizade, National Coordinator for Maternal and Child Health, MOH
- Observation of interaction of Family Medicine doctor, Saida Nasibova, with her patient at Polyclinic # 4
- Tour of Family Medicine training center at Polyclinic # 4, with Elza Bayramova, Dr. Akhundov (Allergist)
- Discussion with Family Medicine faculty from Postgraduate Medical Institute, Saadet Mahmudova and her faculty members, Sulhiyya (Mira) Hasanova and Ilgar Mustagayev
- Nasimi Gasimov, Head of Education Department at Medical University
- Professor Mustafa Salekhov, Head of Family Medicine Department for Medical University and Policlinic faculty
- Nariman Nagdaliyev, Director Postgraduate Medical School for Nurses
- Teymur Gafarov, Deputy Rector (to Academician M. Javadzade, who was ill), of the Postgraduate Institute (Institute for Continuing Education)
- Dr. Huseynaga Huseynov, Chief of Education, Department of Post Graduate Institute
- Farkhad Mekhdiyev, Director of World Bank Health Reform Project, MOH

- Observation of Mos-Mono – Private clinic of Saadet Mahmudova
- Rena Alakbarova, Director of Policlinic # 18 (Adult) and discussion with therapist, Gulchin Kadimova and her nurse, and tour of Policlinic
- Gambarov Khanoglan, Director of Policlinic # 14 (Pediatric), with Sevinj Bashirova, Chief Pediatricain of Narimanov District of Baku, and tour of Policlinic
- Dilara Khanum, Director of Undergraduate Medical School for Nurses and three other staff members
- Jeyhoun Mamedov, Program Coordinator for AIHA
- Marianna Nossa, Engender Health
- Faiza Aliyeva, Director of OB/GYN at Republican Institute/Republican Hospital, also in meeting – Zemfira Huseynova, Administrator/Consultant with National Reproductive Health Office
- Melinda Pavin, Senior Technical Advisor for Health, and Ruziya Ramazanova, USAID Azerbaijan
- Malik Abbasov, Responsible for Licensing and Accreditation, MOH
- Focus Group with graduates of Family Medicine training center and World Bank Working Group members
- Presentation and Discussion with 18 people from MOH, Medical University, and Medical Nursing School – American Doctor and Nurse Education, Licensure, Certification
- Saida Nasibova, Elza Bayramova, Zamina _____, and three nursing staff at Poly Clinic #4 Family Medical Department
- Leyla Almaz-zade, working on Licensure and Certification with the Ministry of Health
- Exit meeting with IMC-Azerbaijan Office staff

APPENDIX III

Presentation - April 2006
Education, Licensure, and Certification of Doctors and Nurses in the USA
John R. Baird, M.D. and Darleen Bartz, Ph,D, APRN

1. Objectives
- **Basic education**
- **Graduate education**
  Doctors
  Nurses
- **Accreditation – teaching institutions**
- **Licensure**
- **Certification**

2. Basic education - Doctor & Nurse
- **Grades 1 to 12**
  Primary School (Elementary School)
  Secondary School (High School)
  Finish at 18 years old
- **After High School**
  Work
  Trade School
  Higher education – College, University

3. Undergraduate education - Doctor
- **University or College**
- **Entrance requirements**
  Good grades in High School
  National Examination – ACT or SAT
- **4 years – Bachelor's Degree**
- **Finish at 22 years old**
- **After University or College**
  Work
  Graduate school

4. Graduate education - Doctor
- **Medical School - Doctor**
- **Entrance requirements**
  Any Bachelor's Degree – Good grades
  Chemistry, Biology, Physics, Algebra, Psychology/Sociology, Language
  MCAT exam
  Interview – Admissions Committee
- **4 years – MD degree,** Finish at 26 years

5. Residency - Doctor
- **3 to 7 years**
  After Medical School
- **Board certification in a specialty**
- **Family Medicine Residency -**
  3 years, finish at 29 years old

6. Medical School Accreditation Teaching
- **LCME –** Liaison Committee on Medical Education
  Accreditation of Medical Schools
- **ACGME –** Accreditation Council for Graduate Medical Education
  Accreditation of Residency Programs
  27 Residency Review Committees

7. Nursing – Defined North Dakota Board of Nursing
- **The performance of acts utilizing specialized:** knowledge, skills, and abilities in a variety of settings.

8. Undergraduate Nursing Education
- **Nurse Assistant – 75 hours total**
  Finish age 18
- **Licensed Practical Nurse – 2 years total -** Associates Degree, Finish age 20
- **Licensed Registered Nurse – 4 years total** Bachelor's Degree – Finish age 22
- **After Nursing Education**
  Work
  Graduate school

9. Graduate Nursing education
- **Advanced Practice Registered Nurse – 3 additional years**
  Master's Degree
  In specialty area
  Finish age 25
- **Doctorate in Nursing – 3 additional years**
  Doctorate of Philosophy Degree
  Usually teach at University Level or do Research
  Finish age 28

10. Nursing School Approval & Accreditation of Teaching
- **The North Dakota Board of Nursing reviews and approves nursing education programs.**
- **Accreditation of Nursing Schools**
  American Association of Colleges of Nursing - Commission of Collegiate Nursing Education (CCNE)
  National League of Nursing Accrediting Commission (NLNAC)

11. Licensure - Doctor

- **Each state – license physician**
  North Dakota State Board of Medical Examiners
- **Can not practice in state without license**
- **Can limit or stop license for problems**
- **Requirements – National examination or state**
  USMLE
  Step 1 – after year 2 of medical school
  Step 2 – after medical school (4 years)
  Step 3 – after 1 year of residency

12. Licensure - Nursing

- **Nurse assistants are not licensed**
- **Nurse assistants complete training & testing**
  skills and knowledge
  listed on a registry as approved for work
- **With additional education and training**
  scope of work can expand to include administration of medication to patients.

13. Each state licenses Nursing

North Dakota State Board of Nursing

- Can not practice in state without license
- Can limit or stop license for problems
- Requirements – Successful completion of National examination following completion of education requirements.
- Added specialty practice areas can be added to licensure with added education and testing.

14. Certification - Doctor

- **American Board of Medical Specialties**
  24 medical specialty boards
- **American Board of Family Medicine**
  Successfully complete approved residency
  One day examination
  Continuing Medical Education – 50 hour/yr
  Recertification every 6 to 7 years
  Includes chart review – patient care + exam

15. Certification - Nursing

- **American Nurses Credentialing Center**
  Advanced Practice Registered Nurse – 8 areas including family nurse practitioner
  Clinical Specialist - 10 areas
  Bachelor's Degree or Higher - 10 areas
  Associate Degree - 9 areas
- **Other Credentialing Centers**
  Association of Women's Health, Obstetric, and Neonatal Nursing
  Association of Operating Room Nurses
  More

16. Privileges - Doctors

- **Scope of work**
  Determined by education, licensure & certification
  Determined by institution where work
  Hospital
  Insurance payments

17. Privileges - Nursing

- **Scope of work**
  Determined by education & licensure
  Where you are employed
- **Advanced Practice Registered Nurse**
  Independent practice
- **Registered Nurse**
  Some independent practice
  Under the direction of the doctor or APRN

18. Privileges - Nursing

- **Licensed Practical Nurse**
  Under the direction of the Registered Nurse or Doctor
- **Nurse Assistant**
  Under the direction of a Licensed Nurse or Doctor

18. Discussion & Questions

APPENDIX IV

Example of Teaching Module

AAFP Reprint No. 267

Recommended Core Educational Guidelines for Family Practice Residents

Health Promotion and Disease Prevention

Health promotion can be described as the application of methods that foster physical and emotional well-being and that increases length and quality of life. The concept of optimal health reflects not merely the absence of disease, but also a high level of vitality.

Disease prevention refers to activities focused on health risk profiling of asymptomatic persons and appropriate use of screening tests for early detection of disease, followed by patient education and therapeutic intervention when indicated.

Principles of disease prevention are applied to individual patients, based on scientific evidence from population studies.

Screening protocols should consider age, gender, family history and be risk-specific and dynamic, with regular reevaluation based on scientific evidence.

Health promotion and disease prevention are implicit responsibilities of family physicians. By offering continuous comprehensive care, family physicians can be catalysts for health promotion and prevention.

The family unit is a natural setting in which to focus on health promotion and disease prevention, because the dynamics among family members are critical in supporting an individual member's health.

Attitudes

The resident should develop attitudes that encompass the following:

A. An orientation toward optimizing health as well as the traditional concept of diagnosis and treatment of disease.

B. Awareness of the importance of a physicians' own health behavior in fostering quality in his or her personal life and enabling the physician to function as a positive role model.

C. Recognition of the importance of both physician and patient working together as partners in promoting optimal health.

D. Encouraging the patients' awareness of self-responsibility in obtaining optimal health.

E. Recognition of the importance of family structure and support systems in health behavior.

F. An understanding of and ability to work with the patients' level of readiness to change and the problem of recidivism.

G. An emphasis on assessment of risks for preventable disease in each patient.

H. Recognition of the importance of updating practice behavior based on continuing review of the medical literature and evidence-based recommendations of authoritative groups such as the USPSTF.

Knowledge

Residents should demonstrate knowledge of:

A. Categories of prevention

1. Primary prevention: immunization, fluoridation, health promotion
2. Secondary prevention: early diagnosis and treatment, such as Papanicolaou test, breast examination, colorectal cancer screening, blood pressure check-ups
3. Tertiary: rehabilitation, such as post stroke physical therapy

B. Nutrition and nutritional counseling

1. Current dietary recommendations and trends
2. Fat/cholesterol
3. Caloric balance
4. Fiber
5. Calcium
6. Folic Acid
7. Iron
8. Food fads
9. Obesity
10. Vitamins, minerals, antioxidants

C. Exercise

1. Current exercise recommendations
2. Types of exercise
3. Caloric expenditures per activity
4. Benefits/risks
5. Injury prevention
   a. Warm-up and cool-down
   b. Conditioning
   c. Balance of strength and flexibility
   d. Avoidance of overuse syndrome

e. Maintenance of equipment
6. Role of living environment and culture on exercise
a. Safety in neighborhoods
b. Successful interventions
D. Psychosocial well-being
1. Internal perceptions
a. Life goals
b. Spiritual beliefs
c. Self-esteem and efficacy
2. External relationships
3. Stress
a. Recognition
b. Management
4. Life adjustment periods
a. Significant life events (e.g., bereavement, divorce, illness)
b. Life transitions (i.e., parenting, adolescence, early adulthood, mid-life, aging)
E. Injury prevention
1. Motorized and non-motorized vehicles
2. Household injury
3. Recreational injuries, including protective equipment
4. Interpersonal violence
5. Role of alcohol in injuries and violence
F. Prevention of sexually transmitted diseases and unintended pregnancy
1. Safer Sexual practices
2. Family Planning
3. Contraception
G. Pharmaco prevention
1. Aspirin
2. Vitamins
3. Folic acid
4. Hormone Replacement Therapy
5. Sunscreens
6. Fluoride
7. Calcium
8. Other (Infectious Diseases related, INH, endocarditis prevention, prophylaxis during surgery)
H. Environmental
1. Occupational safety and health
2. Housing
3. Sanitation
4. Lead exposure
5. Toxic exposures such as air, water, waste sites
6. Secondhand smoke
I. Determination of risk status based on:
1. Age and gender
2. Family history including genetic, ethnic, cultural and behavioral
3. Geographic and environmental factors
4. Socioeconomic status
5. Lifestyle characteristics
J. Criteria for use of screening tests
1. Sensitivity, specificity, predictive values and testing biases.
2. Safety, cost, acceptability
K. Periodic health examination recommendations, particularly those of the American Academy of Family Physicians and the U.S. Preventive Services Task Force

Skills
The resident should demonstrate skills in:
A. Information gathering
1. History
a. Diet
b. Alcohol, tobacco, drug use
c. Exercise
d. Socio economics
e. Stress and coping
f. Sleep
g. Family
h. Occupation
i. Recreation
j. Safety habits (Health Related Behaviors)
k. Health beliefs, including ethnic and cultural
l. Spiritual beliefs
m. Patient awareness
n. Motivation for lifestyle change
2. Physical examination
a. Fitness evaluation
b. Body-fat content, BP, BMI
B. Implementation
1. Modeling a healthy lifestyle and self-responsibility
2. Counseling skills
a. Individual/family/group
b. Behavior change
3. Motivational techniques
4. Stress management techniques
5. Exercise prescription
6. Nutrition prescription
7. Sleep counseling
8. Utilization of physician and patient reminder systems
9. Utilization of community resources and local health department
10. 4-step approach to clinical encounter—risk assessment, risk reduction, screening, immunization and chemoprophylaxis

See the educational guideline on Substance Use Disorders for information about the prevention of tobacco, drug, and alcohol use/abuse.

Implementation
The implementation of this curriculum segment should be longitudinal, offering learning experiences throughout the 36 months of training. The curricular content should be required and should be integrated into the conference schedule and into teaching activities in the family practice center. Relevant materials should be prominent in the residency library and available

electronically. Curriculum should include content that teaches residents to critically evaluate clinical prevention recommendations and effective approaches to behavior change.

Residency faculty should function as role models, conducting their personal and professional affairs so as to reinforce the concepts of optimal health. By so doing, they may effectively instruct patients, residents and students in the value of beneficial health habits. Activities organized for the residency that promote weight control, stress management, regular physical exercise and routinely recommended screening and prevention examinations would be beneficial. Active learning techniques, such as role-playing or simulated patients, are useful. Charts should include prevention flow sheets or computerized reminder systems to encourage appropriate prevention measures. Residents should learn to include notes about health promotion and disease prevention in their progress notes.

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PHC Strengthening Project
International Medical Corps

Trip Report

Preparation of the Program for Introduction of Certification System for Medical Personnel in the Republic of Azerbaijan

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1 Executive Summary

1.1 Background and purpose

Improvement of the quality, access and affordability of essential health services is an overarching goal of current health reform committed by the Government of Azerbaijan. Rationalization of inefficient infrastructure network and qualitative and quantitative optimization of human resources is considered as one of the main directions towards achieving this goal. The Ministry of Health intends to introduce the state certification system for medical personnel as a tool for improving quality of services and addressing the manpower management needs in the health sector. The Ministerial Working Group on Primary Health Care is tasked to come up with proposals on institutional and organizational arrangements for nationwide implementation of medical personnel certification system.

The objective of the consultancy was to provide Technical Assistance to the PHC Strengthening Project and the Ministry of Health of the Republic of Azerbaijan in preparing the program for introduction of certification system for medical personnel.

1.2 Activities and results

The consultant worked with the representatives of the Ministry of Health to review of existing legislative and normative base for certification of medical personnel, development of Program for implementation of certification of medical personnel, elaboration of the Draft Presidential Decree on starting licensing of medical activities and certification of health personnel and of the Draft of Legal Charter of the licensing and certification unit of the Ministry of Health.

During the visit the consultant participated in informal seminar on physician licensing and presented lecture on “Licensing in Health System”.

1.3 Expected Outputs

The consultant was expected to do following:

- Review of existing legislative and normative base for certification and licensing of medical personnel;
- Define the legal charter, functions and responsibilities of the new Human Resource structural unit in the Ministry of Health (to be established) that will be in charge of health sector manpower planning and management and will lead the health worker certification process;
- Elaborate the Program and the Cabinet of Minster's (or Minister of Health) draft decree on implementation of health worker certification mechanism in Azerbaijan.

Following sections of the report provides the requested outputs in the following order:

- Review of existing situation and proposed Program for implementation of certification of medical personnel in the Republic of Azerbaijan;
- Draft Presidential Decree “On Strengthening of the State’s Responsibility in Quality Assurance of Medical Services Provided to the Population of the Republic of Azerbaijan” (or “On Starting the Licensing of Medical Activities and Certification of Health Personnel in the Republic of Azerbaijan”)
- Draft of “Legal Charter of the Health Care Facilities Licensing and Medical Personnel Certification Department of the Ministry of Health of the Republic of Azerbaijan”.

2 Review of existing situation and proposed Program for implementation of certification

1.4 Introduction

One of the key functions of the health management is to ensure the high quality of medical services provided to the population. In turn the quality directly links to the level of equipment and sanitary condition of health care facilities and competence of employed personnel.

Through the licensing of medical and pharmaceutical personnel the State, granting the right to legal and physical entities on conduction of definite medical and pharmaceutical activities, creates the conditions for standardizing the requirements to health care facilities, their equipment and staffing with competent personnel. With these, the State guarantees the population with such level of the quality of health services, below which at this stage provision of services is unacceptable. At the same time the licensing process itself should consider steady increase of the quality of health services simultaneously to the economic development of the Country.

The goal of certification (or licensing) of medical and pharmaceutical personnel is to protect the population from inappropriate and incompetent activities of physicians and pharmacists.

Implementation of certification for medical and pharmaceutical personnel is an integral part of reforming of medical education, focusing on the following priority directions:

- Reorientation of undergraduate medical education towards preparation of physicians of general profile, instead of specialists;
- Development of new model for postgraduate education of personnel through introduction of residency programs and continuous medical education system;
- Identification of the optimal number of entrants to the under- and postgraduate stages of medical education and set-up a mechanisms for its regulation;
- Implementation of the mechanism for control of the quality of medical education, as well as the knowledge and professional skills of personnel through licensing/accreditation of medical schools and **licensing/certification of medical personnel**;

Starting of the certification of medical and pharmaceutical personnel requires (1) legal framework for regulation of the certification process, (2) organizational structure, capable of conducting certification related procedures and (3) financial provision.

Legal framework considers availability of firstly, the Law, Presidential Decree or Pronouncement of the Cabinet of Ministers, determining, that the right on carrying out independent medical and pharmaceutical practice have only individuals having State certificate of physician or pharmacist, and secondly “Charter on granting the State

certificate of specialist to the individuals with higher medical and pharmaceutical education" and "Nomenclature of medical and pharmaceutical specialties".

Organizational structure should consist of (1) structural unit of the Ministry of Health (department, division, administration or sector), responsible for organization of physicians and pharmacists certification and keeping of the "State register of medical personnel", (2) Council on granting the certificates to physicians and pharmacists, (3) Committees on all medical and pharmaceutical specialties included in the Nomenclature, responsible for development and periodic update of examination tests and case studies and for carrying out the certification examinations.

Financial provision. Structural unit should be explicitly funded from the State budget. The Council on granting the certificates to physicians and pharmacists may operate on voluntary basis. As the preparation and periodic update of examination tests and case studies is the prerogative of the State, this process should also be funded from the State budget. Carrying out of certification examinations may be funded both, from the State budget or mobilization of resources from candidates of State certificate in the form of State tax or certification fees. Taking into consideration the fact, that the certification process will not be too popular among the physicians and pharmacists, it would be reasonable at initial stages to cover the expenditures of carrying out the examinations from the State budget. However, in case of negative results the expenses repeated examinations may be covered by the candidate.

1.5 Review of existing situation

"Demonstrative Project of the reform of health system in Azerbaijan" considers carrying out of activities almost in all directions, required for practical implementation of licensing of health facilities and certification of medical personnel *(Table 1)*. Familiarization with temporary parameters of the Project show that new organizational model of the Ministry of Health will be implemented by the end of 2007 and legal framework and a new set of criteria and standards for regulation of licensing for health facilities and certification of medical personnel will be adopted by the end of 2008.

Table 1 Objectives and intermediate outcome indicators related to the licensing of health facilities and certification of personnel

Sub-component	Objective	Intermediate Outcome Indicator	Date
A.1.	Review and reorganize MOH functional and administrative structures	A new organizational model for MOH is designed and adopted.	by end of 2007
A.3.	Support the development of an accreditation and licensing scheme for both public and private health facilities and set-up a mechanism for quality control and assurance of health care services	A new set of criteria and standards for licensing and accreditation of health facilities developed and adopted	by end of 2008
D.1.	Developing a labour adjustment policy	(1) A white paper on long term human resources development is produced and adopted. (2) Legal and regulatory	by end of 2007 by end of

		framework for licensing, registration and certification of health professionals adopted	2008
D.2.	Reviewing the current reform initiatives regarding under-graduate medical education, specialty training and post-graduate training programs, with a view to improving the quality of education. This component would also support the development of a certification program for medical personnel	(1) Curricula for undergraduate and graduate education of physicians, entrance and graduation criteria for medical degree and specialization are revised. (2) Standards for continuous medical education and re-certification developed and adopted. (3) Criteria and standards for certification of health professionals adopted.	by end of 2008 by end of 2008 by end of 2008

For the time being the Ministry of Health of the Republic of Azerbaijan has made definite steps towards practical implementation of the licensing of health facilities and certification of medical personnel. Particularly, the Licensing and control division at the Health services organization department of MoH carries out licensing of private and self-supported health facilities and the Licensing division at the Center for innovations and health care provision of MoH – provides licensing of all pharmacies. Besides, according to the order of the Minister of Health #143 (of 01.12.2005) on "Improvement of personnel activities in health care system of the Republic of Azerbaijan" will start testing of the physicians, applying for hiring on vacant positions. For this purposes the Multi-choice questionnaire for testing in 4 main specialties (internal medicine, surgery, gynecology and pediatrics) have been developed. It is also important to mention that the State Examination Committee, responsible for carrying out examinations for selecting the candidates for vacant positions has the experience of wide scale testing.

1.6 Proposed Program for implementation

Based on all above mentioned, creation of all preconditions and starting of certification of medical personnel by the end of 2007 seems to be quite realistic. For these purposes the draft scheduled Program for implementation of certification of medical and pharmaceutical personnel in the Republic of Azerbaijan is proposed *(table 2).*

Table 2 Proposed Program for implementation of personnel certification

September, 2006	Presidential Decree (or Pronouncement of the Cabinet of Ministers) on starting the certification process
January, 2007	Establishment of the structural unit of MoH, responsible for carrying out the certification/licensing
March, 2007	Order of the Minister of Health on adoption of the "Charter on granting the certificate of the specialist to the individuals with higher medical or pharmaceutical education" and "Nomenclature of medical and pharmaceutical specialties"
April, 2007	Establishment of the "Council on granting the certificates to physicians and pharmacists" and Committees in separate specialties
October, 2007	Starting of certification process

October, 2012	Starting of re-certification process

As for the process of certification of medical and pharmaceutical personnel itself, based on the experience of neighboring countries that already have introduced the certification in practice, full range coverage of all physicians and pharmacists which in the Republic of Azerbaijan amounts to approximately 30 thousand, will take about 4-5 years *(table 3).*

Table 3 Accounts proposed schedule for carrying out of certification examinations

Oct.-Dec. 2007	300–500 physicians in 2–3 specialties with few personnel
2008	5–7 thousand physicians of basic specialties and graduates of higher medical schools
2009	12–15 thousand physicians and pharmacists and graduates of higher medical schools
2010	12–15 thousand physicians and pharmacists and graduates of higher medical schools
2011	Graduates of higher medical schools, rest of physicians and pharmacists and those who failed and are passing the exam for the second (or third) time
2012	Starting of re-certification

3 Draft Presidential Decree

THE PRESIDENT OF THE REPULIC OF AZERBAIJAN

DECREE

ON STRENGTHENING OF THE STATE'S RESPONSIBILITY IN

QUALITY ASSURANCE OF MEDICAL SERVICES PROVIDED TO THE POPULATION OF

THE REPUBLIC OF AZERBAIJAN

or

ON STARTING THE LICENSING OF MEDICAL ACTIVITIES AND

CERTIFICATION OF HEALTH PERSONNEL IN

THE REPUBLIC OF AZERBAIJAN

The most important aspect in the process of Health Care System reform in the Republic of Azerbaijan is to improve the quality of medical services provided for population. Key role in quality assurance of medical services plays correspondence of health care facilities to appropriate standards and competencies of medical personnel.

In order to strengthen the State's guarantee of quality assurance of medical care:

1 Ministry of Health:

1.1. Prior to January 1, 2007* establish the department of MOH for licensing of all health care facilities and certification of medical personnel;

1.2. Prior to March 1, 2007* develop the mechanisms and procedures for licensing of health care facilities and certification of medical personnel;

1.3. Prior to January 1, 2008* develop a modern curricula and standards for post-graduate and in-service training of physicians in different medical specialities;

1.4. Prior to January 1, 2008* in accordance to international experience develop curricula and standards for under-graduate training of feldshers, nurses and midwifes;

1.5. From May 1, 2007* initiate the health care facilities licensing process;

1.6. From October 1, 2007* start medical personnel certification process;

1.7. From academic year 2008-09* start teaching in nurses schools according to new curriculum.

2 Ministry of Education:

2.1. Prior to January 1, 2008* develop curricula and standards for under-graduate training of physicians, dentists and pharmacists according to European Union guidelines;

2.2. From the academic year 2008-09* start teaching in medical schools according to new curriculum.

3 Ministry of Finance:

3.1. Provide necessary financial resources required by Ministry of Health and the Ministry of Education to fulfil the tasks mandated by this decree.

* Indicated in Decree dates are subject to revision by the officials of MoH or GoA

4 Draft Legal Charter of the Licensing & Certification Unit

LEGAL CHARTER

OF THE HEALTH CARE FACILITIES LICENSING AND

MEDICAL PERSONNEL CERTIFICATION DEPARTMENT OF

THE MINISTRY OF HEALTH OF THE REPUBLIC OF AZERBAIJAN

1 General provisions

1.1. Department of the Licensing of Medical Activities and Certification of Specialists (hereinafter – Department) is a structural unit of the Ministry of Health of the Republic of Azerbaijan.

1.2. In its activities the Department is guided by the Constitution, Laws, Decrees issued by the President, Cabinet of Ministers or the Minister of Health of the republic of Azerbaijan, international agreements and given Statute.

1.3. Department is accountable to the Minister of Health, who provides supervision of its activities.

2 Scope of activities and functions

2.1. Scope of the activities of the department include

2.1.1. Organization of the granting the right to the performing of medical and pharmaceutical activities (hereinafter – license) on the territory of the Republic of Azerbaijan to all legal and physical entities, regardless the type of ownership and departmental subordination;

2.1.2. Organization of the granting the right to the performing of physician's and pharmaceutical activities (hereinafter – certificate) on the territory of the Republic of Azerbaijan to the specialists of different medical and pharmaceutical specialties.

2.2. Functions of the Department

2.2.1. Elaboration and, if necessary, preparation for approval of the changes in the "Statute on granting the license on medical or pharmaceutical activities on the territory of the Republic of Azerbaijan" and in the "Nomenclature of the works for providing medical and pharmaceutical services";

2.2.2. Elaboration and dynamic improvement of the conditions and the list of documents, required for granting the license to the legal and physical entities;

2.2.3. Admission of the documents from the candidate and revision of their conformity to the requirements of granting the license;

2.2.4. Check of conformity to particular licensing requirements on site, if required;

2.2.5. Preparation of the materials for discussion by the “Committee of Licensing of Medical and Pharmaceutical Activities” (hereinafter – Committee) of the Ministry of Health the issues regarding the granting of the license;

2.2.6. Preparation of the materials for discussion by the Committee the issues related to the granting, resumption, re-registration, cancellation, extension of the term of validity of suspended licenses or refusal of granting the license based on the verification of the compliance of the candidate with licensing requirements and conditions;

2.2.7. Keeping of the “State Register of Licensed Medical and Pharmaceutical Institutions”;

2.2.8. Elaboration and, if necessary, preparation for approval the changes in the “Statute on granting the State certificate of the specialists to the individuals with Higher Medical and Pharmaceutical Activities” and in the “Nomenclature of medical and pharmaceutical specialties”;

2.2.9. Preparation and dynamic improvement of conditions and the list of documents required for admission of the candidate to the certification examination;

2.2.10. Preparation for approval the staff of the Committees by specialties, responsible for preparation and periodic renewal of examination tests and case studies and carrying out the examinations;

2.2.11. Organization of the conduction of certification examinations;

2.2.12. Preparation of the results of licensing examination for approval at the “Council on Granting the State Certificates to the Physicians and Pharmacists” (hereinafter – Council) at the Ministry of Health;

2.2.13. Preparation of the materials for discussion by the Council the issues related to the suspension, resumption or cancellation of certificates;

2.2.14. Keeping of the “State Register of Certified Physicians and Pharmacists”;

2.2.15. Review of the admitted at the Department applications from legal and physical entities and if required timely response within its competences;

2.2.16. Keeping and storage of all documents related to the licensing of institutions and certification of the personnel;

2.2.17. Assurance of the transparency of the process of the licensing of the institutions and certification of the personnel through processing and distribution of the information about them according to the established regulations.

3 Management and structure

3.1. Activities of the Department is managed by the Chairman, appointed or dismissed by the Minister.

3.2. Department consists of the Division of licensing of medical and pharmaceutical activities and Division of certification of medical and pharmaceutical personnel.

3.3. Hiring or firing of the staff of the department is carried out by the Minister based on the recommendations of the Chairman of the department.

3.4. A Head of the Department assigns the functions among the staff and gives the tasks within his/her competencies.

3.5. At the Department operate “Committee on Licensing of Medical and Pharmaceutical Activities” and “Council on Granting the State Certificates to the Physicians and Pharmacists”.

4 Liquidation and reorganization

4.1. Liquidation or reorganization of the Department is carried out in accordance to existing legislation.

5 Final provisions

5.1. Changes or amendments to the given Statute may be made on the basis of the Order of the Minster of Health of the Republic of Azerbaijan.

Annex 1. List of Contacted Individuals

Oqtay Shiraliyev – Minister of Health

Kamala Mekhtiyeva – Head of the Department of Staff, Science and Education of MoH

Rauf Agayev – Deputy Head of the Department of Staff, Science and Education of MoH

Alekper Tagiyev – Head of the Licensing and control division at the Health services organization department of MoH

Leila Almas-zade – Consultant of MoH (licensing & certification), pediatrician of Medical Center “Dialab”

Vafadar Misirov – Representative of State Examination Committee

Annex 2. Lectures presented at informal seminar "Licensing in health system"

On July 20, 2006 the consultant participated at informal seminar and presented lecture "Licensing in health system".

Seminar participated:

R.Agayev – Ministry of Health

L.Almas-zade – Ministry of Health

N.Guliyev – Institute of Paediatrics

B.Agayev – Institute of Clinical Medicine

R.Mammadova – Institute of Genecology and Obstetrics

G.Aliyeva – Association "Family and Society"

A.Hasanov – ACQWIRE (Reproductive health)

J.Mamedov – AIHA

L.Abdullayeva – UMCOR

P.Hauslohner – Abt Associates. Inc

N.Valeeva – International Medical Corps

A.Zoidze – Curatio International Foundation

Since most of seminar participants were representatives of Azerbaijan PowerPoint Presentations had been designed in Russian.

FINAL

AZERBAIJAN
2006 *primeHEALTH* BASELINE SURVEY
INDIVIDUAL QUESTIONNAIRE

1 RAION _____ [ ]

ABSHERON/BAKU = 1, SHEKI = 2, GAKH = 3, ISMAYILLI = 4, AGDASH = 5, QUBA = 6, YASAMAL/BAKU = 7

2 LOCALITY/VILLAGE _____ [ ][ ]

3 TYPE OF LOCALITY (CHECK ONE) URBAN [1] RURAL [2]

4 HOUSEHOLD NUMBER ..... [ ][ ][ ][ ]

5 RESPONDENT'S GIVEN NAME (First name only)_____

6 INTERVIEW RESULTS FROM LAST BOX IN VISIT RECORD:

INTERVIEW COMPLETED	1	RESPONDENT INCAPACITATED	4
PARTIALLY COMPLETED	2	RESPONDENT REFUSED	5
RESPONDENT ABSENT	3	OTHER(SPECIFY)	6 _____

7 DATE FROM LAST BOX IN VISIT RECORD..... [ ][ ] [ ][ ] [2][0][0][6]

DAY MONTH YEAR

8 INTERVIEWERS NAME AND CODE _____ [ ][ ]

VISIT RECORD

	1ST VISIT		2ND VISIT		3RD VISIT	
	MONTH	DAY	MONTH	DAY	MONTH	DAY
DATE OF VISIT						
RESULT (SEE CODES ABOVE)	_____		_____		_____	
INTERVIEWER'S CODE	[ ][ ]		[ ][ ]		[ ][ ]	
SUPERVISOR'S CODE	[ ][ ]		[ ][ ]		[ ][ ]	

PART I. INTERVIEW

SECTION 1: BACKGROUND CHARACTERISTICS AND MEDICAL SERVICES

Nº	QUESTIONS	ANSWERS AND CODES	SKIP
101	INTERVIEWER, RECORD SEX OF THE RESPONDENT WITHOUT ASKING	MALE ..... 1 FEMALE 2	
102	How old are you?	AGE IN YEARS ..... [ ][ ]	
103	What is your marital status? Are you single, living with a partner married, divorced or widowed?	SINGLE ..... 1 LIVING WITH PARTNER, BUT NOT MARRIED ..... 2 CURRENTLY MARRIED ..... 3 DIVORCED / SEPARATED ..... 4 WIDOWED 5	
104	How long have you been living continuously in (NAME OF VILLAGE, TOWN, OR CITY)?	NUMBER OF YEARS ..... [ ][ ] LESS THAN A YEAR 00	
105	What is the highest level of education you have completed?	LEVEL / GRADE /YEAR PRIMARY SCHOOL(1-4 YEARS) ..... 1 [ ][ ] INDEPENDENT SECONDARY SCHOOL(UP TO 9 YEARS) ..... 2 [ ] COMPLETED SECONDARY SCHOOL(UP TO 11 YEARS) ..... 3 [ ] TECHNICAL SCHOOL(PTU) ..... 4 [ ] COLLEGE/TECHNIKUM ..... 5 [ ] INSTITUTE/UNIVERSITY/ASPIRANTURA..... .....6 [ ] NEVER ATTENDED SCHOOL..... ...0 [ ]	
106	What language do you consider to be your native?	Azerbaijani ..... 1 Russian ..... 2 OTHER (SPECIFY) ._____ 3	
107	Can you read a letter, a newspaper or a magazine written in Azerbaijani using the Latin alphabet easily, with difficulty or not at all?	EASILY ..... 1 WITH DIFFICULTY ..... 2 NOT AT ALL 3	
108	Can you read a letter, a newspaper or a magazine written in Azerbaijani using the Cyrillic alphabet easily, with difficulty or not at all?	EASILY ..... 1 WITH DIFFICULTY ..... 2 NOT AT ALL 3	
109	What is your primary occupation? If respondent mentions more than one category, ask them what they spend most of their time doing. If they mention	Self-Employed (SPECIFY) ..... 1 Contract Employee (SPECIFY) ..... 2 State Employee (SPECIFY) ..... 3 Pensioner ..... 4 Housewife ..... 5 Student (university and above) ..... 6 Unemployed ..... 7 Disabled ..... 8 Military ..... 9 Other (SPECIFY)_____ ..... 10 N/A – child and/or dependent 99	

SECTION 2: MEDIA EXPOSURE

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
201	How often do you read a newspaper?	NEVER		0	→205
		AT LEAST ONCE A WEEK		1	
		LESS THAN ONCE A WEEK		2	
		OTHER RESPONSE (SPECIFY)		3	
202	What newspapers do you read regularly?		YES	NO	
		a. AZERBAIJAN	1	0	
		b. ECHO	1	0	
		c. AZADLIG	1	0	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	d. AYNA	1	0	
		e. BAKINSKIY RABOSHIY	1	0	
		f. BIRJA	1	0	
		g. KHALG GAZETI	1	0	
		h. MUKHALIFAT	1	0	
		i. MUSAVAT	1	0	
		j. EXPRESS	1	0	
		k. RESPUBLICA	1	0	
		l. ZERKALO	1	0	
		m. 525	1	0	
		n. FOREIGN NEWSPAPER	1	0	
		o. OTHER_____ (SPECIFY)	1	0	
203	During the past six months have you read health-related articles or messages on newspapers or magazines?	YES		1	
		NO		0	>205
204	What were the health topics or subjects discussed in those articles or messages?		YES	NO	
		a. NOT SURE / DON'T REMEMBER	1	0	
		b. FAMILY PLANNING / CONTRACEPTION	1	0	
		c. HEALTH CARE FOR DIARRHEA	1	0	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE TOPIC IS CITED BUT DON'T READ THE LIST	e. HEALTH CARE FOR ARI	1	0	
		f. CONDOM USE AS STI PREVENTION	1	0	
		g. BENEFITS OF PHYSICAL ACTIVITY	1	0	
		h. ANTI-SMOKING / SMOKING CESSATION	1	0	
		i. DIET AND NUTRITION	1	0	
		j. AVIAN INFLUENZA	1	0	
		K. Advertisement	1	0	
		l. OTHER_____ (SPECIFY)	1	0	
205	How many days a week do you normally listen to the radio?	NUMBER OF DAYS		[ ]	
		LESS THAN ONCE A WEEK		00	
		NEVER LISTENS TO THE RADIO		88	→212
206	Approximately how many hours a day do you listen to the	NUMBER OF HOURS	[ ]	[ ]	

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
	radio?	LESS THAN ONE HOUR ..... 00 LISTENS TO THE RADIO ALL THE TIME 80			
207	What radio stations do you listen to most often? CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE RADIO STATION IS CITED BUT DON'T READ THE LIST		YES	NO	
		a. 1st STATE RADIO CHANNEL	1	0	
		b. ARAZ	1	0	
		c. ANS 102 FM.....	1	0	
		d. Burj FM	1	0	
		e. 104 FM(Radio Space).....	1	0	
		f. 106 FM (Azad Azerbaijan)	1	0	
		g.107 FM (Lider)	1	0	
		h. EUROPE PLUS	1	0	
		i. local.....	1	0	
		j. OTHER _____ (SPECIFY)	1	0	
208	What types of radio programs do you listen to most often? CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE PROGRAM IS CITED BUT DON'T READ THE LIST		YES	NO	
		a. NEWS AND CURRENT EVENTS.....	1	0	
		b. SPORTS	1	0	
		c. RELIGIOUS PROGRAMS.....	1	0	
		d. MUSIC PROGRAMS	1	0	
		e. WOMEN'S PROGRAMS.....	1	0	
		f. HEALTH PROGRAMS.....	1	0	
		g. BUSINESS REPORTS	1	0	
		h. POLITICAL COMMENTARY.....	1	0	
		i. EDUCATIONAL PROGRAMS.....	1	0	
		h. OTHER _____ (SPECIFY)I	1	0	
209	At what times of the day do you usually listen to the radio? CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE TIME IS CITED BUT DON'T READ THE LIST		YES	NO	
		a.6 AM TO 8 AM	1	0	
		b.8 AM TO 10 AM	1	0	
		c.10 AM TO 12 PM	1	0	
		d.12 PM TO 2 PM	1	0	
		e.2 PM TO 4 PM	1	0	
		f.4 PM TO 6 PM	1	0	
		g.6 PM TO 8 PM	1	0	
		h.8 PM TO 10 PM	1	0	
		i. AFTER 10 PM.....	1	0	
		j. AT VARIABLE TIMES.....	1	0	
210	During the past six months have you heard health-related programs or messages on the radio?	YES..... 1 NO..... 0			→ **212**
211	What were the health topics or subjects discussed in those programs or messages?		YES	NO	

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
	programs or messages? CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE TOPIC IS CITED BUT DON'T READ THE LIST	a. NOT SURE / DON'T REMEMBER	1	0	
		b. FAMILY PLANNING / CONTRACEPTION	1	0	
		c. HEALTH CARE FOR DIARRHEA.....	1	0	
		e. HEALTH CARE FOR ARI.....	1	0	
		f. CONDOM USE AS STI PREVENTION	1	0	
		g. BENEFITS OF PHYSICAL ACTIVITY	1	0	
		h. ANTI-SMOKING / SMOKING CESSATION	1	0	
		i. DIET AND NUTRITION	1	0	
		j. AVIAN INFLUENZA……	1	0	
		k. advertising	1	0	
		l. OTHER _____ (SPECIFY)	1	0	
212	How many days a week do you watch television?	NUMBER OF DAYS.....		[ ]	
		LESS THAN ONCE A WEEK.....		00	
		NEVER WATCHES TELEVISION		88	→**301**
213	What TV channels do you watch most often? CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE CHANNEL IS CITED BUT DON'T READ THE LIST		YES	NO	
		a. ITV	1	0	
		b. AZTV 1 (CHANNEL 1)	1	0	
		c. ANS.....	1	0	
		e. SPACE.....	1	0	
		f. Lider TV	1	0	
		g. ATV	1	0	
		h. LOCAL CHANNELS_____ (SPECIFY)	1	0	
		i. RUSSIAN CHANNELS _____ (SPECIFY)	1	0	
		j. TURKISH CHANNELS _____ (SPECIFY)	1	0	
		k. OTHER_____ (SPECIFY)	1	0	

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
214	What types of television programs do you watch most often?		YES	NO	
		a. NEWS AND CURRENT EVENTS.....	1	0	
		b. SPORTS	1	0	
		c. VARIETY SHOWS	1	0	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE PROGRAM IS CITED BUT DON'T READ THE LIST	d. MOVIES / PLAYS	1	0	
		e. SOAP OPERAS.....	1	0	
		f. RELIGIOUS PROGRAMS	1	0	
		g. WOMEN'S PROGRAMS.....	1	0	
		h. HEALTH PROGRAMS.....	1	0	
		i. BUSINESS REPORTS.....	1	0	
		j. POLITICAL COMMENTARY.....	1	0	
		k. CHILDREN'S PROGRAMS.....	1	0	
		l. OTHER _____ (SPECIFY)	1	0	
215	At what times of the day do you usually watch television?		YES	NO	
		6 AM TO 8 AM	1	0	
		8 AM TO 10 AM	1	0	
		10 AM TO 12 PM	1	0	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE TIME IS CITED BUT DON'T READ THE LIST	12 PM TO 2 PM	1	0	
		2 PM TO 4 PM	1	0	
		4 PM TO 6 PM	1	0	
		6 PM TO 8 PM	1	0	
		8 PM TO 10 PM	1	0	
		AFTER 10 PM.....	1	0	
		AT VARIABLE TIMES.....	1	0	
216	During the past six months have you seen health-related programs or spots on TV?	YES..... 1 NO..... 0			→301
217	What were the health topics or subjects discussed in those programs or spots?		YES	NO	
		a. NOT SURE / DON'T REMEMBER	1	0	
		b. FAMILY PLANNING / CONTRACEPTION	1	0	
		c. HEALTH CARE FOR DIARRHEA.....	1	0	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. PROBE IF ONLY ONE TOPIC IS CITED BUT DON'T READ THE LIST	e. HEALTH CARE FOR ARI.....	1	0	
		f. CONDOM USE AS STI PREVENTION	1	0	
		g. BENEFITS OF PHYSICAL ACTIVITY	1	0	
		h. ANTI-SMOKING / SMOKING CESSATION	1	0	
		i. DIET AND NUTRITION	1	0	
		j. AVIAN INFLUENZA.....	1	0	
		k. ADVERTİSEMENT	1	0	
		l. OTHER _____ (SPECIFY)	1	0	

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
218	What are the names of the health programs you have seen on TV during the past six months?		Yes	No	
	CIRCLE ALL MENTIONED SPONTANEOUSLY.	a. SHAFA(ANS)	1	0	
		b. SAHHAT(SPACE)	1	0	
		c. SAGLAM OL(ITV)	1	0	
		d. SAGLAMLIQ (AzTV1)	1	0	
		e. OTHER _____ (SPECIFY)	1	0	

SECTION 3: HEALTH. MEDICAL SERVICES. PERCEPTION OF HEALTH AND BEING HEALTHY.

Nº	QUESTIONS	ANSWERS AND CODES					SKIP
301	Please evaluate the following statements in terms of your agreement or disagreement with them. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree. Do not read "neither agree nor disagree," but circle if respondent spontaneously gives this response.	Strongly Agree	Some-what agree	Neither agree nor dis-agree	Some-what disagree	Strongly disagree	
	a. My family can afford health care/medical services.	4	3	2	1	0	
	b. My health care needs are satisfied by the health care services available to me.	4	3	2	1	0	
	c. Health care providers and medical institutions contrib-ute in important ways to my community's well-being.	4	3	2	1	0	
	d. I trust health providers to give me the medical advice and treatment I need.	4	3	2	1	0	
	e. Health care and medical institutions play a very impor-tant role in the control of infectious diseases in my community.	4	3	2	1	0	
	f. When I need medical care, I am able to get such care free of charge.	4	3	2	1	0	
	g. Overall, I am satisfied with the skills of the health care providers who have treated me.	4	3	2	1	0	
302	When, if ever, did you last visit a medical professional for a routine check-up?	Within the past 12 months.....1 More than 12 months ago .....2 I've never had a routine check-up 3					
303	In general, would you evaluate your health is excellent, very good, good, fair, poor or very poor?	EXCELLENT ..1 VERY GOOD .....2 GOOD .....3 FAIR .....4 POOR .....5 VERY POOR 6					→305 →305 →305
304	In your opinion, who or what plays the most important role in your current state of health? FIRST, CIRCLE ALL MENTIONED SPONTANEOUSLY (IN-CLUDING RECORDING ALL "OTHER" OPTIONS), THEN PROBE: What else? Are there any others?		YES	NO			All skip to Q306
		a. I AM PERSONALLY RESPONSIBLE	1	0			
		b. GENETIC INHERITANCE	1	0			
		c. MY PARENTS	1	0			
		d. THE COMMUNITY I LIVE IN	1	0			
		e. MEDICAL INSTITUTIONS	1	0			
		f. SPORT	1	0			
		g. HEALTHY LIFESTYLE	1	0			

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
		h. QUALITY OF MY LIFE	1	0	
		i. GOVERNMENT	1	0	
		j. OTHER (SPECIFY)	1	0	
305	Who or what is responsible for your fair, poor or very poor health? **FIRST, CIRCLE ALL MENTIONED SPONTANEOUSLY (INCLUDING RECORDING ALL "OTHER" OPTIONS), THEN PROBE: Is there anything else? Anything else?**		YES	NO	
		a. I AM PERSONALLY RESPONSIBLE	1	0	
		b. GENETIC INHERITANCE	1	0	
		c. MY PARENTS	1	0	
		d. THE COMMUNITY I LIVE IN	1	0	
		e. LOW-QUALITY HEALTH SERVICES	1	0	
		f. MY JOB	1	0	
		g. UNHEALTHY LIFESTYLE	1	0	
		h. QUALITY OF MY LIFE	1	0	
		i. POVERTY (inadequate income)	1	0	
		j. GOVERNMENT	1	0	
		k. OTHER (SPECIFY)	1	0	
306	In your opinion, what is the major cause of health problems in _____(district)? **CIRCLE 'L" FOR THE FIRST MENTIONED. THEN ASK, WHAT OTHER FACTORS OR PROBLEMS LEAD TO POOR HEALTH PROBLEMS IN YOUR DISTRICT. CIRCLE '2' FOR ALL OTHER CAUSES MENTIONED. ARE THERE ANY OTHERS?**		1st	2nd ary	NO
		a. INADEQUATE PREVENTION/ CONTROL OF INFECTIOUS DISEASES	1	2	0
		b. INADEQUATE PREVENTION/ CONTROL OF CHRONIC ILLNESSES	1	2	0
		c. ALCOHOL	1	2	0
		d. DRUGS	1	2	0
		e. SMOKING	1	2	0
		f. FINANCIAL INSTABILITY	1	2	0
		g. EMOTIONAL STRESS	1	2	0
		h. POOR ECOLOGICAL ENVIRONMENT	1	2	0
		i. HIGH UNEMPLOYMENT	1	2	0
		j. POOR HEALTH SERVICES	1	2	0
		k. POOR WATER QUALITY	1	2	0
		l. OTHER (SPECIFY)	1	2	0
307	In your opinion, what—if anything—could the government do to help improve the health of people like you? CIRCLE 'l" for the first mentioned. Then ask, what ELSE WOULD IMPROVE YOUR HEALTH? CIRCLE '2' FOR ALL OTHER CAUSES MENTIONED. Are there any others?		1st	2nd ary	**NO**
		a. REDUCE UNEMPLOYMENT	1	2	**0**
		b. IMPROVE WORKING CONDITIONS	1	2	**0**
		c. IMPROVE THE HEALTH CARE SYSTEM	1	2	**0**
		d. PROVIDE FREE HEALTH CARE	1	2	**0**
		e. IMPROVE QUALITY OF PHYSICIANS' SKILLS	1	2	**0**
		e. ENFORCE LAWS TO IMPROVE ROAD SAFETY	1	2	**0**
		f. PROVIDE SPORTS OR EXERCISE FACILTIES	1	2	**0**
		g. REGULATE THE QUALITY OF THE FOOD SUPPLY	1	2	**0**
		i. PROMOTE GOOD HEALTH PRACTICES IN THE MEDIA	1	2	**0**
		j. ENFORCE ANTI-CORRUPTION LAWS	1	2	**0**
		k. NOTHING	1	2	**0**
		k. OTHER (SPECIFY)_____	1	2	**0**

Nº	QUESTIONS	ANSWERS AND CODES			SKIP
308	In your opinion, what could you personally do would help improve your health? CIRCLE 'L" FOR THE FIRST MENTIONED. THEN ASK, WHAT ELSE WOULD IMPROVE YOUR HEALTH? CIRCLE '2' FOR ALL OTHER CAUSES MENTIONED. ARE THERE ANY OTHERS?		1st	2nd ary	NO
		a. FIND A JOB OR A BETTER JOB	1	2	0
		b. LEARN HOW TO PROTECT MY HEALTH	1	2	0
		c. GO TO THE DOCTOR WHEN SICK	1	2	0
		d. QUIT SMOKING	1	2	0
		e. REDUCE ALCOHOL CONSUMPTION	1	2	0
		f. ENGAGE IN SPORTS AND/OR MORE PHYSICAL ACTIVITY	1	2	0
		g. EAT HEALTH-ENHANCING FOODS	1	2	0
		h. REDUCE STRESS IN THE FAMILY	1	2	0
		i. PRAY, FOLLOW RELIGIOUS OR SPIRITUAL PATH	1	2	0
		j. SPEND MORE TIME IN NATURE	1	2	0
		k. NOTHING	1	2	0
		k. OTHER (SPECIFY)	1	2	0
309	What is your major source of medical and health-related information? Probe: Are there any others? DON'T READ, CIRCLE ALL MENTIONED SPONTANEOUSLY		1st	2nd ary	NO
		a. POLYCLINIC/ HOSPITAL/ MEDICAL CENTER	1	2	0
		b. Television	1	2	0
		c. Radio	1	2	0
		d. Newspapers/journals	1	2	0
		e. BOOKS	1	2	0
		f. SPOUSE	1	2	0
		g. FRIENDS/PEERS (INCLUDING SIBLINGS)	1	2	0
		h. A DOCTOR/NURSE I AM ACQUAINTED WITH	1	2	0
		i. OLDER FAMILY MEMBERS	1	2	0
		j. INTERNET	1	2	0
		k. NEVER SEEK HEALTH INFORMATION FROM ANYBODY OR ANYTHING	1	2	0
		l. OTHER (SPECIFY)	1	2	0

Nº	QUESTIONS	ANSWERS AND CODES	SKIP
401.	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. **Can you name all the ways of preventing pregnancy that you have heard of?** *Interviewer: ask "any more"?*		
	A. The Pill *(clarify, whether daily or emergency pills –if emergency pills, go to J)*	YES.....1 NO.....0	
	B. IUD	YES.....1 NO.....0	

Nº	QUESTIONS	ANSWERS AND CODES	SKIP
	C. Condoms	YES.....1 NO.....0	
	D. Spermicides (Foam/Jelly/ Cream/Foamy Tablets, suppositories)	YES.....1 NO.....0	
	E. Injectables (e.g. Depo-Provera)	YES.....1 NO.....0	
	F. Rhythm / Calendar Method	YES.....1 NO.....0	
	G. Withdrawal (Coitus Interruptus)	YES.....1 NO.....0	
	H. LAM or Lactational Amenorrhea Method	YES.....1 NO.....0	
	I. Abortion	YES.....1 NO.....0	
	J. Emergency contraception	YES.....1 NO.....0	
	X. Other methods (SPEC-IFY):…….…… _____	YES (specify)_____ .....1 NO.....0	

NOTE: Q402 will be asked ONLY in SHEKI

402.	Interviewer: review what methods the respondent has heard of (Q401), and ask: ***For the methods you have heard of, can you please tell me how the user uses the method?*** Interviewer: write down <u>everything</u> the respondent says, and ask, "anything else?"	*Office use only*
A **Pill**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
B **IUD**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
C **Condoms**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
D **Spermicides**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
E **Injectables**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
F **Rhythm/ calendar**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9

G **Withdrawal**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
H **LAM/** **breastfeeding**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
I **Abortion**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
J **Emergency Con-** **traception**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9
X **Other** **Spec-** **ify……** **……**		Correct……1 Semi-correct……2 Incorrect……..3 Don't know……..7 Not applicable…..9

If married or ever married GO TO Q404

If SINGLE /never married AND younger than 20 years of age, skip to Q413

403.	*(If single /never married & 20 years of age of older ask)* Have you ever had sexual relations?	YES.....1 NO.....0	**>Q413**
404.	**FOR WOMEN:** How many living children do you have? **FOR MEN:** How many living children do you have?	NUMBER OF CHILDREN	
405.	Would you say you'd like to have a/another child now, wait at least two years, or do not want to have a child/another child?	Now .....1 Two or more years from now.....2 No more children.....3 Don't know/Never thought about it 7	
406.	**WOMEN:** Have you or your husband/partner/sexual partner ever used anything or tried in any way to delay or avoid getting pregnant? **MEN:** Have you or your wife/partner/sexual partner ever used anything or tried in any way to delay or avoid pregnancy?	YES .....1 NO 0	**→Q411**
407.	What have you used or done?	Yes No a. PILL..... 1 0. b. IUD ..... 1 0 c. INJECTABLES…….. 1 0 d. IMPLANTS ..... 1 0 e. CONDOM..... 1 0 f. FEMALE CONDOM ..... 1 0 g. DIAPHRAGM/FOAM/JELLY ..... 1 0 h. LACTATIONAL AMEN. METHOD..... 1 0 i. NATURAL FAMILY PLANNING ..... 1 0 j. WITHDRAWAL..... 1 0 k. EMERGENCY CONTRACEPTIVE..... 1 0 l. ABORTION ..... 1 0 m. OTHER (specify)_____1 0	
408.	**WOMEN:** Are you or your husband/partner/sexual partner currently using any method to delay or avoid getting pregnant? **MEN:** Are you or your wife/partner/sexual partner currently using any method to delay or avoid pregnancy?	YES .....1 NO 0	**→Q411**

409.	What are you currently using to avoid pregnancy?	Yes No a. PILL ..... 1 0 b. IUD ..... 1 0 c. INJECTABLES ..... 1 0 d. CONDOM ..... 1 0 e. ..... 1 0 f. /FOAM/JELLY ..... 1 0 g. LACTATIONAL AMEN. METHOD..... 1 0 h. NATURAL FAMILY PLANNING ..... 1 0 i. WITHDRAWAL..... 1 0 j. EMERGENCY CONTRACEPTIVE ... 1 0 k. ABORTION ..... 1 0 l. OTHER (specify)_____1 0	
410	Before you started using this method, did you and your spouse/sexual partner talk with each other about the choice of contraceptive methods available to space or avoid pregnancies?	YES ..... 1 NO 0	**>Q413** **>Q412**
411	What is the main reason you are not currently using a modern contraceptive method? **(e.g. pills, condoms, IUD)**?	a. Fear of side effects ..... 1 b. Access/availability of re-supply..... 2 c. Cost ..... 3 d. Method difficult to use..... 4 e. Spouse/partner does not approve ..... 5 f. Effectiveness ..... 6 g. Trying to get pregnant ..... 7 h. Currently pregnant/wife pregnant ..... 8 i. Not sexually active..... 9 j. Husband is away (migrant)..... 10 k. Postpartum/breastfeeding ..... 11 l. Infertile..... 12 m. Menopausal ..... 13 n. Not recommended by doctors ..... 14 o. Family members don't approve ..... 15 p. No partner ..... 16 q. Other (specify……..... 17 r. Don't know..... 97 s. Refuses to answer..... 98 t. Not applicable..... 99	
412	Have you ever discussed spacing or avoiding pregnancies with your spouse/sexual partner?	YES ..... 1 NO 0	
413	Who should take a decision about contraception?	ONLY A WOMAN ..... 1 ONLY A MAN ..... 2 BOTH ..... 3 FAMILY MEMBERS……4 DON'T KNOW / NO OPINION..... 7	
414	Among your friends, acquaintances and relatives would you say that most of them, some of them, few of them or none of them use family planning to space or avoid pregnancies?	MOST OF THEM..... 1 SOME OF THEM..... 2 FEW OF THEM ..... 3 NONE OF THEM..... 4 NOT SURE / DON'T KNOW..... 7	

Q. #	QUESTION	CODES	GO TO Q.
Skip to Q422 if not married & younger than 20 years of age OR responded NO to Q403			
415	**WOMEN**: **Have you ever had an induced abortion or mini-abortion (I do not want you to include natural, spontaneous abortions)?** **MEN**: Has your wife/partner had an induced or mini-abortion?	YES ..... 1 NO ..... 0 **Refuses to answer……..8**	**>421**
416	**WOMEN**: How many abortions have you had?	Write number here ☐ Don't know 97 **→421** Not applicable (no abortion) code 99	**→421**
417	**WOMEN**: When did you have the most recent abortion?	_____Year of abortion	

418	**WOMEN**: How much did you pay for the most recent abortion?	_____			
419	**WOMEN**: Following your most recent abortion, did you receive any of the following services:		Yes	No	Not needed
		a. Treatment of complications (sepsis, septic shock, hemorrhaging)	1	0	**9**
		b. Pain management	1	0	**9**
		c. Post-abortion counseling	1	0	
		d. Family planning services	1	0	
		e. Referral other reproductive health services	1	0	
		f. Follow-up visit	1	0	
420	**WOMEN**: What was the main reason that you decided to have an abortion the last time you had an abortion? Were there any other reasons?		1st	2nd	No
	MEN: What was the main reason for your spouse/partner/sexual partner to have an abortion the last time? Were there any other reasons?	a. PREGNANCY WAS LIFE THREATENING	1	2	0
		b. THERE WAS RISK OF BIRTH DEFECTS	1	2	0
		c. SOCIOECONOMIC REASONS	1	2	0
		d. THE WOMAN DID NOT WANT ANY CHILDREN	1	2	0
	FIRST, CIRCLE THE FIRST REASON MENTIONED. IF RESPONDENT LISTS MORE THAN ONE, ASK: WHAT WAS THE PRIMARY REASON?	e. THE MAN DID NOT WANT ANY CHILDREN	1	2	0
		f. THE WOMAN WAS NOT MARRIED/DID NOT HAVE A PARTNER	1	2	0
	THEN, PROBE: WERE THERE ANY OTHER REASONS?	g. OTHER (SPECIFY)	1	2	0
421	What, do you think, a woman should do if pregnancy is unwanted/ unplanned?		Yes	No	
		a. HAVE AN ABORTION	1	0	
		b. GIVE BIRTH AND KEEP THE BABY	1	0	
		c. GIVE BIRTH AND HAVE THE BABY ADOPTED	1	0	
		e. I DON'T KNOW	1	0	
		d. OTHER (SPECIFY)	1	0	
422	Do you agree with the following statement: Abortions are much more harmful than modern contraceptive methods.	YES .....1 NO .....0 DON'T KNOW / NO OPINION.....7			
423	Do you agree with the following statement: Abortions are the best solution to unplanned pregnancies.	YES .....1 NO .....0 DON'T KNOW / NO OPINION.....7			

SAFE MOTHERHOOD

424	In your opinion, what are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman? PROBE: Any others? FIRST, CIRCLE '1' for ALL MENTIONED SPONTANEOUSLY (INCLUDING RECORDING ALL "OTHER" OPTIONS), THEN PROBE: Is there anything else?		Yes	No	
		a.NONE	1	0	
		b.BLEEDING	1	0	
		c.SEVERE HEADACHE	1	0	
		d.BLURRED VISION	1	0	
		e.CONVULSIONS	1	0	
		f.SWOLLEN HANDS/FACE	1	0	
		g.HIGH FEVER	1	0	
		h.LOSS OF CONSCIOUSNESS	1	0	
		i.DIFFICULTY BREATHING	1	0	

		j.SEVERE WEAKNESS	1	0	
		k.SEVERE ABDOMINAL PAIN	1	0	
		l.ACCELERATED/ REDUCED FETAL MOVEMENT	1	0	
		m.WATER BREAKS WITHOUT LABOR	1	0	
		n.OTHER (specify)_____	1	0	
		o.DON'T KNOW	1	0	
425	In your opinion, what are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman? PROBE: Any others? **FIRST, CIRCLE '1' for ALL MENTIONED SPONTANEOUSLY (INCLUDING RECORDING ALL "OTHER" OPTIONS), THEN PROBE: Is there anything else?**		Yes	No	
		a.NONE	1	0	
		b.SEVERE BLEEDING	1	0	
		c.SEVERE HEADACHE	1	0	
		d.CONVULSIONS	1	0	
		e.HIGH FEVER	1	0	
		f.LOSS OF CONSCIOUSNESS	1	0	
		g.LABOR LASTING >12 HOURS	1	0	
		h.PLACENTA NOT DELIVERED 30 MINUTES AFTER BABY	1	0	
		i.OTHER (specify)_____	1	0	
		j.DON'T KNOW	1	0	
426	In your opinion, what are some serious health problems that can occur during the first 2 days after birth that could endanger the life of the woman? PROBE: Any others? **FIRST, CIRCLE '1' for ALL MENTIONED SPONTANEOUSLY (INCLUDING RECORDING ALL "OTHER" OPTIONS), THEN PROBE: Is there anything else?**		Yes	No	
		a.NONE	1	0	
		b.SEVERE BLEEDING	1	0	
		c.SEVERE HEADACHE	1	0	
		d.BLURRED VISION	1	0	
		e.CONVULSIONS	1	0	
		f.SWOLLEN HANDS/FACE	1	0	
		g.HIGH FEVER	1	0	
		h.MALODOROUS VAGINAL DISCHARGE	1	0	
		i.LOSS OF CONSCIOUSNESS	1	0	
		j. IFFICULTY BREATHING	1	0	
		k.SEVERE WEAKNESS	1	0	
		l.OTHER (specify)_____	1	0	
		m.DON'T KNOW	1	0	
427	Now, I would like to ask you a few questions about the health of newborn babies. In your opinion, what are some serious health problems that can occur during the first 7 days after birth that could endanger the life of a newborn baby? PROBE: Any others?	**Yes No**			
		a. DIFFICULT OR FAST BREATHING	**1**	**0**	
		b. YELLOW SKIN/EYE COLOR (JAUNDICE).....	**1**	**0**	
		c. POOR SUCKING OR FEEDING	**1**	**0**	
		d. PUS, BLEEDING, OR DISCHARGE FROM AROUND THE UMBILICAL CORD	**1**	**0**	
		e. BABY VERY SMALL	**1**	**0**	
		f. SKIN LESIONS OR BLISTERS.....	**1**	**0**	
		g. CONVULSIONS/SPASMS/ RIGIDITY	**1**	**0**	
		h. LETHARGY/ UNCONSCIOUSNESS	**1**	**0**	
		i. RED OR SWOLLEN EYES WITH PUS	**1**	**0**	
		j. OTHER _____ **(SPECIFY)**	**1**	**0**	
		k. NONE.....	**1**	**0**	
428	If a child aged 5 or younger has a common case of diarrhea, what should he or she be given?	YES NO			
		a. NOTHING	1	0	

	Probe: anything else? Don't read responses.	b. MORE LIQUIDS THAN NORMAL ..... 1 0 c. REDUCED LIQUIDS..... 1 0 d. MORE SOLID FOODS THAN NORMAL ..... 1 0 e. LESS SOLID FOODS THAN NORMAL..... 1 0 f. A FLUID MADE FROM A SPECIAL PACKET CALLED _____[LOCAL NAME]..... 1 0 g. A PRE-PACKAGED ORS LIQUID ..... 1 0 h. A HOMEMADE, GOVERNMENT-RECOMMENDED SOLUTION WITH WATER & SUGAR..... 1 0 i. ANTIBIOTICS..... 1 0 j. INJECTION..... 1 0 k. (IV) INTRAVENOUS..... 1 0 l. HERBAL MEDICINE..... 1 0 m. OTHER _____..... 1 0 n. DON'T KNOW 1 0	

Sexually Transmitted Illnesses (STIs)

429	Have you heard of any diseases that can be transmitted through sexual intercourse?	YES.....1 NO.....0 DON'T KNOW.....97		>Q432 >Q432	
430	What sexually transmitted diseases have you heard of?	a. SYPHILLIS	1	0	
		b. GONORRHEA	1	0	
		c. CHAMYDIOSIS	1	0	
		d. **Candida/Thrush, "Gobelek"**	1	0	
		e. GENITAL HERPES	1	0	
		f. TRICHOMONIASIS	1	0	
		g. HUMAN PAPILLOMA VIRUS	1	0	
		h. HIV/AIDS	1	0	
		i. OTHER (SPECIFY) _____	1	0	

431	What can one do to avoid contracting sexually transmitted diseases? Do you know of any others?		Yes	No	
		a. USE A CONDOM	1	0	
		b. BE FAITHFUL TO ONE PARTNER	1	0	
		c. REDUCE NUMBER OF SEXUAL PARTNERS	1	0	
		d. ABSTAIN FROM SEX	1	0	
		e. OTHER (SPECIFY) ._____.	1	0	
		f. DON'T KNOW/NOT SURE	1	0	
		g. NOTHING CAN BE DONE.....	1	0	
		h. REFUSED TO ANSWER.....	1	0	
432	Over the past year, have you had any of the following symptoms? READ THE LIST OF SYMPTOMS. THEN ASK: IS THERE ANYTHING ELSE?		Yes	No	
		a. LOWER ABDOMINAL PAIN……	1	0	
		b. GENITAL DISCHARGE/DRIPPING……..	1	0	
		c. FOUL SMELLING DISCHARGE……	1	0	
		d. BURNING PAIN ON URINATION……	1	0	
		e. REDNESS/INFLAMMATION IN GENITAL AREA……	1	0	
		f. SWELLING IN GENITAL AREA……	1	0	
		g. GENITAL SORES/ULCERS……	1	0	
		h. GENITAL WARTS……	1	0	
		i. GENITAL ITCHING……	1	0	
		j. BLOOD IN URINE……	1	0	
		k. LOSS OF WEIGHT……	1	0	
		l. NO SYMPTOMS	1	0	**>Q435**
		m. OTHER (SPECIFY)	1	0	
433	[If yes to any] Did you see a physician or other medical provider about these symptoms?	YES 1			**>Q435**
		NO.....0			
		REFUSED TO ANSWER 98			**>Q435**

434	Why didn't you seek medical care? Probe: anything else?	YES NO **a.** Too expensive ..... 1 0 **b.** Not necessary..... 1 0 **c.** The symptoms went away ..... 1 0 **d.** Embarrassed ..... 1 0 **e.** Don't trust the medical staff ..... 1 0 **f.** Other (specify)_____ . 1 0 **g.** Don't know..... 1 0	
435	Over the past year, have you been diagnosed with a sexually transmitted or venereal disease?	YES .....1 NO.....0 REFUSED TO ANSER.....98	

SECTION 5: Chronic Diseases and Lifestyles

Nº	QUESTIONS	ANSWERS AND CODES	SKIP
501	**Men:** Have you been diagnosed with any type of diabetes, or been told that your blood sugar level is higher than normal? **Women: O**ther than during pregnancy, have you been diagnosed with any type of diabetes, or been told that your blood sugar level is higher than normal?	YES .....1 NO.....0	**>Q503**
502	Now think back to the time before your doctor told you that are diabetic. What symptoms, if any, did you experience that led you to believe there might be something wrong with you?	YES NO A. FREQUENT URINATION ..... 1 0 B. EXCESSIVE THIRST ..... 1 0 C. EXTREME HUNGER ..... 1 0 D. UNUSUAL WEIGHT LOSS ..... 1 0 E. INCREASED FATIGUE ..... 1 0 F. IRRITABILITY ..... 1 0 G. BLURRY VISION..... 1 0 H. NONE 1 0	**All skip to Q504**
503	To what extent do you believe you at risk of becoming diabetic? Would you say your risk is high, moderate, low, or no risk at all?	HIGH RISK.....1 MODERATE RISK .....2 SOME RISK ....3 NO RISK AT ALL 4	
504	What do you think are the reasons that people become diabetic?	Yes / No a. IT IS A HEREDITORY DISEASE ..... 1 0 b. CONSUME A LOT OF SUGAR ..... 1 0 c. UNHEALTHY NUTRITION ..... 1 0 d. STRESS ..... 1 0 e. BEING OVERWEIGHT..... 1 0 f. LACK OF EXERCISE ..... 1 0 g. OTHER (specify)_____ .. 1 0 h. DON'T KNOW/NOT SURE 1 0	
505	<u>If diabetic</u>: What, if anything, do you currently do to control or manage your diabetes? Anything else? <u>If not diabetic</u>: In your opinion, what can you personally do to prevent diabetes? Probe: Is there anything else?	Yes / No a. HAVE BLOOD TESTS REGULARLY..... 1 0 b. REDUCE BODY WEIGHT..... 1 0 c. AVOID STRESS..... 1 0 d. TRY TO EAT NUTRITIOUS FOOD ..... 1 0 e. EXERCISE ..... 1 0 f. OTHER (SPECIFY) _____ ... 1 0 g. NOTHING..... 1 0 h. NOT SURE / DON'T KNOW 1 0	

506	Have you ever had your blood pressure taken by a health care provider?	YES ..... 1 NO 0	
507	Have you been diagnosed with hypertension/high blood pressure?	YES ..... 1 NO 0	**>Q509**
508	To what extent are you at risk for becoming hypertensive? At high risk, at moderate risk, at low risk, or at no risk at all?	HIGH RISK ..... 1 MODERATE RISK..... 2 SOME RISK ....3 NO RISK AT ALL 4	
509	<u>If hypertensive</u>: What, if anything, do you currently do to manage your hypertension? <u>Otherwise</u>: What can you do to prevent hypertension?	Yes No . HAVE BLOOD PRESSURE MEASURED REGULARLY .. 1 0 . REDUCE BODY WEIGHT ..... 1 0 . AVOID STRESS ..... 1 0 . TRY TO EAT NUTRITIOUS FOOD ..... 1 0 . EXERCISE ..... 1 0 . TAKE MEDICATION..... 1 0 . OTHER (SPECIFY) ....._____ .. 1 0 . NOTHING..... ..... 1 0 . NOT SURE / DON'T KNOW 1 0	
510	WOMEN: Have you ever examined your breasts for signs of breast cancer? Has a physician ever examined your breasts? Have you ever had a PAP smear?	Yes No a. Breast self-examination ..... 1 0 b. Breast examination by a doctor…….. 1 0 c. PAP –smear 1 0	
511	On average, how many days a week do you engage in at least 30 minutes of physical activity? (By physical activity we mean manual labor, gardening, farming, vigorous housework or walking, running, bicycling, lifting, or playing games that require you to exert yourself.)	REGULARLY (at least 5 times a week)..... 1 OFTEN (at least 2-3 times a week) ..... 2 SELDOM (at least 2 times a month)..... 3 NEVER or less than once a month..... 4	**→514**
512	What type of physical activity do you engage in on a typical day? **CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST**	**YES NO** a. GARDENING/HOUSEWORK 1 0 b. MANUAL LABOR/FARMING 1 0 c. WALKING 1 0 d. FITNESS/AEROBICS 1 0 e. JOGGING / RUNNING 1 0 f. BICYCLING 1 0 g. SWIMMING 1 0 h. TEAM SPORTS 1 0 i. OTHER (specify)_____ 1 0	
513	Among your friends, acquaintances and relatives would you say that most of them, some of them, few of them or none of them regularly engaged in physical activity that requires them to exert themselves?	MOST OF THEM ..... 1 SOME OF THEM..... 2 FEW OF THEM ..... 3 NONE OF THEM ..... 4 NOT SURE / DON'T KNOW..... 7	
514	When, if ever, did you last have an alcoholic drink?	I HAVE NEVER HAD A DRINK .....1 NOT IN THE PAST YEAR .....2 MORE THAN 30 DAYS AGO, BUT IN THE PAST YEAR .....3 MORE THAN A WEEK AGO, BUT IN THE PAST 30 DAYS.....4	**1 and 2 skip to 519**

		WITHIN THE LAST WEEK.....5			
515	Last month, what was the average number of days per week or per month that you consumed alcoholic beverages?	a. ____days per week b. ____days per month			
516	For the purposes of this questionnaire, we will assume that one drink is the equivalent of one can/bottle of beer, one glass of wine, one shot of vodka or other hard liquor, or one mixed drink. Approximately, what was the average number of drinks you had on the days you consumed alcohol**?**	____#			
517	With respect to alcoholic beverages of any kind, how many times last month did you have more than five drinks at once?	_____# NONE.....0			
518	What are the reasons you drink alcohol?		Yes	No	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	a. TO RELAX OR RELIEVE TENSION….	1	0	
		b. TO GET DRUNK……..	1	0	
		c. TO HAVE A GOOD TIME WITH MY FRIEND AND RELATIVES……..	1	0	
		d. THERE IS NOTHING ELSE TO DO ….	1	0	**ALL SKIP TO Q520**
		e. TO CELEBRATE ……..	1	0	
		f. TO HELP ME GET MY WORK DONE..	1	0	
		g. I LIKE THE TASTE……...	1	0	
		h. AS REWARD FOR WORKING HARD	1	0	
		i. EVERYONE ELSE IS DRINKING …….	1	0	
		j. IT IS THE ONLY ENTERTAINMENT AVAILABLE ……...	1	0	
		k. TO GET AWAY FROM MY PROBLEMS AND TROUBLES	1	0	
	Skip to Question 520	l. OTHER _____ (SPECIFY)	1	0	
519	What are the reasons for you to choose not to drink at all or to limit your drinking?		Yes	No	
	CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	a. DRINKING IS AGAINST MY RELIGION	1	0	
		b. DRINKING IS AGAINST MY VALUES	1	0	
		c. PEOPLE IN MY FAMILY HAD ALCOHOL PROBLEMS……...	1	0	
		d. IT IS TOO EXPENSIVE……...	1	0	
		e. I DON'T LIKE THE TASTE……	1	0	
		f. MY FRIENDS DON'T DRINK…….	1	0	
		g. I DON'T WANT TO DISAPPOINT SOMEONE I CARE ABOUT……..	1	0	
		h. IT IS BAD FOR MY HEALTH…….	1	0	
		i. OTHER _____ (SPECIFY)	1	0	
520	Among your friends, acquaintances and relatives would you say that most of them, some of them, few of them or none of them drink alcohol?	MOST OF THEM.....1 SOME OF THEM.....2 FEW OF THEM .....3 NONE OF THEM.....4 NOT SURE / DON'T KNOW.....7			
521	Do you smoke cigarettes or cigars?	YES 1			

		NO 0	→ 526
522	Over the past month, did you smoke less than once a week, once a week, several days a week, most days or everyday?	Less than once a week.....1 Once a week .....2 Several days a week .....3 Most days .....4 Everyday.....5	
523	On average, how many cigarettes or cigars did you smoke in a day?	NUMBER OF CIGARS / CIGARETTES ..... _____	
524	**FOR SMOKERS**: How old were you when you started smoking?	AGE _____	
525	Have you ever tried to stop smoking?	YES ..... 1 NO 0	
526	**FOR SMOKERS:** In addition to you, how many other people smoke in your household? **FOR NON-SMOKERS:** How many people smoke in your household?	NUMBER OF SMOKERS ..... _____ NOBODY (ELSE) SMOKES 0	
527	**FOR SMOKERS**: Now I'd like to know if you frequently, occasionally, infrequently or never do each of the following:	Never Infreq Occas Freq **a.** Smoke when children are in the room ..... 0 1 2 3 **b.** Smoke when a pregnant woman is in the room..... 0 1 2 3 **c.** Smoke when non-smoking adults are in the room ... 0 1 2 3 **d.** Go outside the house or building to smoke 0 1 2 3	
528	In your opinion, is smoking very harmful, a bit harmful or not harmful at all to smoker's health?	VERY HARMFUL ..... 1 A BIT HARMFUL ..... 2 NOT HARMFUL AT ALL..... 3 NOT SURE / NO OPINION 7	
529	In your opinion, is smoking harmful only to the person who smokes or it is also harmful to the people around the smoker?	ONLY TO THE PERSON WHO SMOKES ..... 1 ALSO TO THE PEOPLE AROUND ..... 2 NOT SURE / NO OPINION 7	
530	Have ever heard the expression "passive" or "second-hand" smoking"?	YES ..... 1 NO ..... 0 NOT SURE / DON'T REMEMBER 7	>532
531	What does the term "passive" or "second-hand" smoke mean to you? **INTERVIEWER** IF RESPONDENT GIVES MORE THAN ONE RESPONSE, SAY: PLEASE GIVE ME ONE DEFINITION. WHAT DO YOU THINK IS THE BEST WAY TO EXPLAIN THE MEANING OF "SECOND-HAND SMOKE"?	SMOKING WHEN PRESSURED BY OTHERS ..... 1 SMOKING INFREQUENTLY..... 2 REDUCING THE NUMBER OF CIGARETTES SMOKED.... 3 NOT INHALING THE SMOKE..... 4 SMOKING ONLY PART OF A CIGARETTE ..... 5 PASSING CIGARETTES TO A FRIEND OR SHARING OTHERS ..... 6 SMOKING WITHOUT ENJOYING IT ..... 7 BEING IN A ROOM /CONFINED AREA WITH SMOKERS .. 8 BREATHING IN THE SMOKE OF OTHERS..... 9 OTHER (specify)_____ ... 10 DON'T KNOW 97	
532	Now I'd like you to tell me which of the following are acceptable and which are unacceptable in your opinion: (DK=neutral, don't know, etc.)	Accept DK Unaccept a. Smoking when children in the room ..... 1 2 3 b. Smoking in a room with other adults ..... 1 2 3 c. Asking smokers to smoke outside..... 1 2 3 d. Smoking in a room when a pregnant woman is present ..... 1 2 3 e. Smoking in a public building……1 2 3	

533	Among your friends, acquaintances and relatives would you say that most of them, some of them, few of them or none of them smoke cigarettes?	MOST OF THEM ..... 1 SOME OF THEM ..... 2 FEW OF THEM ..... 3 NONE OF THEM ..... 4 NOT SURE / DON'T KNOW 97	

			YES	NO
534	In your opinion, what is anemia? CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	a. DEFICIENCY OF IRON IN THE BLOOD....	1	0
		b. INSUFICIENT NUMBER OF RED-BLOOD CELLS	1	0
		c. HAVING TOO MANY WHITE-BLOOD CELLS	1	0
		d. NOT HAVING ENOUGH BLOOD	1	0
		e. OTHER_____ (SPECIFY)	1	0
		f. DON'T KNOW, NOT SURE	1	0
535	What do you think the reasons for iron deficiency or anemia are? CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	a. NOT HAVING THE RIGHT KIND OF DIET	1	0
		b. NOT EATING ENOUGH.....	1	0
		c. SICKNESSES OR INFECTIONS.....	1	0
		d. OTHER_____ (SPECIFY)	1	0
		e. DON'T KNOW	1	0
536	How can you prevent anemia or iron deficiency? CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	**a.** TAKE IRON CONTAINING SUPPLEMENTS	1	0
		b. EAT IRON RICH FOOD	1	0
		c. DON'T KNOW	1	0
		d. OTHER (SPECIFY)	1	0
537	What foods do you think are good to prevent or treat anemia? CIRCLE ALL MENTIONED SPONTANEOUSLY. DON'T READ THE LIST	a. DON'T KNOW / NOT SURE.....	1	0
		b. LIVER	1	0
		c. almonds	1	0
		d. WHOLE WHEAT BREAD / FLAT BREAD (not bread with bleached or white flour).....	1	0
		e. WHEAT GERM	1	0
		f. RAISINS	1	0
		g. SUN FLOWER SEEDS.....	1	0
		h. BEANS OR PEAS	1	0
		i. apples	1	0
		j. GREEN LEAFY VEGETABLES.....	1	0
		k. BEETS	1	0
		l. WATERMELON	1	0
		m. GREEN BEANS.....	1	0
		n.cheese	1	0
		o. DATES / PRUNES.....	1	0
		p. BEEF / PORK / LAMB	1	0

		q. corn.....	1	0
		r. OTHER_____ (SPECIFY)	1	0
538	What are the symptoms of anemia? Probe: Anything else?		YES	NO
		a. Fatigue	1	0
		b. Weakness	1	0
		c. Breathlessness	1	0
		d. Heart palpitations	1	0
		e. Dizziness	1	0
	DO NOT READ THE LIST	f. Headache	1	0
		g. Ringing in the ears	1	0
		h. Difficulty sleeping	1	0
		i. Difficulty concentrating	1	0
		j. Other_____	1	0
		k. Don't know/Unsure	1	0
539	What are the possible consequences of anemia? Probe: Anything else?		YES	NO
		a. Maternal mortality	1	0
		b. Low-birth-weight infants	1	0
	DO NOT READ THE LIST	c. Fatigue	1	0
		d. Decrease in ability to work	1	0
		e. Other (specify)_____	1	0
		f. Don't know/Unsure	1	0
540	Do you use iodized salt in your household?	YES.....1		
	ASK TO SHOW YOU SALT PACKAGE USED IN A HOUSEHOLD AND THEN MARK THE ANSWER	NO 0		
		NOT SURE / DON'T REMEMBER 97		

541	How many times a day or a week do usually eat:	Several times a day	Once a day	Several times a week	Once a week	Less than once a week	Rarely/ Never
	a. FRESH VEGETABLES	5	4	3	2	1	0
	b. FRESH FRUIT	5	4	3	2	1	0
	c. RED MEAT (BEEF, VEAL, LAMB, PORK)	5	4	3	2	1	0
	d. CHICKEN/BIRDS……	5	4	3	2	1	0
	E .FISH……	5	4	3	2	1	0
	d. EGGS……	5	4	3	2	1	0
	e. FULL-FAT MILK, YOGURT, CHEESE	5	4	3	2	1	0
	f. FOOD COOKED WITH ANIMAL FAT (INCLUDING BUTTER)	5	4	3	2	1	0
542	When you are in a car (driving or as a passenger), how often do you use seatbelts? Would you say you use them always, usually, sometimes, rarely, or never?	ALWAYS 1					
		USUALLY 2					
		SOMETIMES 3					
		RARELY 4					
		NEVER 5					

543	How important for one's safety is it to use safety belts? Is it very important, somewhat important, slightly important, or not at all important?	VERY IMPORTANT ..... 1 SOMEWHAT IMPORTANT ..... 2 SLIGHTLY IMPORTANT ..... 3 NOT AT ALL IMPORTANT 4		
544	How often do you usually brush your teeth?	Never ..... 0 Less than once a week ..... 1 Once a week ..... 2 A few times a week ..... 3 At least once a day ..... 4 Don't know 97	_____	
545	How often, if ever, do you typically brush or scrap your tongue?	Never ..... 0 Less than once a week ..... 1 Once a week ..... 2 A few times a week ..... 3 At least once a day ..... 4 Don't know 97	_____	
546	When you brush your teeth, do you always, usually, sometimes, rarely or never see blood on the toothbrush?	ALWAYS ..... 1 USUALLY ..... 2 SOMETIMES ..... 3 RARELY ..... 4 NEVER 5		
547	How important do you think it is to brush your teeth on a daily basis?	VERY IMPORTANT ..... 1 SOMEWHAT IMPORTANT ..... 2 SLIGHTLY IMPORTANT ..... 3 NOT AT ALL IMPORTANT 4		

548	Now I'd like to discuss another topic. Have you heard of an illness known as "avian influenza, avian flu, or bird flu"?	No ..... 0 Yes 1	
549	If you were to compare avian flu to seasonal flu, would you say avian flu is more dangerous, about equally dangerous, or not as dangerous as seasonal flu?	More dangerous ..... 1 Equally dangerous ..... 2 Not as dangerous 3	

550	Please evaluate the following statements in terms of your agreement or disagreement with them. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree. Do not read "neither agree nor disagree," but circle if respondent spontaneously gives this response.	Strongly Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
	a. When I am suffering from seasonal flu-like symptoms, I visit a medical facility / health care institution	[illegible]	[illegible]	2	1	0
	b. If I were suffering from seasonal flu-like symptoms during a time when many birds were dying in my community, I would go to a health facility or clinic for medical advice.	[illegible]	[illegible]	2	1	0
	c. If I saw birds dying in my community, I would know whom to contact to safely remove the birds	[illegible]	[illegible]	2	1	0
	d. I am confident that I myself could safely dispose of dead birds without contacting veterinary authorities.	[illegible]	[illegible]	2	1	0
	e. It is possible that I could get infected with avian flu.	[illegible]	[illegible]	2	1	0
	f. I am confident that I can protect myself and avoid becoming infected with avian flu.	[illegible]	[illegible]	2	1	0
	g. Avian flu is a serious problem in Azerbaijan.	[illegible]	[illegible]	2	1	0

5[illegible]	How can an individual protect himself from contracting avian flu virus? **PROBE:** Any thing else? (Do not read the list.)	**a. KEEP CHILDREN & ELDERLY PEOPLE AWAY FR**	**Yes**	No
				0
			1	0
			1	0
			1	0
			1	0
			1	0
			1	0
			1	0
			1	0
			1	0
			1	0

		OMBIRDS…….. **b. DON'TKEEPBIRDSATHOME……..** **c. COOKINGBIRDSATADEQUATETEMPERATURELEVEL……**		

		… … … … … … … d. PUTONGLOVESORPLASTICBAGWHENHANDLINGSLAUGHTERED BIRDS…… e. ALWAYSWASHHANDSWITHSO			

		APANDWATER……f. PUTONGLOVESORPLASTICBAGANDCOVERNOSEANDMOUTHWHENHANDLIN		

		G LI V E BI R D S … … … … … … … … … . g. PU T O N G L O V E S O R P L A S TI C B A G W H E N H A N D LI N G D E A D BI R D S … … … … … .. … … … h. NE V E R H A N D L E MI		

		GRATORYBIRDS i. OTHE _____ _____ _____ _____ _____ _____ _____ (SPECIFY) j. It's not possible to protect oneself from avian flu k. Don't know		

Study tour of Azerbaijani decision makers delegation to Turkey on Reproductive Health and Family Planning

Ankara – Istanbul, 16-22 April 2006

Participants

1. Malahat Hasanova – Parlament member
2. Musa Guliyev – Parlament member
3. Tarana Tagi-zade – MOH, National coordinator on maternal and Child health
4. Faiza Aliyeva – National Coordinator on RH
5. Səadət Məmmədova – National Coordinator Family Medicine
6. Gulnara Rzayeva – Consutant on RH
7. Samir Abdullayev – MOH, International Ralations Department
8. Leyla Karimova – State Medical University, Head of Obstetrics and Gyneacology Department
9. Nargiz Shamilova – CTO, USAİD, Azerbaijan
10. Kamala Suleymanova – IMC
11. Nabat Mursagulova – Monitoring and Evaluation Consultant, ACQUİRE
12. Akif Hasanov – AP/RS üzrə Məsləhətçi, ACQUİRE
13. Elsevar Agayev –MOH, Deputy of Minister
14. Zemfira Huseynova – NRHO, Training Coordinator

Trip purpose

The main purpose of the trip was to introduce to Azerbaijani decesion makers the success of Turkey in Reproductive Health and Family Planning, especially the field of development and implementation of laws.

Meetings, presentations and discussions at International RH Training Center of MOH of Turkey:

Leading specialists:

Dr. Rifat Koshe – Senior Director of Maternal-Child and Family Planning Department of MOH of Turkey. He works on this position starting from 1997 and he is one of the leading specialists influencing on the process of implementation of amendments in RH and FP in Turkey

Arzu Kosheli - Specialist of the Maternal-Child and Family Planning Department of MOH of Turkey. She has a great experiencece in collaboration with various international and donor organizations.

Dr. Zerrin Baser – Family Doctor, Manager of Law Project financed. The goal of the project was to achieve changes in law through relationships with government and to assure the continuous contraceptive provision in Turkish FP program.

Dr. Hakan Shatiroglu – obstetrician-gyneacologist, professor of Ankara University. Head of Turkish Family Planning Association, Head of Center for Infertility problems

Dr. Dolunay Polat – Consultant -Physiologist, Coordinator of Turkish Pharmaceutical Union's Center for sexual health, training and counseling.

Dr. Levent Chagatay – Family Doctor, Senior Technical Consultant for Engender Health in Asian and African countries

Ibrahim Achikalan - Specialist of the Maternal-Child and Family Planning Department of MOH of Turkey.

Dr. Ayshen Bulut – Head of Mother and Child Heath Department in Istanbul University. Has a great experience in collaboration with donor agencies in RH. She piloted numerous services and models in Turkey.

Dr. Semra Koral – Senior Director of Turkish Family Planning Association. She is crucial person of this foundation in implementation of it's various programs Has a great experience in RH activities in the country.

Mahfuz Guler – Turkish Parliament member. The leader of Population and Development Working Group.

Gaye Erbatur - Turkish Parliament member. The member of Population and Development Working Group.

Yashar Yasher – Head of Family Health and Family Planning Foundation. This foundation played an exceptional role in rolling out of sustainable social marketing activities in Turkey. This foundation is a main agency in developing intersectoral dialogues.

Presentations:
LEGISLATION AND RH AND FP POLICY

Rifat Koshe

- **Introduction of Turkish RH program**
  - History
  - Coordination of RH and FP in Turkey

Rifat Koshe

- **Legislation and legislative environment**
  - National strategy on RH and FP
  - Activities in legislative system to assure of accessibility and variety of contraceptive commodities
  - Addressing medical and social problems emerged during service provision
  - "Informed choice" as legislative basement

- Factors ensuring success

Arzu Koseli

- **Role of NGO-s in RH Program In Turkey**
  - Legislative changes in 1980-es
  - Efforts in development and implementation of National Strategy on RH/FP
  - Application of new pilot models

Zerrin Basher

- How to achieve collaboration with high-level authorities (KIDOG Experience – Women Support Group)

Hakan Satiroglu

- **Low and decision making process in Turkish RH Program**
  - IPPF and international relations
  - Collaboration with Parliament
  - Factors ensuring success

CONTINIOUS PROVISION OF CONTRACEPTIVES

Zerrin Basher

- **Continuous provision of contraceptives in Turkey (1)**
  - **Progress in Continuous provision of contraceptives in Turkey**

Ibrahim Ajikalan

- **Continuous provision of contraceptives in Turkey (2)**
  - How to achieve the diversity of used methods
  - Forecasting for contraceptive
  - Prioritizing RH/FP services in process of financing and recourse allocation

Rifat Oktem

- **Role of state and private sectors**
  - Market segmentation
  - Market conditions for provision of services and commodities by private sector

Zerrin Basher

- **Social marketing of contraceptives**

Mahfuz Guller, Gaye Erbatur, Semra Coral

- **Turkish Parliament and RH/FP issues**

Tunga Tuzer

- **UNFPA activities in RH/FP**

ON JOB TRAININGS

Burgju Ajikalan

- **Management of on job trainings**
  - Development and use of national protocols on RH/FP
  - Legal frame for undergraduate and on-job trainings
  - Increase number of medical providers providing RH/FP services
  - Licensure and certification

Levent Chagatay, Chigdem Bulut

- Informed choice
- FP after abortion and delivery

Ayshen Bulut

- Support of Turkish Universities in RH/FP program

Yasher Yashar, Nurjhan Muftuoglu

- Social marketing and other activities of Turkish Family Health and Planning Foundation

Visits:

International training center of Reproductive Health of Ministry of Health
Maternal-Child health and FP center #9
Maternity
Training center on Sexual Health
Turkish Family Planning association
Zekai Tahir Burak Woman Health and Research Center
Maternal and Child health department of Istanbul University
Turkish Family Health and Planning Foundation

FINAL REPORT

"Strengthening Primary Health Care in Azerbaijan"
A conference organized by the Ministry of Health of the Republic of Azerbaijan and the USAID Primary Health Care Strengthening Project, presented at the Ministry of Health of the Republic of Azerbaijan,

February 15, 2006

On 15 February 2006, the Ministry of Health of the Republic of Azerbaijan (MOH) and the USAID Primary Health Care Strengthening Project (PHC Strengthening) presented a one-day conference on "Strengthening Primary Health Care in Azerbaijan." The conference was held at the MOH with the plenary sessions in the MOH's main conference hall. The Minister of Health, Dr. Oqtay Shiraliyev, and the United States Ambassador to Azerbaijan, the Honorable Reno Harnish, each spoke to an invited audience of more than 60 representatives from the MOH, other ministries of the Government of Azerbaijan (GoAZ), the parliament, USAID, other international donors, and both international and national NGOs.

The conference consisted of three plenary sessions, two general and two technical presentations, a working lunch, and two working group sessions on issues in primary health care reform and health financing reform, respectively. More than 30 persons took part in the working group discussions, each of which lasted nearly two hours.

The conference was organized with several broad objectives in mind, each of which was accomplished with great success:

1. Commitment to Health Reform by the new Ministry of Health

The conference helped significantly to publicize and underscore before a broad domestic and international audience the profound commitment to health reform that the new Minister of Health, Dr. Oqtay Shiraliyev and his deputies and staff have shown since Dr. Shiraliyev's appointment on 20 October 2005. Persuading health professionals and other sectors in Azerbaijan that the new Ministry is both determined and competent to undertake effective, far-reaching changes in health policy is essential in order to generate the support needed from other sectors, including increased financial support.

2. PHC Strengthening Project Identity

The conference helped to establish a clear, concise identity of the PHC Strengthening Project in the minds of the Minister of Health and his deputies and staff and among other governmental and non-governmental organizations in Azerbaijan, both (1) as a

partnership of four different organizations led by IMC, and (2) as a technical assistance project. Clear principles also were articulated: that the Project will work only in close collaboration with the MOH and GoAZ and in support of their goals. Establishing the Project's identity and principles clearly in the minds of the MOH and GoAZ is essential in order to secure the government's shared "ownership" of the Project's activities in support of health reform in Azerbaijan.

3. Promoting a National Health Policy Debate

The conference helped to stimulate, broaden, and deepen a growing debate over health policy reform in Azerbaijan among a large audience representing a broad, high-level cross-section of policymakers, health policy experts, and international donors and partners. It will, of course, require several years before there is a broad, sophisticated, multi-sectoral consensus in Azerbaijan with respect both to a vision of health sector reform and a practical strategy for realizing that vision. This conference played a small but important role in fostering that consensus by exposing a significant number of potentially influential experts and policymakers persons to ideas and possibilities they had not previously considered in detail.

4. Facilitating and Supporting Health Policy Reform

The conference helped to crystallize and underscore the need for the establishment of high-level working groups on health financing and health systems restructuring/primary care reform, respectively; and it helped to identify specific individuals who may be able to contribute directly to the work of these groups.

The formation of these two working groups is essential if the process of health policy reform is to be advanced effectively, for such groups are needed to serve as venues (1) for discussing and debating both general principles and various technical aspects of health reform and (2) for developing concretely the numerous, complex technical components of reform that are required to fundamentally reform the health financing system, and to bring about the institutional and policy restructuring needed to strengthen primary care services. Before the conference, these working groups were no more than a vague idea in the minds of the Minister of Health and his deputies. Presently, after the conference, these working groups have become a well-defined, formal policy proposal which the Minister of Health is considering. Official establishment of these working groups by the Minister will help significantly to broaden and accelerate the deliberative process that is an essential condition of effective reform.

5. Attachments

A. Agenda
B. Working Groups Summaries
C. Participant List

Afternoon Session on Primary Health Care

Objectives:

- Review of the main constrains of the existing PHC system
- Who should lead the reform process and main tasks of the leading group
- Discuss critical elements of the national PHC concept
- Discuss the process of National PHC concept development

Participants: total 19 people (MOH-7, INGOs- 7, private sector -1, Gov rep-2, Donor organizations-2)

Main outcomes of discussion:

1. Review of the main constrains of the existing PHC system:

Conclusion:

- Low health status of Azerbaijani population
- Low financial allocation for the health sector in general and very low for PHC
- High out-of-pocket payment for health
- Financial and geographic barriers for access health care
- Low quality of care (providers skills, poor infrastructure, equipment, and low patient's satisfaction)
- Lack of population awareness about health problems

2. Who should lead the reform process and main tasks of the leading group:

MOH should lead the process and take overall responsibility for mobilizing internal resources, organizing, structuring and implementing proposed health care reforms including PHC strengthening and health care financing.

It is important that MOH establish special PHC Working Group (PHC WG) and provide official recognition of this group

The critical tasks of the PHC WG will be (1) elaboration of the National PHC Concept and (2) Development of the Strategic PHC reform implementation plan

3. Discuss critical elements of the national PHC concept

National PHC Concept should present a new PHC model which will ensure equity, accessibility, efficiency, and cost effectiveness.

Key elements of the National PHC Concept:

- What services will be included at the PHC level
- Where these services will be provided
- Who will provide the identified services
- Referral system
- Legal status of PHC providers and PHC system

- Models of PHC system: Family Doctor, General Practitioner, and Group Practice, or combination of different models

4. Discuss the process of National PHC concept development

PHC WG needs to implement the following tasks in elaboration of the National PHC concept

- Evaluation and analysis of the past PHC reforms projects in Azerbaijan (WB/UNICEF, IMC, etc.)
- Evaluation and analysis of successful PHC reforms in NIS and Western countries (models of the Family Doctor, General Practitioner, and Group Practice, or combination of different models

PHC WG needs to carry out the following activities to complete the:

- Evaluation and analysis of the past PHC reform project in Azerbaijan:
    - Field visits to the project sides
    - Familiarize with project reports
    - Prepare evaluation report
    - Workshop/seminars to discuss evaluation

Note: Short term goal – leas than 12 months

- Evaluation and analysis of the past PHC reform in NIS and Western countries:
    - Study tours
    - Information sources (reports, studies, researches, etc)
    - Invitation the PHC reforms best practices representatives
    - Workshop/seminars, conferences

Note: Short term goal – leas than 12 months

- International consultancy for drafting National PHC
- Coordination with Health Financing WG
    - Joint meetings
    - Joint seminars/workshop

Note: Along with national concept development

HEALTH FINANCING WORKING GROUP MEETING

MAJOR ISSUES RAISED

1. **Problems identified**
   - lack of health economists
   - lack of financial management skills at health facilities
   - unknown costs of health services
   - SHI is not able to cover all costs

2. **Solutions proposed**
   - introduction of social health insurance probably starting from the government employees
   - establishment of a separate fund for SHI
   - financing targeted health programs for poor
   - provider payment: per capita or per service provided
   - optimization of current public health expenditures
   - increasing the responsibility of health facility heads for their expenditures
   - allocation for health sector from the State Oil Fund
   - identification of the benefit package financed by state
   - creation of a Health Policy unit at MOH
   - privatization and restructuring of state health facilities
   - spending the revenues from privatization on health
   - insurance for catastrophic events
   - personal health accounts
   - adoption of the special program for rural healthcare
   - involvement of rural communities into financing their own health care
   - shifting the expenditures from the hospitals to PHC
   - providing health facilities with the financial autonomy
   - financing health services not health facilities
   - considering the balance between the quality and scope of and access to the services to be financed by state

Trip Report

Workshop on Health Care Management in Tbilisi

May 16-18, 2006

Natik Umarov

Consultant

Abt Associates Inc.

Scope of Work

1. Observe, participate in, and evaluate workshop. Review and assess relevance and usefulness of curriculum, materials and hand outs for possible application to PHC Strengthening project in Azerbaijan. Obtain (if possible) electronic version of lectures and all other relevant materials.

2. Collect information on PHC Reforms in Georgia. Identify appropriate individuals or institutions to contact, as well as other sources of information on Georgian reforms.

3. Build working relationship with other Azerbaijan participants, who are representatives from three of the project's pilot districts; assist the other participants (if necessary) to better understand the course content. Inform the other participants about the PHC Strengthening Project and its support of the MOH-World Bank project.

4. Collect information about the health situation in Sheki, Gakh, and Ismaylli from the other Azerbaijani participants, which may be relevant to the institution of PHC reforms in those districts.

Deliverable:

short trip report (4-5 pp), describing briefly the course and other activities in Tbilisi; and providing initial assessments on the following:

a) scope and effectiveness of the workshop, including materials;
b) content and effectiveness of PHC reforms in Georgia;
c) training, experience and attitudes toward reform of other participants from Azerbaijan;
d) health situations in Sheki, Gakh and Ismaylli districts.

A. Scope and effectiveness of the workshop.

Workshop was organized well and topics (see attached summary of topics introduces during the workshop) were introduced by lecturers who are experienced in Georgian Health Care planning and management. Teachers were representing institutions such as:

- Public Health cathedra of Georgian State Medical University;
- Constant Foundation which implements financial analysis and planning;
- State Foundation of social insurance;
- Department of continuous professional education of Tbilisi Central Children Hospital.

Materials for the workshop were developed under USAID funding based on AIHA collaboration with different US universities incorporating Georgian experience in health care management after reforms of health care services in Georgia started.
During the workshop several topics that are important for health care management in PHC facilities were introduced:

- International review of modern development tendencies and directions of Primary Health Care services. This topic described some crucial changes in the view of role PHC services play in overall health care concept since important WHO documents such as Alma-Ata Declaration, Ljubljana charter, HFA were endorsed.
- Trends in health status of population in Azerbaijan and Georgia over the past 10-15 years were reviewed.
- Topic of management of human resources in health care introduced major principles in modern human resources management concept analyzing peculiarities of work with health care personnel in primary health care.
- Next lecture introduced basics of health care planning and financing with exercise helping make simplified calculation of expected financial expenditures over one year time for small physiotherapeutic department in PHC facility.
- Also peculiarities of interrelations between PHC facilities and different institutions financing PHC services were discussed.
- Knowledge on application of information management in the process of services quality improvement followed by introduction of Information management systems. System that is being used for electronic registration of hospital patients was introduced to the participants.
- Types of communication between physician – nurse – patient was discussed and role of effective communication was emphasized with practical examples.
- Following topics related to peculiarities of working with children, role of PHC doctor in patients' hospitalization, continuity of care, interrelations and communication between PHC and hospital doctors.

Electronic version of all the lectures was obtained. Each participant was given a hand out book in Russian which included lectures/presentations made during the workshop as well as some additional materials on topics introduced (electronic version was not available). While language of presentations were quite easy to understand by participants who is not familiar with health care management, additional materials especially those regarding to

management of information on health care expressed in a bit sophisticated language that can be partly due to complexity of translation from English. That's the reason why having English version might be helpful too.
In general topics introduced during the workshop would be very useful for PHC managers in PHC strengthening project pilot districts since they describe well major trends and principles of PHC management in changed environment. Moreover, materials of this workshop can be incorporated with those conducted last year on "Problems in PHC health care management in modern conditions"(electronic version of all related materials was obtained). Reforms in Primary Health Care in Azerbaijan will require good management skills to organize and manage the services in a way to ensure high quality of services. All participants including those from PHC pilot districts found the workshop useful emphasizing the challenges and opportunities while implementing Primary Health Care reforms.

B. Content and effectiveness of PHC reforms in Georgia

Information on Health care reforms in Georgia was gathered from lecturers and participants of the course and Curatio International Foundation. Health care reforms in Georgia started in 1995. In 1999, the Ministry of Health joined with the Ministry of Social Welfare to become what has been named, from 2000, the **Ministry of Labour, Health and Social Affairs** (MoLHSA). It is responsible for the development and implementation of government policy on health care and medical research. Its social welfare responsibilities include distribution of pensions and provision of care for the disabled, elderly and other vulnerable groups. Under the 1995 reforms, restated in the 2000–2009 health programme, the Ministry has changed its emphasis from implementation of health care to support for preventive activities, as well as regulation and accreditation of health services and training. It directly funds a range of preventive health services, such as the national vaccination programme.
State Commission for Regulating Social Policy: The Committee, set up as part of the 2000–2009 Strategic Health Plan of Georgia, is intended to play a role in coordination at the highest level of national health activities. The committee, which is supposed to be made up of representatives from different sectors of government and business, was designed to look at the roles of different
sectors that influence health issues and activities and to monitor how the responsibilities of these sectors are carried out.
The National Health Management Centre, which reports to the MoLHSA, provides scientific and technical advice to the MoLHSA for the health reform process.
Regional health departments (RHDs): Reporting to the MoLHSA are the 12 regional health departments that were set up in 1995. These departments were developed as part of the process to decentralize the health system. Each administers a regional health fund to which municipalities in the region contribute. In the 10-year period beginning in 2000, their responsibility will be to develop regional health plans
in line with the national health plan and to monitor local activities. The role of the RHDs is, however, currently somewhat limited by the MoLHSA.
Regional health committees: The concept of regional health committees was established under the Strategic Health Plan for Georgia for 2000–2009. These committees

are intended to be made up of people from the region who represent different sectors that influence health. They should report directly to the State Commission for the Regulation of Social Policy, as well as to the regional health administration in their area, and are also intended to communicate with other health related sectors. However, as noted earlier in relation to the State level health committee, this structure is not yet functioning adequately.

Regional Commission for Regulating Social Processes: The concept of the creation of regional commissions was based on the strategic health plan. The commissions are to be formed with the representatives of the region and should represent various sectors linked to health sector.

Municipalities: There are 65 municipalities in Georgia. Each municipality administers a municipal health fund (MHF). Money from the fund is channeled to the regional health fund on a per person basis. The municipalities must support five compulsory municipal health programmes.

Health care providers: The decentralization contained in the 1995 reform programme and subsequent developments made most health care providers financially and managerially autonomous from MoLHSA control. Now nominally independent from the state, they are responsible for administering their own affairs under contract with the SMIC or the municipalities. Contracts are made with municipalities for the municipal programmes, with the MoLHSA for the state health and prevention programmes, or with SMIC for programmes

covered under the national health insurance programme. In addition, a large number of polyclinics and hospitals have recently been privatized, as have nearly all dental clinics and pharmacies.

Health care training institutes: Prior to independence the Tbilisi State Medical University was the only institution in Georgia providing higher medical education. The current day Medical Academy, which today provides part of the Georgian postgraduate residency programmes, was previously the Institute of Retraining. As the Institute of Retraining under the former Soviet system, it provided periodic retraining of physicians as required by the law at that time.

Since independence, however, over 50 new medical training institutions have opened. Unsurprisingly, this vast expansion of training facilities contains many of dubious quality, creating a major challenge for policy-makers.

State Medical Insurance Company (SMIC): The SMIC is responsible for running the state health insurance programme. The national headquarters of SMIC is in Tbilisi, but it also has twelve regional branches. It was established in 1997. It is rather a special type of state organization, designed to administer the financing of the state compulsory medical insurance programmes.

It is fully publicly owned, has no shares and is a non-profit venture. It collects mandatory health premiums from the population and employers and finances the Basic Benefits Package through contracts with health care providers.

Private health insurance companies: Seven private health insurance companies exist in Georgia in 2001, in response to new legislation permitting their establishment. The market is relatively undeveloped, and few people have taken out policies due to the relatively high price of the premiums and low purchasing power of the population.

To run the social insurance programme, a **State Health Fund**, was created in 1995. Its sources of revenue were a mandatory payroll tax together with central budget transfers. In 1996, it was replaced by the State Medical Insurance Company (SMIC). The SMIC funds are collected from employees and employers, with employers contributing 3% and employees 1% of salary.

Contributions for the unemployed, pensioners, and children are covered by transfers from general government revenues. The municipal health funds receive revenues from municipal budgets.

Contributions to the health funds are a flat rate per person, depending on the number of people living in the municipality, but they must be at least 2.5 GeL (in 2000). The municipalities are, however, permitted to increase this sum if their budgets allow. In 1997, because of the variations in the economic situations of the municipalities, it was decided to pool municipal funds to create regional funds that permit risk sharing between them. The regional health funds became effective in 1999. The funds gathered at the regional level in the regional health funds are then redistributed back to the municipalities for funding the portion of the basic benefit package (BBP) that falls under municipal responsibility. The expected results of spreading the risk through the regional health funds through pooling, increasing local contributions and increasing local level input into programme design have, however, not yet been seen. For all health care services not provided under the BBP, direct fees-for-service must be paid. Under the health reforms, payments for services not in the BBP were legalized and co-payments for some BBP services formalized. Today, both legal and informal fees-for-service make up a large part of the health system financing.

Initially the BBP consisted of nine federal (state) and five compulsory municipal health programmes. Since then, this package has gradually expanded to 28 federal and 8 municipal programmes. The expansion was, however, not accompanied by a corresponding increase in funding.

The BBP is administered by the three different administrations of the MoLHSA, the SMIC and the municipal health funds. The MoLHSA, administers a number of public health programmes, such as immunization, while others, such as treatment of cancer patients, are administered through the SMIC. The SMIC has taken on an increasing number of programmes from the MoLHSA throughout the reform process. The municipal health funds cover health services, such as emergency health service provision. Under the BBP concept, all services included in the BPP list are either free or partially subsidized. In general, programmes under the BPP that are financed and run by the municipal health authorities require some form of co-payment, while those funded through the central government budget do not.

While the programmes outlined under the BBP appear to be wide-ranging, what is covered in programmes is fairly limited. Condition, socioeconomic status or age determines eligibility for treatment. For example, free prenatal care covers only four antenatal visits after the third month of pregnancy and delivery, with two possible additional visits requiring some co-payment. The way the somewhat complex BBP is designed in Georgia requires an understanding by the patient of which services are free, which require copayment and how much, and which require full costs to be paid. At least one survey has highlighted that the population is inadequately informed about their rights to certain free or subsidized services. Complementary sources of finance in Georgia

include direct formal payments by patients for health services not covered by the BBP or for those services under the BBP which include a co-payment. Informal charges for health care also make up a large part of the complementary source of finance.
As a result of the low state funding of the health system, direct out-of pocket payments now account for most health expenditure in Georgia. According to the World Bank, in 1999 only about 22% of all health care expenditure came from state or municipal budgets or insurance funds.
The primary health care (PHC) structure currently in place in Georgia is essentially that inherited from the Soviet era. Although it was generally hospital-oriented, it did create a large network of primary care units in rural and urban areas. However, these units were generally staffed by subspecialists, and an integrated model of family medicine did not exist. The primary care system currently faces financial constraints and is poorly attended. As part of the health reforms, the MoLHSA is trying to strengthen primary care provision. A number of pilot programmes to develop family medicine has been started with the support of international organizations.
Although there is a plethora of structures, the PHC system is currently poorly utilized. Many facilities see few patients each day. As the referral process has nearly ceased to function in many areas, many patients bypass the primary care level altogether and see specialists at higher levels directly. There are low expectations among the public and also an inability to afford out-of-pocket payments that are often requested. The related under-financing of the facilities also contributes to the under-use. Many facilities are short of very basic equipment such as thermometers and sterilizers. Primary health care facilities are now free-standing independent legal entities. They provide state, SMIC and municipality health programmes (which should be free or with a co-payment requirement), in addition to providing feefor- service activities. Polyclinics are generally paid on a capitation basis by the public purchasers (SMIC, MoLHSA) for the care covered by the state and municipal programmes. Staff in primary care facilities in sparsely populated remote or mountainous regions receive a higher reimbursement from the SMIC and the municipalities for services performed. A portion of any profits generated
from official fees paid by patients should be transferred to the state budget. However, such transfers are rare and, more often, the state is in debt to thenproviders due to late payment for health-care activities undertaken.
Family Medicine: A Society of General Practitioners and Family Medicine was established in December 1995. Georgia was one of the first countries in the former Soviet Union to recognize family medicine as a specialty in 1998, and a licensing exam for primary care specialists was introduced in 1999. A department of primary care was established within the MoLHSA in 2000. In 2001, this was merged with Public Health Department. Under the new national health strategy, it is intended that primary health care be given additional emphasis, and it is planned that resources will be shifted from the hospital sector. The strategy set targets to establish national and regional centres for family medicine by 2003, financing mechanisms by 2005 and completion of a national network of primary care centres staffed by trained primary care teams by 2008.
Sixteen family medicine trainers and 48 family medicine specialists have been trained under the Family Physicians Training programme since it began in 1997, funded by the United Kingdom Department for InternationalDevelopment (DFID). Under a second

DFID Project, a further cohort of family medicine specialist trainers, as well as specialist trainers of primary care nursing and
management, are being trained. The establishment of five family medicine demonstration sites, including a National Family Medicine Training Centre, is also being funded under the initiative. A rural primary care development is funded by United States Agency for International Development (USAID) and implemented by the American International Health Alliance (AIHA) and International Medical Corps (IMC) programme. A second AIHA programme is training health system managers. The British nongovernmental organization, OXFAM, is also supporting a pilot primary health care project in both urban and rural areas. Although the final model that will be used is not yet finalized.

Ambulatories: These are the frontline of PHC in the rural areas and usually serve a catchment of about 1000 people. They provide only outpatient care and have been traditionally staffed by around four to five part or full-time medical staff. The staff are usually "generalists", paediatricians, gynaecologists, surgeons and dentists. In 1999, there were 683 such centres in Georgia.

Polyclinics: The adult polyclinic provides outpatient care and was originally designed to cover
10 000 adults (defined as those over 15 years old). They are staffed by both generalist physicians and usually at least 10 part-time specialists, typically employing between 30 and 60 staff overall. The clinics thus provide both primary care and specialty care under one roof.

Children's polyclinics: Children's polyclinics provide basic and some specialized services to children up to the age of 15 years. They are located in both rural and urban areas and have outpatient facilities. Services include immunization and home visiting of new-borns. When the clinics were built, they were intended to cover a catchment of 10 000 children under 15 years of
age. The clinics mainly employ paediatricians but, depending on the size of the catchment and funds available, may also have a minimum of nine part- or full-time specialists.

Women's consultation clinics: Women's consultation clinics provide antenatal, gynaecological and obstetric care to women on an outpatient basis. Abortions are also undertaken at the clinics. The clinics are usually staffed by at least five staff, including obstetricians, gynaecologists and nurses. The clinics are located in urban areas, though clinic staff should carry outreach programmes into the communities using ambulatory facilities.

Private PHC centres: These centres, based mainly in the urban areas, are staffed by family doctors and offer fee-for-service primary care. Diagnostic and emergency services are provided in some. Several private clinics/companies (four organizations) have been providing pre-paid health plans. They pioneered family doctor practices and case management in Georgia.

Family planning services: These are provided mainly by the hospitals (obstetric/gynaecological wards), women's consultation clinics and maternity wards. However, not all women's primary care facilities offer family planning services.

Through the health reform programme, the government has tried to reduce excess capacity; however, while bed numbers have dropped substantially, they remain unaffordable for most people, and occupancy rates remain low. The referral system to

secondary and tertiary care has effectively ceased for most conditions, and many of those who can afford it bypass primary care altogether. Low incomes of health staff are compounded by the lack of financing, poorly maintained hospital buildings and inadequate funds for new investment.

The recent reforms made hospitals responsible for generating all running costs through fee-for-service charges and through contracts with public purchasers. It was envisaged that unprofitable hospitals would go out of business. However, it soon became clear that while capacity did fall with the closure of some hospitals and reductions in staffing, the reforms failed to reduce capacity at the expected rate. Moreover, professional incomes have fallen disproportionately as a result of the reforms, because facilities failed to reduce staff in line with falling income. For these reasons, Georgia developed a plan in 1999 to rationalize the hospital sector. This identified which hospitals should remain open and which should be closed down or privatized. The plan also identified the need to use funds so liberated from asset sales to be reinvested in the health sector. The hospital sector, like the primary care sector, is facing problems in maintaining facilities and providing equipment. Health care facilities in Georgia are largely old, costly, and costly to maintain, due to high utility expenses.

Social care and health programmes were administered and funded separately. Social care programmes in Georgia are facing pressure on two fronts: large numbers of people requesting assistance and inadequate resources available to carry out programmes of care. At the local level, social welfare services are provided by both the health sector (hospitals and ambulatories) and by the social sector through day-care and residential centres.

The government recognizes that there is a clear over-provision of medical personnel, particularly at the secondary and tertiary care levels. However, a decision was made to leave market forces, subject to certain regulations, to reduce the over-supply of personnel. Payment of doctors on a fee-per-service basis (rather than salaries), introduced under the health reforms, either under the BBP or for other services, was intended to reduce staff numbers.

All pharmaceuticals, with the exception of those supplied free or with some co-payment required under the BBP, public health or municipal programmes, must be purchased directly by patients.

Physician reimbursement is different in hospitals and polyclinics. In hospitals, physicians are mainly paid on a fee-for-service basis. In polyclinics, physicians are paid on both a fee-for-service basis for some services and a capitation basis for others. As noted earlier, physicians working in primary care facilities in sparely populated remote regions receive higher rates for services provided to the population.

Licensing of physicians and nurses and accreditation of health facilities was introduced although the rules for licensing was recently simplified.

Since 1999 there is list of essential drugs for Georgia.

When reforms planned major directions planned were:

- create the legal basis for the new health
- care system
- decentralize the health care system
- management
- move to programme based financing
- prioritize primary health care

- reform the “sanitary-epidemiological
- service” move to a system based upon health insurance
- ensure social security for employees of the
- health care sector
- reform pharmaceutical policy
- support privatization
- accredit and license medical institutions and
- personnel
- reform medical education
- reform medical science
- reform the health information system

Despite achievements reforms in Georgia did not achieve yet fully its objectives. There are few reasons to my opinion although comprehensive evaluation was not carried yet. One of the reasons is that scarce funds for health care that results in wide list of co-payments and fee for services as well as informal payments.
Large number of specialists and hospital nets. Despite reductions in hospital staff number of doctors working in hospitals is quite high. Patients can visit specialists and hospitals without any referral.
Despite the fact that Family Medicine was recognized as a specialty, there are not enough family doctors trained and practice as a real family doctor will take much more time. In fact while financing of health care changed and providers became comparably independent, structure of health care services left as unchanged currently. Some further steps are going to be implemented. As I was told by participants family practice is going to be implemented in whole Tbilisi starting from the next year. Also capitation fees being increased in favour of children under 3 years and adults over 65.

C. Training, experience and attitudes toward reform of other participants from Azerbaijan

Participants from the pilot districts took an active part in training. Topics were interesting and useful and participants asked questions and participated in discussions as well. Despite, doctors from the pilot districts did not participate in training for last 10 or even more years, they interested in new approaches and methods to management and financing of health care, information management. Discussions were also interesting related to the Family medicine practices. Overall, there is understanding of importance in comprehensive reforms of health care services mainly directed to primary health care. It will give more independence to local health facilities that would better manage their needs and improve quality of the services. There is also understanding of excessive number of hospital beds which are underutilized. There is a common concern about unemployment among health professionals in case of reduction among hospital staff, although strengthening of PHC system will require additional staff in that level of health care. Participants also participated in meeting held with Keti Chkharatashvili, Program manager of Curatio International Foundation that helped them understand better the content and effect of reforms in Georgia. Attitude towards reforms of primary health care was positive, although familiarity with the reforms in Georgia emphasized their opinion

that reforms should be planned carefully, taking into consideration every small detail having potential impact.

D. Health situations in Sheki, Gakh and Ismaylli districts.

Health situation in potentially pilot districts are more or less similar. Health facilities in district center and rural hospitals are financed through the Ministry of Health. Rest of health facilities are financed through local budget. Utilization rates of hospitals ranging in different districts, but generally don't top 35%. Hospitals provide ambulatory services mainly. Some of rural facilities are understaffed and most are poorly equipped. Utilization rate of rural health facilities are low. There is no effective referral system. Patients usually bypass rural PHC facilities. While immunization coverage is high, prenatal services are poorly delivered. Salaries of health professionals are low which results in informal out of pocket payments. This fact decreases access to the health services for poor population. There is no private PHC facility in the districts. Most of doctors have not been retrained over the last 10 years.

As I was told supply with drugs for PHC facilities financed through the MOH improved recently.

There is hope that reforms in health care financing would result in fair distribution of health care services.

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Technical Working Group of Governmental Coordination Council on Health Care System Modernization

Meeting Notes
June 7, 2006

Agenda:

- Introduction (Dr. Viktor Gasymov, Dr. Farkhad Mekhdiyev)
- Presentation of the draft "Proposal on Health Financing Reform Program for Azerbaijan in 2006-2011" (Akaki Zoidze)
- Discussion

Introduction

Dr. Viktor Gasymov, the Head of the SanEpid Service of MoH opened the meeting and introduced the participants with meeting objectives. He informed them that the staff of MoH with the assistance of the PHC strengthening Project has prepared the draft proposal for "Health Financing Reform Program for Azerbaijan in 2006-2011", which will be presented for their review

Dr. Farkhad Mekhdiyev, (Director of the MoH Health Project Implementation Unit) has presented main goals and objectives of the long term health sector and health financing system reform in Azerbaijan. He described main shortcomings and inefficiencies of the country's health system inherited from Soviet Union and aggravated during the last fifteen years of underinvestment in health sector. Dr. Mekhdiyev underlined the importance of increased public spending on health and fundamental health financing reform, as a necessary precondition for any tangible improvements in health services provision to the population and health outcomes. He relayed the desire of the Minister of Health to launch ambitious health financing reform that will be supported by the international donor organizations including the World Bank (through upcoming Health Sector Reform Project) and the USAID (through Primary Health Care Strengthening Project implemented by the consortium of organizations led by IMC). Dr. Mekhdiyev then introduced PHC Strengthening Project representative Dr. Akaki Zoidze.

Presentation of the draft "Proposal on Health Financing Reform Program for Azerbaijan in 2006-2011"

Dr Akaki Zoidze presented draft "Proposal on Health Financing Reform Program for Azerbaijan in 2006-2011" (please see attached the document and presentation).

Discussion

Dr. Zoidze answered number of questions posed by the working group members regarding the nature of Social Health Insurance, definition of “single payer” institution, possible institutional set up of the “single payer” – National Health Insurance Fund, Basic Benefit Package (BBP) and provider payment options.

Dr. Gasymov in his closing remarks summarized the discussion and requested working group members to provide their feedback on the document in one week’s time.

It was decided to conduct next meeting of the working group on June 16th after the working group members will carefully review the document and prepare their suggestions and comments.

Attachments

Proposal for Health Financing Program for Azerbaijan – 2006-2011 (Draft)

Program Rational

Low level of health sector financing from state sources. Even with twofold increase of the health budget up to app. 160 Million USD (less than 2% of GDP) in 2006 compared to the 2002-2003, the per capita state health expenditure is only 20 USD[1]. The average figure in OECD countries is 2,000USD and CIS is app. 30USD (in Baltic countries Russia, and Kazakhstan health expenditures are significantly higher). As a result state expenditures are not enough to cover the total cost of production of health services and this burden is shifted to the patients and population. This leads to high out of pocket (OOP) and informal (unregistered) payments estimated at app. 94 USD per capita in 2003. Respectively State expenditures on health represent only 25%-30% of estimated total health expenditures in Azerbaijan.

Fragmented management of available health revenues (financial flows). The MoH controls only 25% of the state health budget. More than 75% of state health budget is managed by the local governments (district authorities). Annual health budgets are elaborated based on inadequate normative and actual expenditures from previous year (historical line time budgeting) which does not take into account the real cost of health care and geographical specificities demographic, epidemiological, socioeconomic factors. Decisions on health investments and expenditures are adopted by different governmental structures (MoF and MoED). This situation constrains the role of MoH as a key governmental Ministry for elaboration and implementation of the national health policy and leads to the duplication and resource waste.

Absence of insurance (risk-pooling) against high health care costs. The insurance (both state and private) is one of the main mechanisms used in most of the developed and transition countries to cope with high cost of production of health services. The health insurance allows redistribution of financial risks from sick to healthy and from poor to rich, allowing access to essential health services when needed. In Azerbaijan the Mandatory State Health Insurance system has not been yet implemented, despite the law passed in 1999. Only insignificant (0.2%) of relatively wealthy share of the Azerbaijan population is covered by the Voluntary Health Insurance.

Poor quality of many of the country's hospitals, polyclinics, and other health care facilities. Since Azerbaijan achieved independence, there has been very little investment in health care

[1] It should be noted that this is planned expenditure, while actual expenditure in 2005 was 12USD per capita

infrastructure, especially outside of Baku. The consequence of this has been a profound deterioration in buildings and equipment, which discourages both health care personnel and patients, and which is a prime reason why patients who can afford to do so come here to Baku for care. But the flow of patients to Baku overloads facilities here, while reinforcing the deterioration of facilities and physicians' skills elsewhere.

Ineffective methods for financing health facilities and health personnel (health providers). Input based, rigid line item budgeting for health institutions fosters inefficiency. With existing system of financing administration of the health facilities do *not have any motivation* to decrease the cost and increase quality of health services provided in their institutions: The facilities treating less or no patients and providing low quality care or no care at all, - are better off, than those facilities treating more patients and providing better care, as level of financing to outpatient and inpatient health facilities will be the same in case if they treat thousands of patients or no patients at all. Current system of financing does not allow for increased motivation of medical personnel, - the administration of even well performing state facilities are limited in the ability to reallocate funds from other budget line items and increase salaries for best personnel, in the situation when the salaries for medical personnel are highly inadequate and represent less then 40% of national average salary.

In Summary:

Low level of government health expenditures, high OOPs and absence of insurance, aggravated with low ability of population to pay for health services (according to official figures up to 46% of the population is poor), fragmented management of available health resources, ineffective methods of financing of health institutions and health personnel contribute to deteriorating health infrastructure, increased cost of services, financial barriers to access, low quality in country's health care sector, worsening financial protection of population from cost of health services and low access to quality essential health services, particularly for poor[2]. This situation in turn leads to worsening health outcomes: morbidity and mortality of Azerbaijan population.
Health Financing Reform Program of Azerbaijan is a framework set by the Government of Azerbaijan for to address current problems in health financing system over 5 year period.

Overall Program Goal:

To ensure access to quality essential health care services for the population of Azerbaijan

Specific goals:

- promoting access to care and protecting against financial risk;
- promoting solidarity by distributing the burden of funding the system relative to individual capacity to contribute and by distributing health care services and resources in accordance with individual need;
- promoting efficiency through explicit incentives and streamlined administrative arrangements; and
- being transparent and understandable.

[2] According to the Household Budget Survey regularly conducted by the SSC, one in three households declared that they could not use health services because of their inability to pay (2002).

Objectives:

- Increase the public spending on health care
- Improve risk pooling in the health sector
- Improve the planning, budgeting and allocation system for health sector
- Introduce financial incentives for health care institutions to provide quality health care services for the population

Objective 1. Increase Public Spending on Health Care

Government of Azerbaijan (GoA) declares that increased government spending on the health sector is an absolutely necessary precondition for achievement of MDGs through significant change in access to essential health services for the population. Considering the current and future economic outlook for Azerbaijan, GoA sets **5 year (2006-2011) target of 100 USD per capita or app. 800 million USD, - five fold increase from current level -** for the government health expenditures from all sources (including SHI when introduced). By the year 2015, this figure is intended to reach 200 USD per capita (considering the 7% inflation rate) or up to 2 billion USD as proposed by the State Program for Poverty Reduction and Economic Development (SPPRED). This level of spending on health care should permit as much as 70%-80% of essential health services to be provided to all of the population free of charge and increase the net monthly salaries for physicians to more than 1,000 USD and for nurses to more than 500 USD. Fiscal analysis shows that this sum of 2 Billion USD will represent app. 3 percent of GDP and up to 10 total public budget expenditures (see Annex 1), which is in line with what most of the Eastern European governments spend on health care. GoA intends to achieve these targets through increased health allocations from general budget and introduction the State Mandatory Health Insurance (Social Health Insurance - SHI). Along with SPPRED, the respective three year and annual health expenditure targets will be reflected in country's Medium Term Expenditure Framework (MTEF) and annual budgets.

Investments in Infrastructure

Major investments are needed in physical infrastructure. Expert evaluation show that approximately 1.2 Billion USD is required to bring needed hospitals, polyclinics, and other health facilities up to acceptable standards of quality. GoA intends to design special long term Health Sector Investment Program (HSIP) that will proceed in parallel with the rationalization of existing health facility networks and fundamental improvements in the functioning of the health infrastructure. The HSIP will encompass health infrastructure rationalization plans on regional and national level and will set annual targets for public investments (including those through State Oil Fund of Azerbaijan - SOFAR) for upgrading health facilities nationwide.

Objective 3. Improve risk pooling in the health sector

Major increases in public expenditures on health—higher budget allocations, greater capital investment—are essential requirements if the accessibility and quality of public health care services are to improve. *But they are not sufficient*. Increased expenditures must be utilized far more effectively than public funds are used presently. In order to achieve a major increase in the

effectiveness of public expenditures on health, the GoA strives for fundamental reform of the entire health care system. Reform of the health financing system on national level and introduction of SHI are one of the major directions of the health care reform. .

Introduction of Social Health Insurance[3] - SHI

Introduction of SHI and establishment of National Health Insurance Fund (NHIF) is one of the most viable means for addressing current problems in health financing system of Azerbaijan. SHI will become the additional revenues source for the health sector and will also address the problem of fragmented health funds through pooling of all governmental health resources in this entity: The NHIF is proposed to be a single financier or purchaser of health services financed by the government, i.e. all health allocations from the state budget intended to finance the health services (including those currently allocated to district self governing bodies) will be eventually concentrated in this fund. The introduction of a single pooling agency will enhance planning in the health sector. NHIF also be given the authority to do selective contracting (i.e., contract with only some providers, whether public or private) and thus increase technical efficiency and promote the gradual downsizing of the number of healthcare facilities. The probability of selective contracting usually increases with the introduction of a new pooling agency (separate from the MOH), since it leads to the separation of the purchasing and delivery functions in healthcare and allows MoH to more concentrate on policy making and regulatory functions for health sector. In summary, the introduction of the SHI system and creation of NHIF will help to:

- Create new source of health care financing and bring additional resources to the system
- Eliminate current fragmentation of public resources on health care and concentrate them in single pooling agency for better policy planning and greater efficiency of health care funds.
- Separate the regulatory, purchasing and delivery functions within the health system for improved governance and policy making
- Introduce greater transparency in the system

The basic features of legal and institutional framework for SHI and NHIF is presented in the annex II.

Following activities phased in time are intended for the establishment of fully functional SHI system in Azerbaijan:

Year 1

- Elaboration and adoption of changes in the “Law on Mandatory Health Insurance”
- Legal and institutional establishment and staffing of NHIF with central and small regional branches
- Delegation to NHIF the function of financing of central institutions (republican institutions, central hospitals, SES, etc.) currently included in the MoH budget;
- Commissioning of costing studies to identify “real” cost of health services

[3] Social Insurance or pooling means that an insurance scheme is created whereby people who are wealthy and in good health will help pay for the health care needed by the poor and the sick. People in a society share (or pool) their risks of bad health and the consequent high costs of health care services. Of course, people may change from low-risk to high-risk as they pass through life – and can therefore change from being a subsidiser of care for others into being a recipient of subsidy from other people.

- Elaboration of new financing and contracting mechanism for these institutions allowing the move from current normative based line item budgeting to the financing schemes tied with actual volume of services that this institutions provide to the population.
- Development of internal organizational structure and policies
- Human resources development for central office of NHIF

Year 2-3

- Full or partial delegation of the financing function for health institutions currently financed by the local district administrations in selected pilot regions (selected for the new World Bank Health Project - Agdash, Apsheron, Gakh, Ismayili and Sheki).[4]
- Adoption of new financing (payment) and contracting mechanisms for health institutions under the financing responsibility of NHIF;
- Definition and delineation of Essential Package of Services (benefit package - EPS) to be financed through the SHI and General Budget that will support clear formulation of state responsibilities in health care
- Piloting of EPS in pilot districts
- Human resources development for regional branches of NHIF

Year 4-5

- Adoption of new EPS
- Adoption of new financing (payment) and contracting mechanisms for all health institutions under the financing responsibility of NHIF
- Final revision of legal, regulatory and institutional framework of NHIF
- Institutional and human resources development for contracted health institutions

Time lines and responsible state agencies for implementation of these activities in presented in the Program Implementation Plan. Program Implementation Plan

Objective 3. Improve the planning, budgeting and allocation system for health sector

Changes in current budget management mechanism for health is an essential precondition of introduction of the SHI system and at the same time major step in improving the overall health financing system. Introduction of single treasury system and "hardening" of rigid line item budgeting mechanism through the 2002 Law on Budgeting System of Azerbaijan (amended in May 2003) has been progressive step towards enforcement of fiscal discipline. Public funds have undergone substantial structural changes. Following important measures have been undertaken in this regard: a treasury system has been established, transparency and accountability in the public funds have been brought to the forefront, municipalities have been established and their financing sources identified. Changes in the legal framework also allowed introducing the Medium Tem Expenditure Framework (MTEF) as a tool for improved public expenditure management and concrete link between budget and SPPRED. Further implementation of MTEF envisages the improved budget preparation and execution for main public sectors by the line ministries responsible

[4] Financing of capital expenditure and part of recurrent costs (rehabilitation, utilities) may be retained by the local administrations

for respective sectors, including the health sector and MoH. Current budgeting system for health sector based on historical "rigid" line item budgeting for the time being represents major impeding factor for introduction of efficiency in this sector. The GoA intends gradual transition from this practice towards more autonomy of the MoH for health sector budget preparation within "hard expenditure ceilings" defined by the MoF for the sector. So called "performance based budgeting" will be introduced, which basically means the allocation of health budget according to the "targeted programs", e.g. Public Health, PHC, hospital care, TB, maternal and child care, etc. Each program will contain major aims, objectives, activities and outputs for respective program. Required expenditures for the program will be tied to these concrete objectives, activities and outputs and also be broken down by economic classification. This approach allows to tie the funds spend by the government to concrete goals and objectives for each state program, or effectively and transparently tie expanded funds with desired results and make it transparent and clear for what and how the money spent on health care is used. This change is also important for launching the process of optimal EPB definition and financing arrangements and finally for the introduction of functional SHI system.

Presented below is possible break down of the health budget according to targeted programs and possible distribution of financing roles between the MoH and NHIF when fully fledged SHI system and NHIF and main purchaser of health services will be established:

State Health Programs	MoH	NHIF
Public Health (population-based surveillance, epidemiological control, prevention of communicable and non-communicable diseases)	+	
PHC services		+
PHC consultation		+
Immunization		+
TB		+
STI		+
Outpatient diagnosis and treatment at the PHC level		+
Emergency ambulance		+
General Hospital Care		+
Special Programs		+
Program for Poor (Socially Vulnerable Population)		+
Pharmaceuticals for Chronic Patients		+
Psychiatric		+
Oncology		+
TB		+
STI		+
Capital Investments and Rehabilitation of Health Facilities	+	

Preparation of sectoral MTEFs and annual budgets in such manner will require linking the population health needs with available resources, accurate costing of health needs and health services and significantly improved planning, monitoring and evaluation systems within the health sector.

Linking the financing to health care need on national and regional levels

Public resources are best allocated when the budget is linked to the healthcare needs of the population. The Program intends to introduce the principle for allocation of health funding on a per capita basis, with adjustments made for patient characteristics, including demographic, epidemiologic, socioeconomic and other relevant factors. Further refinements will include

adjustments for the cost of delivering care to remote areas. The Program aims at developing a population-based resource allocation formula nationwide and piloting it in the five selected districts.

Defining the Essential Package of Services Financed by the State

At present, a most of the services produced in public medical facilities are provided free of charge, while co-payments apply to others. However, high level out-of-pocket payments found through household surveys suggest that the real cost of services is higher than the amount of public funds allocated for their financing. The gap between real costs and reimbursement rates is currently covered by individual patients on a fee-for-service basis.
In addition to increasing of public spending on health care, the issue of high OOP, equity and access to essential healthcare will be addressed through revision and costing of a essential package of services. The provision of existing services will be reassessed in terms of affordability, various scenarios of population coverage, the size and content o f the service package and the service mix. One option is to define an essential package that would be provided to the entire population free of charge and financed by general tax revenues. This package would include all primary and preventive care, plus public health interventions and some secondary and tertiary care. An expanded version of the package could include additional curative services that would require a financial contribution from the population, yet offered free of charge to the poorest. Again, the potential cost of expanded coverage will be realistically assessed to ensure that it is affordable. Wider consultation will be held with various stakeholders and general society to adopt a strategic decision whether the government should gradually assume full responsibility for financing all health services or limit its scope o f responsibility to a basic service package, thus allowing for expansion of the health insurance market. Regardless of this decision, there will be a clear delineation between services covered by the government and those covered by health insurance. Ideally, the latter should not cover the same mix of services, but supplement the government package.

The principal aims of a benefits package are therefore to:

- Provide a universal package of essential health services, ensuring coverage for the poor;
- Reflect the epidemiological profile and national health priorities;
- Maximise health benefits relative to per capita expenditure, through services which are as far as possible equitable, effectively administered, cost effective and contribute to improved health outcomes;
- Meet the health ‘needs’ of the population.

Elaboration and practical application of the EPS involves deliberation on and adoption of two main sets of policy decisions:

(1) Defining the benefits and population covered with limited public funds for health.

This policy decision has both a political and a technical component. The political component is to choose among three options for distributing the current limited health budget across services and populations (see below). The technical component is to develop the specific content of the package of services to be covered within the envelope of available resources and the appropriate targeting mechanism to identify the beneficiary population.

(2) Identifying the expansion path for covered services and population as government funding increases in future years.

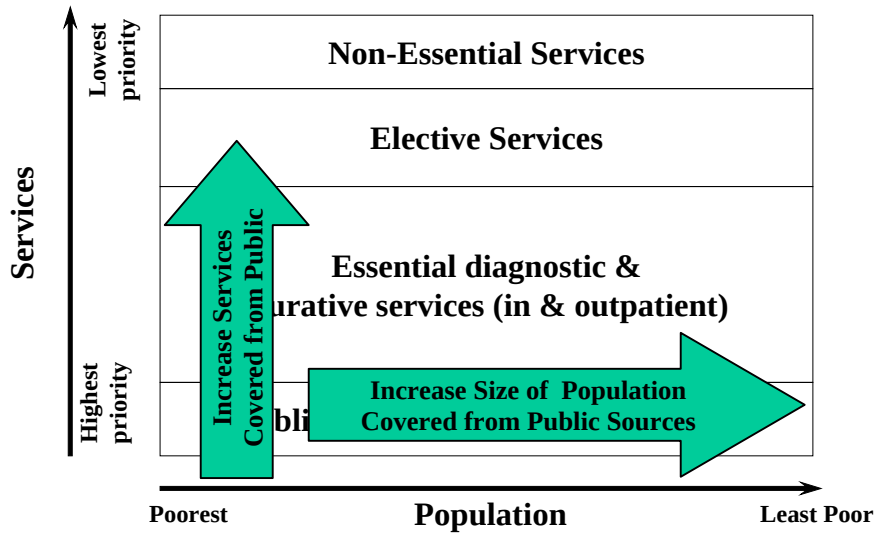
This policy decision also has a political and a technical component. The political component is the decision about how increased government funding for health increases will be distributed between increasing coverage of services and increasing the population covered. The technical component is to calculate the costs of expanding coverage of services and population to support budget formation, and to present the budgetary implications of alternative scenarios of expanding coverage.

There are several policy options for consideration for GoA:

Policy Options: Distributing Government Health Funds across Priority Services and Populations

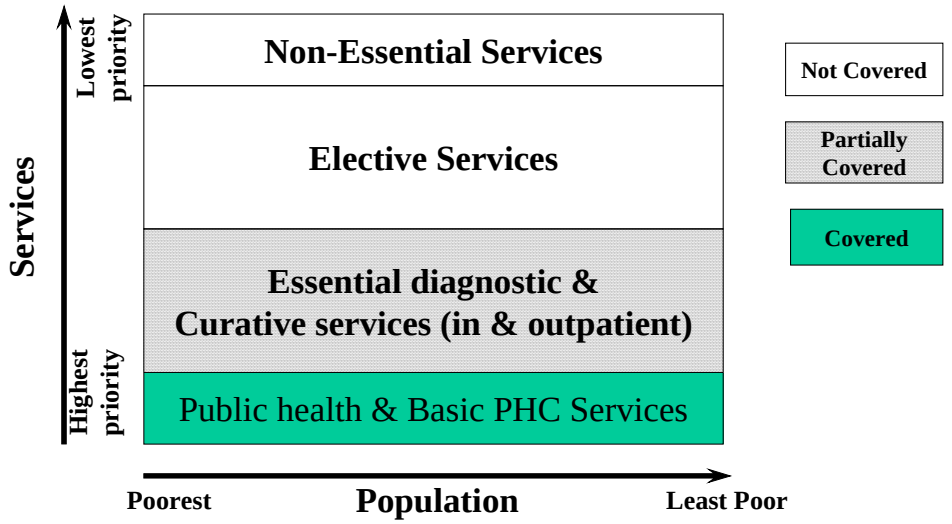
Once the government commits to responsibility for policy and regulation of the entire set of essential health care services, it is possible to develop effective policies that appropriately integrate public and private sources (fee for service, voluntary health insurance) of financing, and ensures that as the availability of public funding for health increases, the range of services financed and the population covered will increase in an appropriate way that furthers the Government's health policy priorities (see Figure 2). The health services can be ranked from highest priority to lowest priority, and the population from most vulnerable to least vulnerable (according to socioeconomic or other criteria), which identifies the expansion path for government funding according to these priorities.

Figure 1. Expansion of Government Funding for Health Care



The main decision needs to be made about how the government intends to prioritize limited public funding for health. Other policy areas can then be developed to support and complement the implementation of that decision. Figure 2 shows the current formal distribution of government funding for health across services and population groups. A limited package of basic primary health care (PHC) is provided to the entire population. Essential diagnostic and curative services (both outpatient and inpatient) are only partially covered in reality for most of the population, with some lack of clarity in exactly which population groups are entitled to how much coverage for which services.

Figure 2. Current Coverage of Services and Population with Government Health Funding



If the Government of Azerbaijan decides to establish the mandate to include the entire set of essential health services under the health financing policy umbrella and identify the expansion path for increasing government funding for health care along priority services and priority populations, the following options for allocating current government budget funds across services and populations are the following:

Option 1: **Everyone gets the same**
[*The entire population is entitled to the same limited set of services*]

Under Option 1, government budget funds are used to cover the entire population with the same set of services. Given the current health resource envelope, this would result in a very limited package of services being covered for everyone (Figure 3). The expansion path for coverage with government funds under this option would be to gradually increase the services covered for the entire population (Figure 4).

Figure 3. Coverage of Services and Population with Government Health Funding Under Option 1

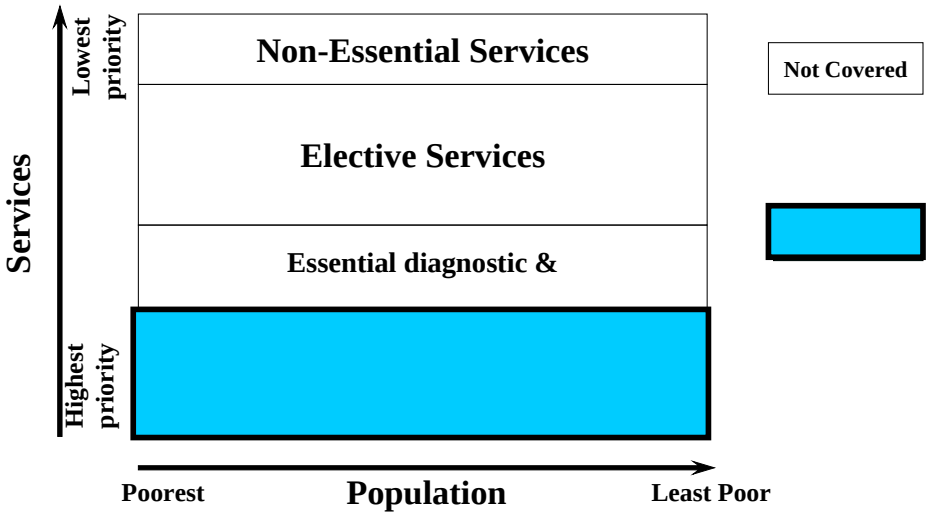
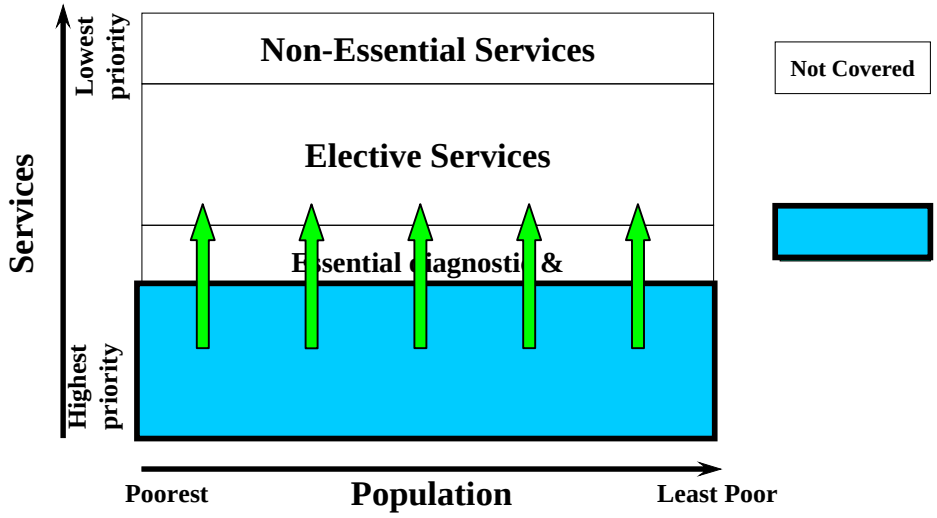


Figure 4. Expansion of Coverage of Services and Population with Government Health Funding Under Option 1



Option 2: **Only the poor and insured are covered**
[*Only the poorest population and insured in formal sector are entitled to government-funded services*]

Under Option 2, government funds are targeted only to insured under SHI (formal sector employees) and to the poorest population group, so a more co`mprehensive package of services can be covered (Figure 5). Significant part of the population in informal sector (e.g. agriculture), however, would be left to finance health care completely out-of-pocket. This option creates the risk of households who are currently on the margin of poverty, or even significantly above the poverty line, falling into poverty when faced with catastrophic health expenditures. The expansion path for coverage with government funds under option 2 would be to expand coverage to include more of the population with a comprehensive set of services (Figure 6).

Figure 5. Coverage of Services and Population with Government Health Funding Under Option 2

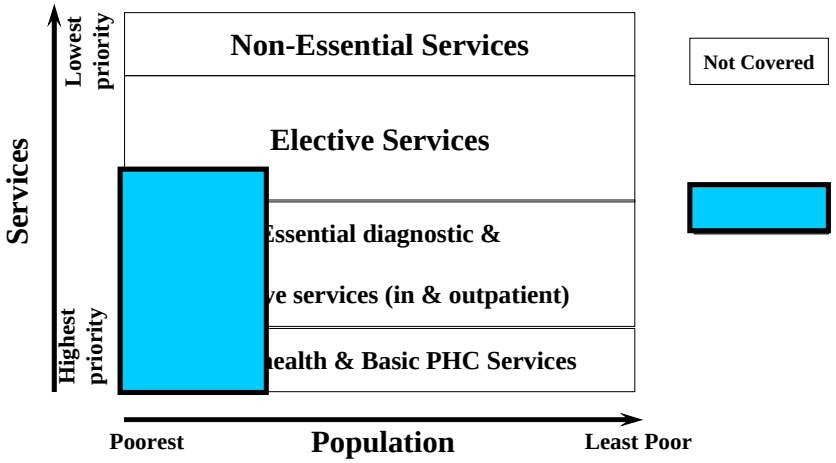
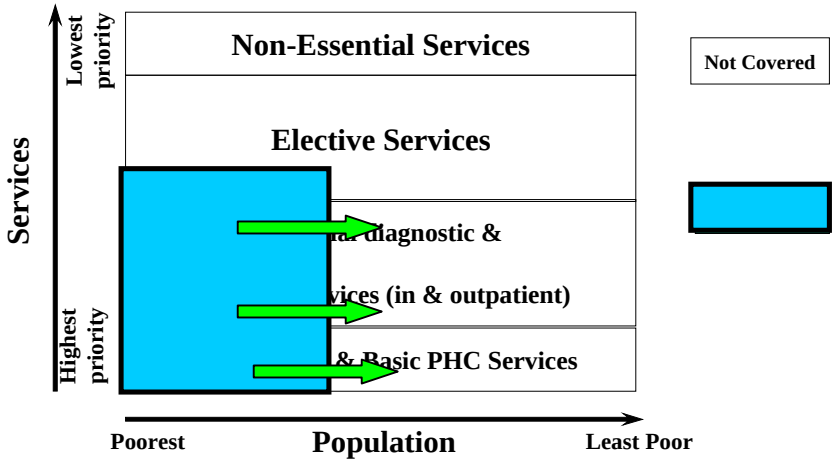


Figure 6. Expansion of Coverage of Services and Population with Government Health Funding Under Option 2



Option 2 is theoretically possible, and should therefore be included in the universe of options to be considered. In practice, however, this option is neither realistic nor desirable. The basic set of public health services include public goods, such as disease surveillance and community-based disease prevention, and "quasi-public goods," such as immunization and diagnosis and treatment of infectious diseases, that are not adequately provided, or not provided at all in the case of pure public goods, if left to the market and entirely out-of-pocket payments.

Option 3: **Combination of Universal Coverage and Targeting to the Poor**
[*The entire population is entitled to a limited set of basic services, and the poor are entitled to an expanded set of services*]

Under Option 3, the government funds a limited set of basic services for the entire population, and also funds an additional set of services for the insured and poorest population (Figure 7). The expansion path for coverage with government funds under option 2 would be to expand coverage to cover a combination of both more of the population and a more comprehensive set of services (Figure 8).

Figure 7. Coverage of Services and Population with Government Health Funding Under Option 3

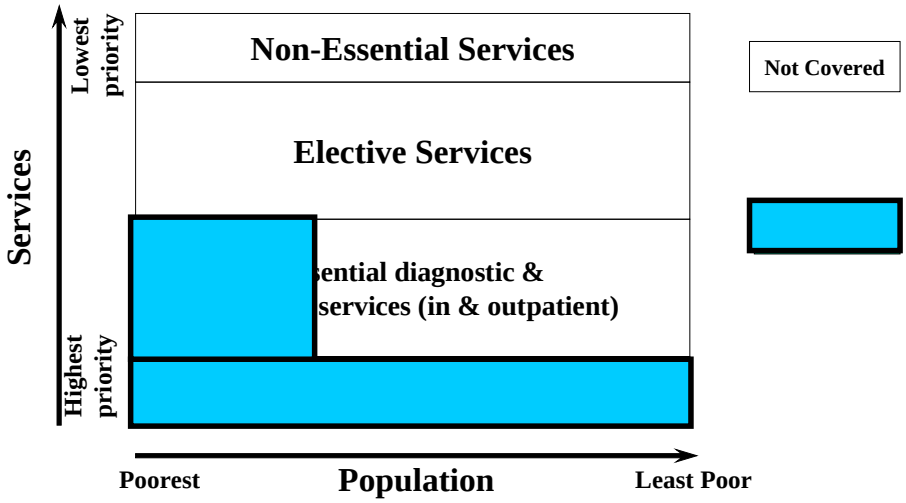
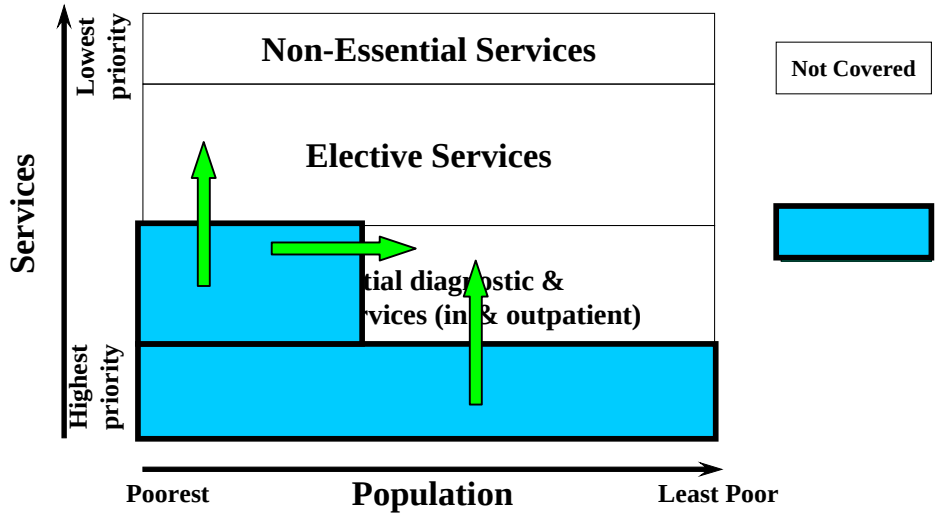


Figure 8. Expansion of Coverage of Services and Population with Government Health Funding Under Option 3



Decision on which policy option to pursue will be even more critical for defining the path of the health financing reforms for the next 5 years until appropriate level of public expenditures on health is achieved.

Objective 4. Introduce financial incentives for health care institutions to provide quality health care services for the population

The Program plans to introduce new prospective provider payment mechanisms for primary and secondary facilities in the five pilot districts in order to improve technical efficiency, cost containment and quality. Ambulatory facilities could receive payments on a per capita basis, with flexibility for generating savings that could then be reallocated for pharmaceuticals and equipment purchases. Prospective payments could also be used for hospitals and connect payments to activities. Starting with a simple system where payments will be based on measurable units of hospital outputs, more sophisticated mechanisms can be introduced where services associated with a particular treatment will be grouped in bundles and a monetary value will be assigned to them. The hospital, knowing the monetary value per bundle, could make a profit by carefully administering inputs and hospital stay. Diagnostic Related Group (DRG) is among the most well known prospective payment mechanisms. International experience also shows that prospective payment mechanisms in a fiscally tight environment can be applied within a global budget, which is used to cap hospital expenditures with case-based payments (see annex IV).

PHC

In order to introduce improvements in technical efficiency, cost-containment and quality of care, performance-related payments to primary health care providers need to be put in place. Primary-care facilities (polyclinics, DACs, FAPs) could receive payment on a per capita basis, with the flexibility to generate savings that could be reallocated for pharmaceuticals and equipment. The per capita payments to PHC providers will be performance related. *Performance withholds*[5] and *bonuses*[6] of up to 10% of budgeted funds for the providers will be used to create financial incentives for better performance and outcomes. Such an approach could improve levels of equipment and supplies, as well as enhance national training programs for physicians and nurses. These changes would need to be combined with a more systematic approach towards monitoring user charges and wages in the state healthcare system.

Hospitals

Performance-related payments should also be introduced for hospitals. Gains in efficiency could be made by replacing current budgeting with payment mechanisms that reward hospitals for higher throughput while motivating a decrease in cost per case. Based on the experience o f other countries, performance-based payments are best applied within a global budget. Lowering the average length of stay and staffing levels could lower the cost per case and result in overall cost savings, particularly if combined within a global budget (Annex IV).

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[5] Portions of the health provider compensation that are held back by the purchasing public agency and released only upon the evidence of success in attaining agreed upon performance goals.

[6] Additional payment, predetermined in the contract with health provider that is paid to the provider upon successful attainment of specific performance indicators.

Conclusions and Next Steps

According to the Program, the main health financing policy directions for Azerbaijan over the next five years will focus on the priority of providing a larger share of the population with access to essential health care services through: (1) increased budget allocations to the health sector; (2) allocation of government funding prioritized by services and population groups covered; and (3) the development, support and regulation of risk-pooling mechanisms for private health expenditures and (4) Improved provider payment mechanisms

The immediate policy decision that must be made is how to prioritize current limited public funding for health based on the three options for elaboration and implementation of EPS. When this decision is made, the following next steps are suggested:

1) Initiate policy discussions on the overall funding allocations for health to be reflected in the MTEF.

2) Arrive at a consensus on the policy and regulatory role of the state in overall health financing, as discussed above. Decisions should be made on issues such as integrated health financing policy for public health expenditures as a transition to an integrated or unified national risk pool using public funds, integrated policy for purchasing and provider payment, and health sector optimization.

3) Conduct an analysis of the overall resource requirements to provide essential health care services to the population, financing all inputs at adequate levels (including salary increases for health professionals) under the current service delivery structure and alternative structures.

4) Conduct a cost analysis and simulation of alternative definitions of the package of health services to be financed from government funds and different definitions of the populations to receive varying levels of coverage. These estimates can be used as a basis for defining government commitments for health care in 2007, and through the MTEF process as a basis to expand health sector budget allocations in future years. These estimates will also provide guidance for intra-sectoral allocation of the government health budget, including relative allocations for public health, primary health care, and hospital care, as well as allocations across population groups.

5) Elaborate during 2006-2007 a consolidated health sector strategy that reflects health financing policy decisions related to:

    a) Overall legal and regulatory framework for health financing

    b) Legal and regulatory framework for risk-pooling for private expenditures (public and/or private insurance market)

    c) Institutional structure of the health sector

    d) Revenue collection and flow of funds

e) Benefits and coverage
   i) Definition of essential set of health care services
   ii) Allocation of government health sector funds to priority services and populations

f) Institutional development of public and/or private insurance market

g) Purchasing (contracting and provider payment)

h) Structure of the service delivery system

Timelines for these activities and responsible governmental agencies for carrying out these steps are presented below in Program Implementation Plan

Program Implementation Plan

ACTIVITIES	*STAKEHOLDERS*	*DATES*
TASK 1. Improving of mobilization of public finances for health care		
1.1 Increased allocations for health care from the consolidated state budget		
1.1.1. Adoption of the SPPRED with relevant public expenditure targets on health care through 2015	**Cabinet of Ministers, Ministry of Economic Development (MoED)**	**2006**
1.1.2. Adoption of Medium Term Expenditure Framework (MTEF) with three year targets on health care allocations	**Ministry of Finance (MoF), MoH**	**2006-2007**
1.1.3. Adoption of annual budgets with health expenditure targets according to the SPPRED and MTEF	**Ministry of Finance, MoH, Parliament**	**2007-2015**
1.2 Introduction of earmarked health insurance contribution		
1.2.1 Development of legislative environment/documents	**MoH, Cabinet of Ministers**	**2006**
1.2.2 Development of draft laws, presentation and negotiations of the amendments in Parliament	**MoH, MoF and MoJ, Parliamentary Committee on Health Affairs**	**2007**
1.2.3 Approval of draft laws and amendments in Parliament	**Parliament**	**2007**
1.3 Establishment of National Health Insurance Fund (NHIF)		
1.3.1 Development of legislative documents (Charter and Organizational Structure)	**MoH, MoF,**	**2006**

1.3.2 Adoption of Cabinet of Ministers' Decree	**Cabinet of Ministers**	**2006**
1.6 Definition of Package of Essential Service (PES) Financed by the State, including the benefit package financed through SHI 1.6.1 Development of proposals for PES 1.6.2 Pilot testing of PES 1.6.3 Approval of PES by the Cabinet of Ministers for nationwide implementation	**MoH, MoF** **MoH, MoF, Local Health Administrations** **Cabinet of Ministers**	**2006** **2007-2009** **2008-2009**
1.7 Shifting to targeted program based budgeting system in health sector 1.7.1 Development of health sector programs 1.7.2 Elaboration of health sector budget proposal based on targeted programs 1.7.3 Approval/adoption of the State Budget Law by Parliament	**MoH, NHIF** **MoH, MoF, Cabinet of Ministers** **Parliament**	**2007** **2008** **2008**
Task 2. Improving management capacity of public finances		
2.1 Health economists and managers capacity development 2.1.1 Training of administrative personnel Mastering in health economics and management 2.2.3 Training of health care management specialists	**MoH, World Bank** **Baku State Medical University, Postgraduate Medical Institute**	**2007-2010**
Task 3. Improving public purchasing of health services		
3.1 Elaborating new payment systems for outpatient and inpatient care	**MoH, MoF**	**2006-2007**
3.2 Testing new payment systems in pilot districts	**NHIF, MoH, MoF, Local Administrations**	**2007-2008**
3.3 Nationwide implementation of new provider payment systems	**MoH, MoF, NHIF, Local Administrations**	**2008-2010**
3.3 Quality assurance and patient's satisfaction (ranking of health care providers, accreditation of facilities,)	**MoH, NHIF**	**2007-2010**

3.4 Improvement of public awareness by more emphasis on PR (EPS and health care institutions contracted by state accreditation)	**MoH**	**2007-2011**
3.5 Masterplan for the provision of health care, resulting in a licensing system based on needs	**MoH**	**2007-2009**
3.6 Selection criteria for contracting by purchases	**MoH, NHIF**	**2007-2008**
3.7 Regulate the tariffs of extra package services	**MoH**	**2007-2008**
3.8 Regulation of pharmaceutical market	**MoH**	**2007-2009**
3.9 Prioritization of cost-effective programs	**MoH, MoF**	**2007**
3.10 Balancing man-power planning, man-power management and man-power education	**MoH, Ministry of Education**	**2007-2011**
Task 4 Improving risk pooling for effective spending on health		
4.1 Concentration of funds allocated for health care on central level	**MoH, MoF, Parliament**	**2006**
4.1.1 Reallocating most of the MoH funds for health care institutions to the NHIF n the draft State Budget Law	**MoH, MoF, Parliament**	**2007-2008**
4.1.2 Reallocating (or increasing) health care expenditures on local level to the NHIF in pilot districts, employing new regional allocation formula linked to regional specificities	**MoH, MoF, Cabinet of Ministers Parliament**	**2009-2010**
4.1.3 Reallocating (increasing) of (all) health care funds on central level through NHIF and MoH		
4.2 Improvement of public awareness of patients rights, coverage of health insurance packages, payment systems, co-payments etc.	**MoH, Private Insurance Companies**	**2008-2009**
4.3. Introduction of tax incentives for people purchasing private health insurances	**MoH, MoF, Parliament**	**2008-09**

Annex I . Fiscal Analysis[7]

In 2005, public spending on health in Azerbaijan was US$121.9 million[8] (0.97 percent of total and 1.66 percent of non-oil GDP and 4 percent of the Government's consolidated budget) (Table 1). According to the 2004 household survey private spending on health was equal to 1.6 percent of total and 2.3 percent, non-oil GDP.[9] Assuming that in 2005 private spending on health remained unchanged in terms of GDP, total spending on health in 2005 was 2.56 percent of total GDP (3.96 percent of non-oil GDP). In per capita terms, public spending in 2005 was around US$14.5 while private spending was US$23.5 (total per capita spending on health was equal to US$38).

Table 1. Total health expenditures, 2005

	Health expenditures		
	% of GDP	% of non-oil GDP	Per capita US$
Public spending	0.97	1.66	14.5
Private spending	1.59	2.29	23.5
Total	2.56	3.95	38.0

Source: MOF for public spending and 2004 National Household Survey for private spending.

In order to estimate the total cost of health care services in Azerbaijan in 2015, the analysis uses as starting point an estimate of the health sector wage bill and assumes that the gross labor cost is 60 percent of the overall health care cost. It also makes the following assumptions[10]:

- Population: 9.2 million[11]
- Number of physicians: 33 per 10,000; total 30,500[12]
- Number of nurses and midwives: 75 per 10,000; total 69,317
- Support to medical staff ratio 1:1: 99,817
- Average monthly wage in 2015: US$718[13]
- Total number of formal sector employees: 1.85 million[14]
- Gross to net wage ratio 1.4:1.0
- Physicians' average net monthly salary (1.4 times the average salary): US$1005

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[7] The fiscal analysis is prepared by the World Bank Team for the Project Appraisal Document (PAD) for Health Sector Reform Project. Certain figures are modified for the current document.

[8] Exchange rate for 2005: 1US$=0.9 AZM.

[9] According to a 2002 health expenditure household survey, the estimated total health expenditures were between 3.3 percent and 4.1 percent of the GDP, with a public-to-private ratio varying between 20/80 and 25/75. It is worth noting that the 2002 estimate might be more reliable than the 2004 estimate (public-to-private ratio: 40/60) as it was based on a special health expenditure survey as opposed to a general household survey. Nevertheless, the analysis uses the 2004 estimate because it is the most recent one.

[10] All figures are nominal.

[11] Source for 2005 population: MOH; average population growth rate 1 percent after 2005: this is the average growth rate of the population for the period 1998-2004, State Statistical Committee of Azerbaijan, Statistical Yearbook of Azerbaijan, 2004, www.azstat.org.

[12] In 2003, Azerbaijan had 36.1 physicians per 10,000 population (as compared to 33.1 physicians per 10,000 in the European Region) and 84.2 nurses and midwifes per 10,000 population (as compared to 72 nurses and midwifes per 10,000 in the European Region), WHO/Health for all database.

[13] The average nominal wage increase is assumed to be 15 percent after 2005.

[14] The net job growth is assumed to be 30 percent until 2010, 2.5 percent afterwards.

- Nurses' average net monthly salary (50 percent of physician's salary): US$502
- Support staff salary is estimated at US$200
- Nominal GDP in 2015: US$56.8 billion (non-oil GDP: US$34.9 billion)

Based on the above, the gross labor cost for the health sector in 2015 will be equal to US$1.4 billion and the total cost for health care services US$2.39 billion (4.21 percent of total and 6.85 percent of non-oil GDP) (Table 2).

From total health expenditures of US$2.39 billion, the Government is expected to finance the EPS.[15] Under the assumption that the unit cost of the EPS is US$100 today (US$184 in 2015 with an inflation rate of 7 percent), the total cost for the provision of the EPS in 2015 will be equal to US$1.7 billion (2.89 percent of total and 4.87 percent of non-oil GDP). Compared to the Government's consolidated budget (US$17.7 billion – SPPRED projections), public spending on health in 2015 will represent approximately 9.6 percent of total government spending. It is worth noting that (i) EPS resources are also expected to cover salaries for health personnel and (ii) the total cost for the provision of the EPS is below 3.6 percent of GDP (US$2.04 billion) that the Government envisages to spend under the SPPRED (Table 9.4). The ratio of public to private spending has changed from 40/60 in 2005 to 70/30 in 2015. The latter ratio is one commonly found in countries that offer universal risk protection against out-of-pocket health expenditures.

Table 2. Fiscal impact analysis – Total health expenditures, 2015

	Health expenditures		
	% of GDP	% of non-oil GDP	% of Consolidated Budget
Public spending	2.89	4.87	9.6
Private spending	1.32	1.98	-
Total	4.21	6.85	-

As far as the financing of total health expenditures is concerned, various combinations are possible. Here the option of mandatory health insurance contributions is explored together with direct budget transfers. Taking into account an estimated net wage bill for Azerbaijan equal to US$15.9 billion, mandatory health insurance contributions equal to 4 percent of the wage bill and with 100 percent compliance would provide US$636 million. In order to each US$1.7 billion, the Government budget would have to provide US$1,074 million (5.5 percent of the Government's consolidated budget) and the population share would cover the rest US$690 million (Table 3). Alternatively, if mandatory health insurance contributions were equal to 8 percent of the wage bill, they would provide US$1.2 billion, leaving the Government budget to finance US$428 million (2.4 percent of the Government's consolidated budget) and the population US$742 million.[16]

Table 3. Financing scenarios, 2015 (million US$)

	Scenario A (4% mandatory contributions + 5.3% of CB)	**Scenario B (8% mandatory contributions +**

[15] For simplicity reasons we assume that no other health items will be financed from the Government given that the BBP is expected to be the main expenditure item.

[16] Total spending for health increases marginally under the scenario of health insurance contributions of 8 percent because the assumption of gross to net wage ratio changes from 1.4:1.0 to 1.43:1.0.

		2.4% of CB)
Health insurance contributions	636	1,272
Government's budget	1,074	428
Private spending	690	742
Total	2,390	2,442

Sensitivity analysis has also been carried out assuming higher salaries for health workers and support staff. In particular, it is assumed that by 2015, physician salaries will be 2 times the average salary (US$1,436), nurse and midwife salaries will be 50 percent of physicians' salary (US$718) and salaries for support personnel will be equal to US$287. Higher salaries result in the gross labor cost for the health sector in 2015 being equal to US$2.05 billion and the total cost for health care services equal to US$3.42 billion (6.02 percent of total and 9.81 percent of non-oil GDP). Under a financing scenario of health insurance contributions equal to 4 percent and an additional budget transfer equal to 5.5 percent of the Government's consolidated budget, the extra funds to cover increased salaries would come from higher out-of-pocket payments equal to US$1.72 billion. The ratio of public to private spending under this scenario would be 50/50.

Annex II. Legal and Institutional Framework for SHI and NHIF[17]

Parties to Health Insurance

The social health insurance system is characterized by the delineation of roles and responsibilities of three parties:

- **Health care providers:** health care establishments, physicians, dentists, specialists – working in either public sector or private sector;
- **Health care purchasers** - National Health Insurance Fund – funded through contributions or the tax system;
- **Consumers** - the insured people.

The introduction of social health insurance will have the following consequences for the above mentioned participants:

- For health care providers – effective competition will increase the incentive for the provision of a better quality of services and cost containment. The relationship with the purchaser (NHIF) will be on the based on a contract that defines rights and obligations for both parties.
- For the NHIF, as a new player - it is very important that it is accepted by all stakeholders in its principle role as the financier of a guaranteed package of health care services.
- For the insured person, social health insurance will allay the basic risk of uncertainty in being able to afford expensive health services.

Principles of Social Health Insurance

The key principles of social health insurance relate to equity and solidarity and are discussed below.

Mandatory participation - This is the most significant principle of the social security systems and usually implies the mandatory collection of contributions from all economically active people and/or their employers.

Accessibility to basic package of health care services - Within the guaranteed package all insured people have equal rights of access to health care services.

Solidarity - The principle of solidarity assumes the possibility for re-allocation of contribution resources from the healthy to the ill, from the rich to the poor and from employed to unemployed people.

Shared responsibility for health - Depending on the system of government, the principle of shared responsibility for health is supported by the participation of all levels of government and their agencies.

Freedom of choice of health care provider - The health insurance regulatory framework should provide the freedom of choice of a healthcare provider.

[17] This section of the document draws largely from "Health Financing Study" prepared in by *G&G Consulting + HIC + ANKON* in 2005 under the World Bank Azerbaijan Health Sector Learning and Innovation Loan.

Purchaser / Provider split - Health insurance funds are not involved in the provision of health care.

Status and Institutional Interrelations of NHIF

Relations with the Government. The NHIF should be operationally autonomous specializing in performing legal and financial functions for the implementation of the State health financing policies. The NHIF will not be a ministerial dependency, but a legal person linked to the Government via the Ministry. Thus, it will work closely with the MoH, with the Ministry of Finance/Treasury, Parliament and other public and private stakeholders.

Relations with the MoH. The MoH plays an essential role as the highest-level entity representing the interests and responsibility of the State regarding health. The Ministry formulates the national health policies, has the overall responsibility for public health, and has numerous functions with respect to improving the health status of the population, designs the general State strategy towards health, determines health needs, and exercises broad regulatory functions regarding the health sector. Thus, the NHIF needs to work in close collaboration with the Ministry to properly implement the national health care financing strategies. An adequate form to ensure autonomy and the proper relations with the Ministry is by having the Minister (or his/her representative) as Chairman of the NHIF governing body (a Board of Directors or a Supervisory Body), and through continuous reporting and consultation mechanisms.

Relations with the Ministry of Finance/Treasury. The Ministry of Finance controls the actual allocation of State financial resources. For the NHIF to play an effective and credible role as purchaser, it needs to secure that the State resources will be available, and that they will not be just a promise with no consequences if unfulfilled. Therefore, the NHIF needs to closely work with the MOF/Treasury so that the budgetary commitments are fully honored and the financial resources are made available to the NHIF to honor its contract obligations with providers and third-party intermediaries. This is a critical matter if contracting is to properly work as the vehicle for mobilizing financial resources in exchange for health care good and services. It cannot be acceptable, as it is today, that contracts signed by NHIF contain a *Force Majeure* clause exempting the NHIF of responsibility in case of incomplete disbursement of State funds that precludes the NHIF from honoring its contracts.

The NHIF, a semi independent entity under the control of the MoH should be established as principal agency responsible for the implementation of the SHI and a single purchaser of health services for the population. The MoH is proposed to chair the governing board of the NHIF. MoF, MoED, Ministry of tax Revenues and possibly representatives of professional associations (medical association), major employers and trade unions will be represented on the Board to ensure participation and transparency.

The key elements that require regulation in the establishment of NHIF functions are:

- the legal framework;
- benefits package and eligibility;
- prices paid to providers and manner of payment;
- budget;
- Quality of care.

These issues are discussed below.

Creation of Legal Framework for SHI

- Parliament approves changes, or adopts new Law on Mandatory Health Insurance (or Social Health Insurance)
- MoH develops policy and the Cabinet of Ministers approves legislation to establish NHIF and its functions, governance framework including the establishment of the NHIF Governing Board.
- MoH/MoF elaborates method of supervising NHIF activities.

Regulation of benefits package and eligibility

- NHIF Governing Board - approves the contents of the benefits package, eligibility and co-payment protocols that accord with the available resources
- Cabinet of Ministers – approves the benefits package and eligibility after consideration of the socio-political implications.

Regulating Prices and reimbursement methods

- Governing Board of the NHIF – approves a framework for provider payment, categorization of services and their prices.

Allocating NHIF Budget

- NHIF Governing Board approves the budget based on the outcomes of decisions with respect to benefits package, eligibility, co-payments and prices/
- Cabinet of Ministers sends NHIF budget to Parliament;
- Parliament approves NHIF budget.

Regulation of quality of care

- MoH promulgates policies related to good medical practice, appropriate care, provider licensing and accreditation.
- MoH develop evidence based practice guidelines and education programs.
- NHIF Governing Board includes quality of care issues among the conditions in the provider contract.

Monitoring NHIF Operations

In order to protect the interest of insured people, the Azerbaijan National Health Insurance Fund (NHIF) should be subject to regulation and supervision. This supervision should be provided by either the MOF or MOH. There should also be a supervisory role for the National Audit Office.

Supervisory functions should include:

- Ensuring that NHIF activities comply with the legal framework;
- Monitoring and analysis of NHIF activity for the preparation of annual reports and accounts;
- Audit of the NHIF's budget.

NHIF organisation

The NHIF will be established as a centralized structure with a head office in Baku and branch office network throughout the regions (one branch serving several rayons), with the staff consisting from 25 people at initial phase – year 1 and 2 (central office and small regional office for pilot regions). Gradually the staff of NHIF will be increased up to the 120-140 nationwide.

Main tasks of the NHIF central office:

- implementation of mandatory health insurance;
- managing the system of provider contracting;
- managing equity of access to the basic benefits package;
- managing the finances for the national social health system, including budgeting and reporting;
- development and management of provider payment models;
- management of the health information system;
- management of the regional branch network and reporting on branch performance.

Main tasks of regional branch offices

- advising NHIF central office on local conditions, with respect to health priority areas, socio-economic conditions and provider network;
- contracting with providers in the region and the administration of the contracts;
- monitoring the collection of contributions from the insured and their employers in the region;
- managing data inputs into the NHIF health information system;
- performance reporting to the central administration.

Budgeting and Performance

The basic national budget formula will be population-based and take into account population demographics, social need and prospective utilisation. The formula would consist of the following variables:

- population size;
- age structure;
- gender structure;
- health profile;
- health priorities.

The initial budget development process would involve the following steps:

- Estimation of the revenue available to NHIF from member contributions and government payments;
- Actuarial analysis of health service utilisation rates within the draft benefit package design;
- Costing of the benefits package according to the estimated service use and development of expenditure estimates for NHIF;
- Comparison of revenue and expenditure estimates and adjustment of variable elements such as benefits package entitlement or co-payment.

Although the branch offices would not directly manage the regional budgets, they would need to take steps to ensure that the funds allocated to their regions are spent as effectively as possible. The

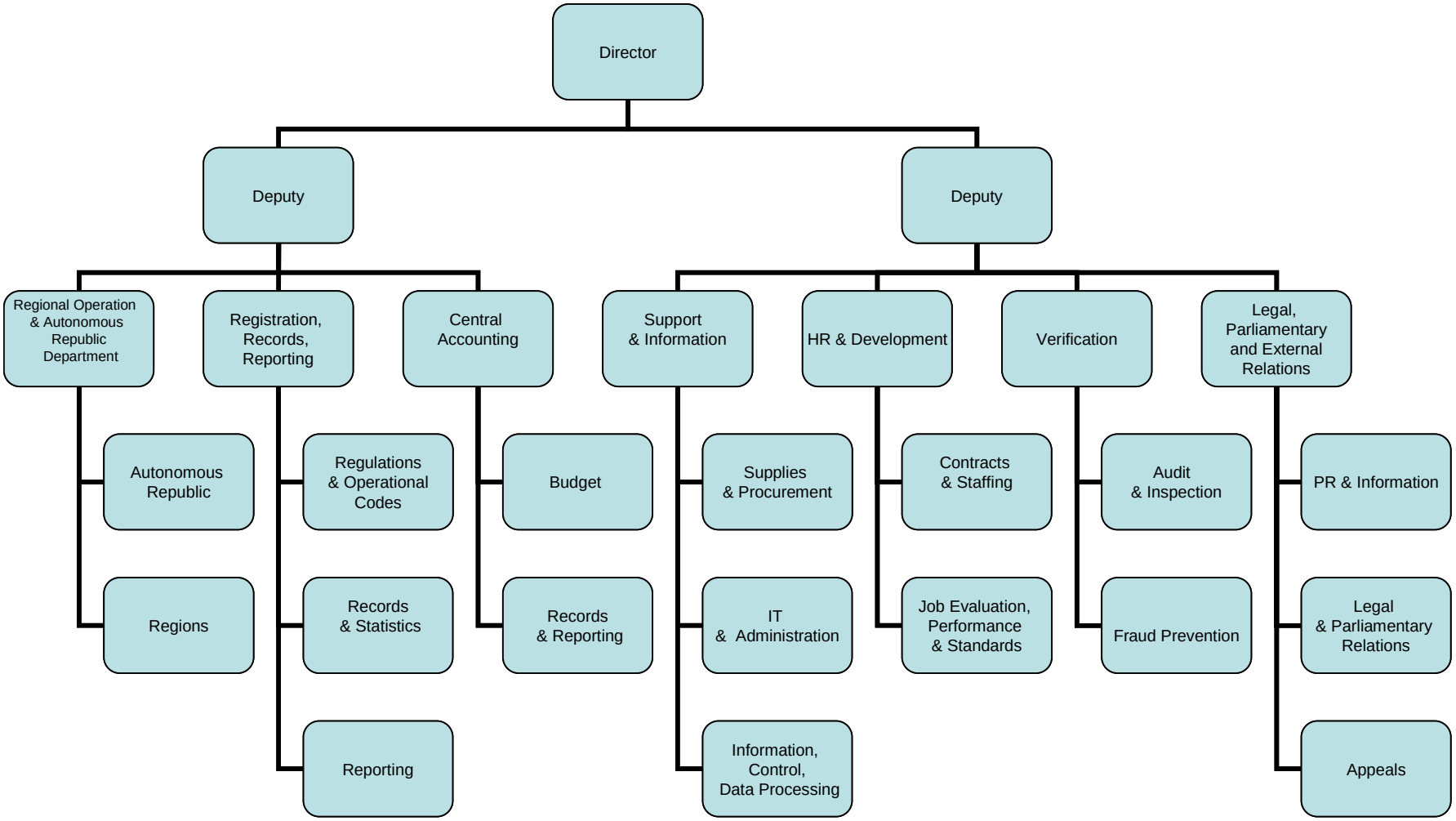
NHIF would monitor and benchmark the performance of the regional branch offices according to criteria such as:

- service expenditures compared to the needs of the population;
- overhead costs of branch office operations;
- percentage of the population who are registered in the Fund;
- customer satisfaction and responsiveness to member needs;
- contribution collection rate from salary earners and self-employed in their regions;
- numbers of provider contracts signed;
- primary care to specialist referral rates;
- Average Length of Stay (ALOS), utilisation and re-admission rates in hospitals;
- pharmaceutical utilisation related to approved guidelines;
- data accuracy and integrity;
- reported incidence of informal payments to providers;
- Immunisation rates and other preventative initiatives.

In order to provide incentives to continually improve system efficiency in their regions, the regional branch office executive would be paid bonuses that would be based on the performance score of their institutions.

Proposed organogram for NHIF is presented below.

National Health Insurance Fund Organogram



Annex III. Provider Payment Methodologies

General Description of Payment Methodologies

Methodology 1

Definition:	Program financing
Typology:	Payment according to the volume of medical service
Conditional unit:	Nosologic standard
Payment category:	Retrospective
Mode of payment:	Directly to the provider by presenting the financial demand
Price-setting:	Tariffs fixed by purchaser
Foreign analogies:	DRG (Medicare)
Technological process:	I: Purchaser - state agency lays down[18] unified standards reflecting: a) tariffs of medical services according to diagnosis, b) specification of medical intervention[19] according to diagnosis (service volume and type), c) tariff of each medical intervention; II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs; III: The provider submits at fixed intervals to the respective state financial institute an invoice[20] (receipt) reflecting the cost of the medical services provided under the program with reference to the diagnosis and corresponding standard cost; IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed at the standard-prescribed tariff irrespective of the volume of the medical intervention actually performed by the provider. V: The invoice presented may be verified by the purchaser.

Methodology 2[21]

Definition:	Conditional standards (case payment model with an agreed protocol of diagnostic and therapeutic procedures)
Typology:	Payment according to the volume of medical service
Conditional unit:	Aggregated Medical Economic Standard
Payment category:	Retrospective
Mode of payment:	Directly to the provider by presenting the financial request
Price-setting principle:	Tariffs set by purchaser's (by fixing the ceiling)
Foreign analogies:	DRG (Medicaid &Blue Cross)
Technological process:	I: Purchaser - state agency lays down[22] aggregated standards reflecting: a) tariffs of medical services according to groups of

[18] *through a panel of hired experts*
[19] including treatment with medications
[20] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*
[21] *Currently applied payment system*
[22] *through a panel of hired experts*

diagnosis and medical conditions, b) specification of medical intervention[23] according to diagnosis (service volume, type and complexity);
II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs;
III: The provider submits at fixed intervals to the respective state financial institute an invoice[24] (receipt) reflecting the cost of the medical service provided under the program financing with reference to the diagnosis and the list of medical interventions and costs provided by the standard;
IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed within the standard-prescribed tariff according to the volume of work actually performed by the provider. The costs of medical interventions performed beyond the standard are not covered. The cost of unused medical intervention is deducted from the amount prescribed by the tariff[25].
V: The invoice presented may be verified by the purchaser

Methodology 3

Definition:	Payment according to bed-days
Typology:	Payment according to the volume of medical service
Conditional unit:	Bed-day according to profile
Payment category:	Retrospective
Conditional unit:	Nosologic standard
Mode of payment:	Directly to the provider by presenting the financial demand
Foreign analogies:	Holland-budget nursing homes (partly France)
Technological process:	I: Purchaser - state agency lays down[26] unified standards reflecting according to *profile*: a) allowable quantity of bed-days, b) bed-day tariffs; II. Under respective contracts accredited health care providers are authorized to receive payments under state health care programs; III: The provider submits at fixed intervals to the respective state financial institute an invoice[27] (receipt) reflecting the cost of the medical services provided under the program financing with reference to the medical *service profile* and *number of actually spent bed-days* provided by the standard; IV: According to the presented invoice the financial institute effects payment with the provider; the payment is performed within the standard-prescribed tariff according to the volume of work - *number of*

[23] including treatment with medications
[24] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*
[25] *from the total cost prescribed by the tariff.*
[26] *through a panel of experts*
[27] *According to the accepted international practice, invoices are presented on electronic carriers (in the form of computer files) in order to optimize the invoice processing and payment process that normally requires adequate information management systems*

	bed-days - actually performed by the provider. The cost of medical intervention *(bed-days)* performed beyond the standard is not covered. V: The invoice presented may be verified by the purchaser.

Methodology 4

Definition:	Global budget
Typology:	Fixed annual financial limit
Conditional unit of service volume:	Profile and capacity (number of bed-days or number of registered patients, logistical base, staff schedule, etc).
Payment category:	Subsidy (federal or federal+local budget)
Mode of payment:	Periodic supply of amounts fixed beforehand
Price-setting principle:	Historical or functional
Foreign analogies:	FSU, Veterans' System in the USA, Kaiser Permanente in the USA, Great Britain, Canada
Technological process:	I: Purchaser - state agency forms[28] according to profiles a sectoral budget within the program financing to reflect: according to profile expected *demand* for medical services and required *capacities*. II. Out of the accredited health care providers the purchaser selects (according to competition, as a rule) the health care institutions that together provide the profile-needed capacity and ensure, within the allocated resources, medical service prescribed by the *quality standard* in the accounting period. III: Global budget is drawn up at the beginning of the financial year at prescribed intervals independent from the volume of actually performed work or capacity[29] IV: At the end of the year (or at fixed intervals) the provider presents full statistical and financial report to negotiate on budget for the next financial cycle. Budgeting is made by the so-called *historical or functional* method. V: The need for the purchaser to perform auditing-control is minimal in the accounting period.

[28] *through a panel of experts*

[29] *Some models envisage a selected version: the budgeting relevant to the necessary minimum capacity merged with additional capacity financing at the final stages of the accounting period or payment for each so-called extra-plan service by the case-based system.*

Brief description of the payment methodologies

	Methodology 1	*Methodology 2*	*Methodology 3*	*Methodology 4*
Definition	Program financing	Conditional standards	Payment according to bed-days	Global budget
Typology	Payment according to the volume of medical services performed	Payment according to the volume of medical services performed	Payment according to the volume of medical services performed	Fixed annual financial limit
Conditional payment unit	Diagnosis (standard)	De-facto performed work envisaged by diagnosis (by standard) (sum≤standard)	Bed-day according to profile	Profile and capacity (number of beds or number of registered patients, logistical base, etc)
Payment category	Retrospective	Retrospective	Retrospective	Subsidy (federal or federal+local)
Payment mode	Directly to the provider after the invoice specifying the diagnosis has been presented	Directly to the provider after the invoice specifying the diagnosis and volume of performed work has been presented	Directly to the provider after the invoice specifying the profile and number of bed-days has been presented	Periodic provision of the sums of fixed amount
Price-setting principle	Purchaser's standards (fixed)	Purchaser's standards (semi-fixed)	Purchaser's standards (according to profile)	Historical or functional
Foreign analogues	DRG (Medicare, USA)	Medicaid& Blue Cross	Holland	FSU, Veterans' System in the USA, Great Britain, Canada

Essential features of the Global Budget payment method to providers

The global budget principle for health care institutions/providers is the procedure for the funding of the pre-agreed amount of work according to duly approved state standards, tariffs, rates, and control indices.

- ***Global Budget Calculation (example)***

Taking into account the state program and the specific provider participating in it, the global budget is calculated in accordance with:

- ✓ the annual estimated volume of the performed health care service according to nosologies under the program;
- ✓ the average cost (complexity index) of a medical case calculated at the state health care service standards and tariffs prescribed by the nosology code.

At the same time, the total estimated number of bed/days and the average cost of bed/day determined according to the state health care service standards are also used as the controlling parameter of the global budget.

The production within the state program (the annual number of cases according to nosologies) are calculated by comparison of the expert appraisals of the expected annual number of cases according to nosologies with the actually production for the last two years, -

with the number of the same nosologies carried out by the institution participating in the program according to the country, region and particular provider.
The controlling parameters of the estimated budget of the program (provider) are:

- the average price of the medical case;
- the average cost of bed/day.

Itemization of the global state program budget is made according to the economic classifier. The controlling indices for financial and resource items for the particular state program (institution) are:

1. Percentage ratio (%) of direct expenses to total expenses:
   including:
   - the salaries – (% of the total expenses) for direct and indirect personnel;
   - pharmaceuticals and other medical items - %;
   - lab and instrumental tests - %.
2. Percentage ratio of indirect expenses to total expenses (%).
3. The number of general medical personnel (physicians, assisting personnel and attendants) participating in the program shall be determined according to the particular program and institution in accordance with the normative rates determined by the state standards and the standard rates of the medical personnel workload.
4. The minimal and average wages of the general medical personnel shall be determined in accordance with the normative rates by the state standards and the standard rates of workload of the medical personnel.

Indices 3 and 4 are duly determined and approved within the state health program. For particular health care institution/providers the same indices are determined in the contract made with the State Health Insurance Company according to the controlling indices determined by the appropriate program and against the specific functions of the particular health care institution/provider.

Technical Working Group of Governmental Coordination Council on Health Care System Modernization

Meeting Notes
June 16, 2006

Agenda:

- Introduction
- Discussion

Introduction

Dr. Viktor Gasymov, the Head of the SanEpid Service of MoH opened the meeting and introduced the participants with meeting objectives. He informed the working group members regarding the agreements reached during the previous meeting and opened floor for discussion on the draft proposal for "Health Financing Reform Program for Azerbaijan in 2006-2011", which was presented at the meeting of the working group held on June 6th.

Discussion

Following working group members actively participated in the discussion:
Viktor Gasymov, Adel Kerimov and Farkhad Mekhdiyev from the Ministry of Health; Namik Khalilov from the Ministry of Finance; Ahmad Veliyev from the Ministry of Economic Development, Vafa Mutallimova from the Ministry of Labour and Social Protection and Idris Isayev from the Republic Social Protection Fund.
In overall the working group members positively evaluated the draft document and proposed some minor revisions. During the discussion it was suggested to:

(a) Change the name of the single payer – National Health Insurance Fund (as presented in the draft document) to National Health Insurance and Health Financing Fund, to reflect the fact that this entity will receive both the insurance contributions and transfers (non insurance) from the central budget;
(b) Select one option (option # 3) on development of the Basic Benefit Package as a principal option preferred by the working group and leave in the document presented to the Governmental Council this single option.
(b) Adjust the time lines and responsible agencies in the program implementation plan (attachment I of the draft document) according to concrete proposals suggested by the working group members.

After expressing their opinion and comments and suggestions, each working group member supported the proposal to submit the draft Program to Governmental Council for their consideration and approval. In case of approval the program was suggested to be formally endorsed through Cabinet of Ministers Decree to turn the Program into the road map for long term health financing reform in Azerbaijan.

Dr. Farkhad Mekhdiyev and Dr. Akaki Zoidze were asked to incorporate changes and revisions suggested by the working group and finalize the draft for the submission to the Governmental Council.

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- Natik Umarov, Health Financing Officer

BISHKEK TRIP REPORT
IMC PHC Advisor Aybeniz Ibrahimova
May 20-25, 2006

22.05.06 – 24.05.06

1. Meeting with Suyumjan Mukeeva, Administrative Director of Family Group Practice Association (FGPA).

She used to be involved in reforms of secondary care, and was mainly responsible for analysis and development of recommendations to rationalize the hospitals and health financing issues. Today PHC services in Kyrgyzstan provided by Feldsher-Akusher Points (FAPs), Family Group Practices (FGPs), Family Medicine Centers (FMCs) and Ambulance Services (AS). FAPs are supervised either by FGPs or by FMCs. According to her through coercive method Children's Policlinics, Adult Policlinics and Women's Consultations were merged and renamed into the FMCs. This had happened in urban area. In rural area district level policlinics attached to CDHs departed from them and also renamed into the FMC. FMC supervised FGPs and FAPs, although some FGPs are independent juridical units. By 2002 former SVAs were either reorganized into the FGPs or just abolished. Introduction of FM began in 1997 with yearlong TOT program. First initiative started in FM training center in Issikul oblast and then second TOT program opened in Bishkek in Kyrgyz State Medical Institute for Retraining and Continuing Education (KSMIRCE). This training center became the national hub for ongoing TOT courses. TOT trainers were selected from pediatricians, therapeutics and gynecologists. There was a selection process, but the age, experience and wishes for to be a faculty was taken into account. First team of selected trainers had a different background, i.e. some of them had pedagogical experience advance degree, but others did not have pedagogical experience and degree and had big clinical experience (doctors from policlinic). Second type of trainers had a problem, they couldn't teach, because in academic system they could carry out only the clinical cycle and seminars, but not lectures. The problem was solved through involving them in teaching the courses within the vertical programs, for that they first were certified to teach various internationally recognized short courses such as WHO's courses on IMCI, Healthy Life Style, TB/DOTS, Practical Approach to Lung Health (PAL) and others. The Director of the FGPA said it was impossible to prepare family physicians of desirable level through retraining of pediatricians and therapeutics. It is not worth to spend money and efforts and time trying to prepare family physician from gynecologist. 15-year experience shows that retraining especially in urban conditions does not work. It might be the result of non-comprehensive consideration of legislative bases as well. For example, the retrained doctors received the certificate and were formally recognized as family physicians, but they were placed on the positions of the pediatricians and therapeutics and did not provide consultations for all groups of population. So a pediatrician continues to consult only children, therapeutics only adult population and gynecologist only women. Although in range of the reforms the population enrolled to the family physician and financing is per capita, the old catchments population norms still in place: pediatricians – 800-900, therapeutics – 1500-1700, gynecologist – 3500; i.e. 5000-7000 population enrolled for FGPs, though according to the law on family physician 1 family physician should consult 1500 people of general population. Even if more than 1500 people enrolled for a given family physician, he/she is not paid accordingly, because of a budget deficit. The other reason why FGPs doesn't prove themselves in urban area is that family doctors work at the same building with specialists. Workload of narrow specialists is low and they mainly examine conscripts (prizivnik). That's why if there is a narrow specialist sitting next door, a family physician doesn't burden him/herself and sends patients to specialists if there is any little justification to do so. Currently a family physician who is paid comparably low salary is overburdened with provision of adult, pediatric and ob/gyn services plus implementation of number of vertical programs such as: TB/DOTS, PAL, IMCI, STI, HIV/AIDS and etc. Mrs. Mukeeva believes that if narrow specialists are separated from family physicians and located in outpatient departments of hospitals number of

referrals will decrease considerably. On the other hand if conscripts are examined by family physicians (under condition of salary increase) overall workload of specialists will decrease as well, that would be a good basis for reducing number of specialists and retraining them as family physicians. The other problem is migration of family physicians to neighboring Kazakhstan and Russia where salaries are considerably higher (appr. USD 50 in Kyrgyzstan, while USD 500 in Kazakhstan and USD 1000 in Russia). Additionally, being a family physician is not prestigious in Kyrgyzstan.

As a result of reforms funds allocated to PHC increased from 20% up to 29%, but it is nothing if inflation and economical crises are taken into consideration. In her opinion a family practice in urban area should start with family doctors who graduate from family doctor residency program and occupy pure vacancies of family doctors (not as a part of a Family Group Practice). She also mentioned that reforms of FM residency program in medical academy were not right. After replacing free internship with two-year residency program, which charged some fee for education, a graduated family doctor still works in groups either as a pediatrician or therapeutics. Promised salary increase did not happen as well as status of family physician did not rise. As a result number of applicants for family physician residency program decreased significantly.

2. Meeting with Barton Smith, FM Consultant, STLI

He is in Kyrgyzstan for 4 years. At the first year he learned Russian and following 3 years he worked as an STLI volunteer on development of FM in Kyrgyzstan. Now he is a Consultant on FM. Retraining program was developed primarily by foreign doctors. As local trainers went through education they made some changes in a curriculum. All together the curriculum was amended tree times. First year of retraining: master trainers were only foreigners. The training started at the Policlinic #1 and then moved to the KSMIRCE. According to the agreement 2 FGPs serving certain catchments areas were placed in KSMIRCE fulfilling the role of practical base for retraining program. Thus, trainees were given an opportunity to examine patients under control of trainers (practically they borrowed patient from FGPs). In second year Master-trainers consisted of foreign and local trainers. TOT was prepared by volunteer doctors staying in Kyrgyzstan for more than one year. TOT was designed for 11 month and consisted of 40 modules. Training was designed in a way that 50% of time is devoted to theoretical presentations with the other 50% to clinical skill development/improvement. Unfortunately Master Trainers or better to say faculties are not allowed to practice currently. Thus they are academician teachers fulfilling continuous training and supervision. This is a wrong approach, since it results in them loosing practical skills. He mentioned that while FGPs were successful in rural places, it did not work in urban area. There are few reasons such as: plenty of vertical programs with a lot of paper work consuming considerable time of physicians; a specialist sitting next door and easily making referral to specialists; lack of motivation; non-defined legal status of FD etc. Barton suggested calling retrained physicians differently from those who graduated residency on FM, since the level of their training is different. Calling retrained doctors a FD depreciates value of Family practice in community. As an answer to my question about what would be the best option in his opinion whether to send physicians abroad for TOT or bring specialists to train master trainers in the country, he replied that each option had its advantages and disadvantages. First of all, in order to be considered for sending abroad physicians should know English, second if abroad training lasts less than 6 month it doesn’t make sense. On the other hand during the abroad training they will not be allowed to receive patients and may not gain required practical skills. Additionally, in western countries the FD equipped differently in comparison with NIS countries, which makes application of knowledge upon their return difficult. On the other hand in-country TOT will never give full sense of real Family Practice atmosphere. Therefore combination of in-country training with abroad study tour may be the best option, although sending physician abroad for education always includes a risk. For example, STLI selected one doctor and send her to USA for education and she did not return back.

Major factors informing decision on longitude of the retraining program include how long rural doctor can afford to stay in the capital or oblast centers and scope of skills intended to be developed.

Barton considers that 4-month re-training is sufficient for rural doctors today. Kyrgyzstan had only a general curriculum for all trainees, but, if possible, it is better to have separate curricula for pediatricians and therapeutics. Kyrgyz training was not of problem based learning type, although it's desirable. He also mentioned that in urban area FGPs i.e. a pediatrician, therapeutic and gynecologist should receive on-going training in their own field and not re-trained into the FD. The level of these doctors is low, they even do not provide the services within their Scope of Services and therefore they need to deepen knowledge in own area first.
After the meeting I went to the FM Center Kyrgyz State Medical Institute of Retraining and Continuing Education (KSMIRCE). FMC looked like a usual policlinic with physicians' consultation rooms, procedure room (minor surgery), administrative department, faculties' room, library, computer/data base room and conference room. FMC have full time IT staff. First establishment and design of the database were done with the support of Zdrav Plus IT staff. I would like to mention that equipment of the FGPs room was consisting of the following: examination table with the capacity to have gynecological examination, otoscope, ophthalmoscope, stethoscope, BP cuff, laboratory tests and dressing materials.

3. Meeting with Burul Juzenova Head of Family Medicine Department of the KSMIRCE.

She gave overall picture of the reforms described later in this report. FM initiative started from merging the policlinics (adult + children + gynecology consultations) into the FMC. Each FMC could have several FGPs. The objective was to retrain all PHC physicians (2.500) and all PHC nurses (5.000) into FDs and Family Nurses accordingly. In order to implement this idea there was a need to open the branches of the KSMIRCE in the oblasts and organize FM Training Centers. After accomplishment of the structural preparations TOT for master trainers was started. First year TOT was provided for 10 doctors/faculties. 3-4 of them were from KSMIRCE and 5-6 from the policlinics. 2-3 of them were from oblasts for branches of the KSMIRCE located there. Bulk of master trainers received TOT during first year, while this process continued from 1997 till 2004 and resulted in training of 64 master trainers for the whole country. Please find below some figures from TOT and retraining:

Preparation of Master Trainers on FM for physicians (1997-2004)

Kyrgyzstan	Kazakhstan	Tajikistan
64	9	12

Preparation of Master Trainers on FM for nurses (1997-2004)

Kyrgyzstan	Kazakhstan	Tajikistan	Uzbekistan
65	6	8	3

TOT and retraining

Oblasts	Master Trainers prepared	Master trainers left	Retrained physicians
Bishkek	15	11	544
Chuy oblast			501
Issikkul oblast	4	2	295
Osh oblast	6	4	575
Batken oblast	4	2	161
Djalilabad oblast	6	5	362
Narin oblast	3	2	123
Talas oblast	3	3	100

While Kyrgyzstan conducted TOT, Kazakhstan, Tajikistan and Uzbekistan made the agreement and included some of their staff into the training. TOT course was very intensive: lectures, practical part, and reception of patients. As mentioned above two FGPs were resettled in the building of the KSMIRCE and these Family Group Practitioners received bonuses for sharing the patients. TOT schedule:

- 8:00 – 12:00 patient examination
- 12:00 – 13:00 lunch break
- 13:00 – 14:30 lecture
- 14:30 – 16:00 seminars + working in the library + internet research

At the end of the first year there was an exam (they called state exam) which consisted of:

- Written 100-question test (>90 – "5", 80-90 – "4", 70-80 – "3")
- Clinical situations (verbal)

Each year 12-13 master trainers graduated from the TOT, although some part weeded out. Now FM department consist of 30 master trainers/faculties. Big flow out of the FD and master trainers started recently, because of economical situation. Salaries of Master Trainers/Faculties are not sustainable, they receive the salary around 100 US$ starting from the first day from ZdravPlus and it was raised now up to 115$. Government did not allocated special budget for FM department. They justified it by the fact that other faculties within KSMIRCE receive even less salary which is not paid regularly. ZdravPlus officially could not pay the salary for the employees of government institute. KSMIRCE created own NGO and Zdrav Plus gave amount necessary for the salary as a grant.
After the first year of TOT the retraining process started. For Kyrgyzstan the priority was to rather covering entire country than to do retraining deeply in some parts (for example in Uzbekistan about 1 year). In her opinion retraining should not be as long as the residency program and retraining is an intermediate solution of the FM gap. Retraining schedule consists of the following:
I phase:

- 1 month training on surgery and ob/gyn
- 1 month training on pediatrics
- 1 month on therapy

Between these courses they gave breaks from 1 to 3 months depending on the availability of groups (mainly oblast level).
II phase:

- 1 month training of vertical programs, such as TB/DOTS, PAL, IMCI, STI, HIV/AIDS and etc.

Final exam was conducted after approximately 1 month and consist of:

- Tests (written)
- Clinical situations (verbal)
- Different questions

For clinical situations they use system called OSKE (objectively structured examination - obyektivno strukturirovanniy examen), which means role plays.
Now after accomplishing all TOT and retraining program the master trainers/faculties mainly conduct short 5 days trainings on different topics and test the trainees after 1 month.

TOT and retraining of nurses had the same scheme. Training of nurses was conducted by nurses, since they have nurses with high education.
Total the retraining process lasted 5.5 years. For that period of time 5 doctors from US lived in Kyrgyzstan. Two of them Paul Fonken and Tom Chew were the most useful and Azerbaijan can contact them for future collaboration. In her opinion for development of the TOT and training materials it is better to have the foreign consultants in country rather than to send faculties abroad for TOT. After accomplishment of FM retraining program, Burul Juzenova is not so optimistic. As all people whom I met she stated too that in oblast level everything is going well unlike urban area, and financial sustainability of FM department is under the question.

She mentioned also about residency program. Three years ago 2-year residency programs were opened within Medical Academy (undergraduate) and KSMIRCE (postgraduate) separately with the same level of status i.e. Family Doctor specialty diploma. They both competed with each other which was confusing for graduates. Recently it was decided to merge both structures and use 2 clinical bases from KSMIRCE and 3 clinical bases from Medical Academy. Despite all efforts to attract graduate students to FM residency, very few students applied for FM residency program due to economical reasons.
Burul Juzenova also mentioned that in order to have successful education program it was necessary to train physicians on evidence-based medicine. To achieve it Kyrgyzstan created Evidence Based Medicine Department (EBM) within Center for Healthcare Development (CHD).

4. **For clarification of the situation with EBM department I met with Zdruv Plus staff – Director of EBM /QI - Marat Turgunbayev**

Kyrgyzstan initiated the single payer system through introduction of Mandatory Health Insurance Fund (MHIF). For monitoring of physicians work they needed clinical protocols and clinical guidelines. In the beginning (2001) they prepared several clinical protocols but there was no system in place yet as well as any evidence based materials. In 2004 Zdrav Plus suggested to create Guidelines on Family Medicine. Then the idea had overgrown to develop Evidence Based protocols. Zdrav Plus started this activity with four medical Associations: association of therapeutics, association of pediatricians, association of gynecologists, and association of surgeons. First, the associations prepared the list of diseases for development of clinical protocols. The following issues were taught for EBM initiative group:

- Teaching methodology
- Clinical standardization practice
- Use of evidence base

Zdrav Plus started from orientation seminars for high officials and academical staff, who did not accept evidence based medicine at all. They invited Dr. Denisov, a famous Russian Academician on EBM. After that the attitude of officials towards EBM changed completely. Since people were irritated from word EBM they used expression such as “Scientifically Grounded Medicine”. Then series of seminars on EBM were conducted and preparatory work for the transition to EBM started. Center of EBM was organized. People who prepared the protocols started to teach EBM in Medical Academy for 6-year students. The faculties were very enthusiastic about teaching the EBM. They expected that they would receive the additional teaching hour’s and accordingly additional money, but it did not happen, they were suggested to change the program. It was decided to introduce courses on Biostatistics and Clinical Epidemiology for post-graduate students (aspirants).

5. **Next meeting was with the chief specialist of EBM department within Healthcare Development Center – Olga Pankova.**

She mentioned that the development of Clinical protocols started from 2001 and improved from year to year. There are 180 protocols for PHC, secondary care and tertiary care. Practically all health conditions covered by clinical protocols. Clinical protocols are very short description of complains, etiology, clinics, diagnostics and treatment. Starting from last year they began developing the Clinical Guidelines with more detailed information. Following guidelines were developed:

- Acute coronary syndrome – developed by Cardiologists
- Eclampsia & Preeclampsia – developed by Ob/Gyn
- Acute Bronchial asthma in Children - developed by pediatricians
- Bleeding from upper gastro-intestinal tract - developed by Surgeries

17 working groups on different specialties was organized for the development of the Clinical protocols (CP). In order to coordinate activities Coordination Council under MOH was established. Coordination Council approved clinical protocols, decided how many copies necessary to print out, etc. There are two groups, which check the CP:

- 1st group evaluates methodological quality
- 2nd group evaluates clinical content

Clinical protocols developed based on Scotland Diagnostic Network and evaluated by AGREE methodology. AGREE stands for "Appraisal of Guidelines Research and Evaluation". It originates from an international collaboration of researchers and policy makers who worked together to improve the quality and effectiveness of clinical practice guidelines by establishing a shared framework for their development, reporting and assessment. www.agreecollaboration.org
Different Guidelines will be implemented through different methodology. For example for implementation of "Bronchial Asthma" guidelines nurses should also be involved or for implementation of "Acute coronary syndrome" guidelines emergency medicine specialists should be involved.
According to this instrument timeframe for clinical guideline development lasts 18 months if started from the beginning. If guidelines are adapted to the country context usually it lasts 12 months. Based on one Clinical Guidelines several CP will be worked out in future. All doctors were taught CP by Association of FGPs.

6. **Meeting with Country Manager of Zdruv Plus - Mark McEuen.**

Mark gave all information regarding the health reform starting from 1996 till present. Following is systematized information received from Mark.

Primary health care and public health services

Primary care is provided by feldsher-obstetrical points (FAPs), family group practices (FGPs), family medicine centers (FMCs) and ambulance and emergency care services. Formerly subordinate to central rayon hospitals, currently feldsher-obstetrical points report to either the family group practices or family medicine centers of their rayon.

Family group practices
Family group practices have been formed in recent years on the basis of preexisting health facilities (feldsher-obstetrical points, rural doctor ambulatories, polyclinics and rural district hospitals). Family group practices are staffed by at least one physician, in addition to nurses and midwives, and serve villages with a population of more than 2000 inhabitants. The number of staff depends on the size of the village. Piloted in Issyk-Kul oblast in 1995, with the support of the USAID-funded ZdravReform (now ZdravPlus) project, the model of family group practices has been gradually introduced throughout the country (Chui oblast and Bishkek in 1996 and 1997, Osh and Jalal-Abad oblasts in 1999, and the rest of the country subsequently). Family group practices are responsible for providing comprehensive primary care to their enrolled population. With the introduction of family group practices, the principles of family medicine were introduced in the health sector. In the Soviet health system, all primary care providers were specialists. When family group practices were established, an extensive retraining program offered a first training in family practice to specialists. To guarantee quality of care while family doctors are trained, family group practices usually consist of doctors representing the three specialties of internal medicine, pediatrics and obstetrics/gynecology, as well as midwives and nurses. The advantage of such an organizational unit is that it enables the provision of integrated primary health services to the whole family, whereas such services were previously provided in separate health facilities for adults, children and women (women's reproductive health care). Following the initial USAID support referred to above, family group practices have been supported by the World Bank, the Asian Development Bank, USAID and the Swiss Agency for Development and Cooperation. This support has included the renovation of buildings and the provision of equipment and training.

Rural doctor ambulatories
Rural doctor ambulatories were Soviet health facilities with the capacity to serve populations of 6000–10 000 in rural areas. These facilities were staffed by a specialist for internal medicine ("therapist"), a pediatrician, an obstetrician-gynecologist, a dentist, midwives and nurses. Rural doctor ambulatories could render a wider range of services than smaller health facilities in rural areas, but they were still limited to general medical care. As rural health facilities, both feldsher-obstetrical points and rural doctor ambulatories were accountable to the central rayon hospital, which was in turn accountable to the rayon

authority, as well as responsible for collecting health statistics for the rayon. By 2002, the remaining rural doctor ambulatories had been closed or transformed into family group practices.

Family medicine centers

Family medicine centers are the largest outpatient health facilities and are situated in the main settlement in the rayon. They combine primary care and secondary outpatient care services, ranging from general medical care to specialized care and diagnostics (including X-ray and ultrasound). Family medicine centers provide care for children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, pharmaceutical prescriptions, certification, home visits, and preventive and health promotion services. Health personnel in family medicine centers usually comprise 10–20 specialists. One family medicine centre has been established in every rayon, replacing polyclinics. Family medicine centers are also responsible for all family group practices and feldsher-obstetrical points in their rayon, although there are some family group practices that are independent juridical entities. For some time the value of family medicine centers has been questioned. In particular, the extensive provision of specialist services in close proximity to territorial hospitals does not seem to be justified in the resource-poor setting of the country. Attempts are under way to define the outpatient department of territorial hospitals as the place of specialized outpatient care.

Polyclinics

During the Soviet period, polyclinics were specialized, and separate polyclinics existed for adults, children, students, women and dental care. There were also polyclinics for special groups of the population, e.g. polyclinics of the Ministry of Interior for militiamen or polyclinics for construction workers. Organizationally, polyclinics were set up both as separate health facilities and as polyclinics accountable to the central rayon, city or oblast hospitals. As part of the restructuring of the health delivery system, different types of polyclinics (excluding stomatological polyclinics and those owned by other public agencies) were merged into comprehensive polyclinics. Initially, family group practices were formed as structural subdivisions of polyclinics. By 2002, merged polyclinics had been reorganized into family medicine centers.

Primary care issues

A high level of self-referred hospitalizations in recent years has indicated that the population was forgoing primary care in seeking health services. To solve this problem, family group practices are expected to function as gatekeepers by referring patients to higher levels of health care according to clinical protocols. Under the single payer system, incentives to encourage the use of the referral system have been designed and built into the State Benefits Package. Without a referral from a family group practice, patients have to pay higher levels of co-payment. The population enjoys the formal right to choose a family group practice. A mass information and education campaign was carried out in Chui oblast and Bishkek in 1999 to encourage enrolment in family group practices. Actual choice exists in some urban parts of the country, whereas elsewhere people are effectively assigned to family group practices according to their place of residence.

The reorganization of primary care is still being carried out. Family group practices are taking on more and more responsibilities in the health care system. In particular, they are now responsible for carrying out screening interventions, immunization and social patronage (including antenatal care). An increasing amount of time is also being spent on administration and paper work. Because small family group practices began to encounter difficulties in rendering services, given their limited capacity, since 2001, small family group practices have started to merge in order to create economies of scale. As a result, between 2000 and 2003, the number of family group practices decreased from 800 to 668. Further decisions on the status of family group practices still have to be made in the context of the ongoing restructuring of the health delivery system.

Human resources in the health sector are distributed unevenly. The northern regions are better staffed than the southern regions, where physicians are lacking. In addition, there is a countrywide excess of physicians in cities and a shortage in rural areas. In Bishkek there are almost twice as many physicians as in the oblasts of Jalal-Abad and Batken. There are several reasons for this uneven distribution of human

resources. The previous system whereby graduating health personnel were compulsorily assigned to rural areas has been discontinued in the years of transition. Efforts by the Ministry of Health to re-establish mandatory postings to rural areas have so far been unsuccessful. Another reason for the concentration of physicians in urban areas is the concentration of health facilities in the capital and oblast centers.
Rural health facilities, in contrast, are often poorly equipped and supplied, and living conditions in rural areas tend to be worse. Irregular payment of salaries is also more common and contributes to the reluctance of health professionals to work in rural areas. Besides being paid irregularly, the salaries in the health sector are very low. According to official statistics, the average monthly wage of health personnel was 92% of the national average of all occupations in 1994 and fell to 49.2% in 2003. Many well-qualified health workers have left for the private sector or changed their occupation to economic activities that offer higher incomes. Low salaries in the health sector also lead to poor motivation, poor quality of care and the request for informal payments. It is hoped that incentives under the single payer system will change this situation for the better.

Training

Medical education has undergone some changes through a reform of the National Program on Medical Education, but much more needs to be done. Systems of on-the-job training and retraining of health personnel are fragmented and mainly oriented towards inpatient care. There is also a need for better cooperation among different institutions providing medical education. Existing curricula have so far not been brought in line with the planned restructuring of the health delivery system; nursing education, in particular, needs further reform. The training of doctors is provided by the Kyrgyz State Medical Academy in Bishkek and the medical schools of the Kyrgyz-Russian Slavic University (KRSU), Osh State University (OSU), Jalal-Abad State University (JASU), Kyrgyz-Uzbek University (KUU), Kyrgyz-Turkish MANAS University (KTU MANAS) and the private Jalal-Abad University of the Peoples' Friendship named after A. Batyrov (JAUPF). The training of middle-level health personnel is provided by 10 medical colleges and a School of Nursing which is accountable to the Kyrgyz State Medical Academy. Since 1997, the State Medical Academy and the International University of Kyrgyzstan (IUK) have jointly run the School of Health Management, which offers education to future health managers in the framework of a two-year Master's program. The State Medical Institute of Retraining and Postgraduate Education and six training centers for family medicine at the oblast level provide training in family medicine and general practice. The State Medical Academy is the leading institution providing medical education in the country. The Kyrgyz-Russian Slavic University, Osh State University, Jalal-Abad State University, Kyrgyz-Uzbek University, Kyrgyz-Turkish MANAS University and Jalal-Abad University of the People's Friendship medical schools were established in the mid- and late 1990s. The training of doctors consists of 6 years full-time education after 11 years of high school, followed by a 2-year "internatura" specialization (one year before 1998), during which medical graduates practice in health facilities. Those who want to specialize further enter "aspirantura", a 2-year clinical residence in a scientific research institute or national centre. Aspirantura graduates can practice as narrow specialists. They can start working on a candidate thesis to obtain the academic degree of Candidate of Medical Sciences. Candidates of Medical Sciences can embark on writing a doctoral thesis to obtain the academic degree of Doctor of Medical Sciences. In the public sector, an academic degree is used as a coefficient that significantly increases salaries. Postgraduate training includes regular short refresher courses for physicians, which are usually provided at scientific research institutes or national centers. These courses are very important, because they determine qualifications and salary levels in the public sector. The training of middle-level health personnel consists of 3 years full-time education after 11 years of high school (2 years after 9 years of secondary school before 1998). The School of Nursing of the State Medical Academy provides higher education for nurses. The Association of Nurses is an active member of the European Nursing Association and has developed guidelines on standard practices for nurses, which have been approved by the Ministry of Health. The State Medical Institute of Retraining and Postgraduate Education and the Family Medicine Training Centre provide three-month courses in family medicine to district doctors and nurses. Short refresher courses are provided locally to health workers who have completed retraining. Thirty percent of all family group practice workers, including 43.7% of family group practice doctors and 20.6% of family group practice nurses, have so far been retrained. The

State Medical Institute of Retraining and Postgraduate Education also provide a one-year course to trainers in family medicine. Graduates of this course are now working in oblast training centers for family medicine. The Institute has been supported by USAID and the Health-I project of the World Bank. The number of admissions to the State Medical Academy, medical schools of the Kyrgyz-Russian Slavic University, Osh State University and Kyrgyz- Turkish MANAS University and medical colleges has not been fully regulated by the Government in recent years. Besides planned admissions which are free to students and covered by the state budget, these institutions have allowed additional admissions for which they charge fees. Recognizing that this may result in an oversupply of health personnel in the country, the Ministry of Health has started to regulate all admissions to the State Medical Academy. In 1999, the Ministry initiated a tripartite arrangement between students, the medical academy and the Ministry, which envisaged that upon graduation, students would have to work three years in a region determined by the Ministry of Health. This arrangement has not, however, been successful, as 90% of students failed to comply with their contracts and stayed to practice in Bishkek. Nevertheless, similar measures are anticipated for other medical institutions. They will require the cooperation of the Ministry of Education and Culture, which has been reticent to institute controls over private elements of higher education.

Pharmaceuticals

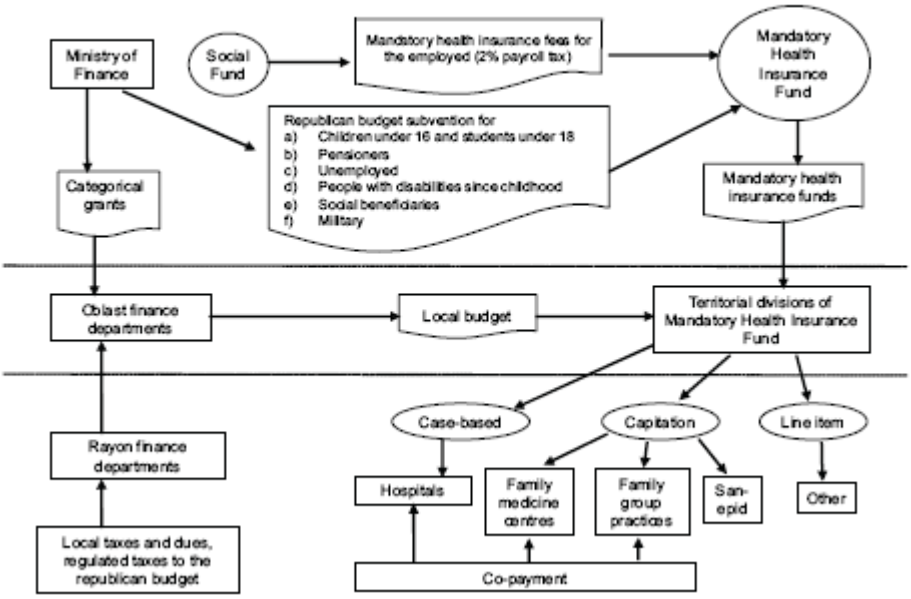
To achieve economies of scale, pharmaceuticals for health facilities in the public sector are centrally procured following competitive bidding, as set out in the Law on State Purchases. Health facilities can also purchase their own drugs, based on the Essential Drugs Formulary that promotes the use of generics. They can use funds from the mandatory health insurance to purchase drugs that are not included in the Essential Drugs List, but this purchase is limited to 10% of total procurement costs. The co-payments as a new funding source seem to have improved the provision of drugs to patients. The first list of essential drugs was developed in Kyrgyzstan in 1996, based on WHO guidelines. It was revised in 1998, 2001 and 2003. A national drugs policy was adopted by government decree in December 1998. WHO provided technical assistance in the development of the essential drugs list and the essential drugs formularies. Since 1998, it has also supported the Drug Information Centre of the Department of Drug Supply and Medical Equipment. The Drug Information Centre monitors the side-effects of drugs and issues a bulletin on rational drug use. Rational drug use has been promoted at all levels of health care. The development of 180 clinical protocols according to the principles of evidence-based medicine should enhance rational drug use. In 2000, the MHIF introduced an ***additional drugs package*** on a pilot basis in three polyclinics in Bishkek and the Alamudun rayon of Chui oblast. As from the second half of 2001, it covered all family group practices of Chui and Issyk-Kul oblasts, the family group practices of Bakai-Ata rayon of Talas oblast and Bishkek. In 2002 the additional drugs package was introduced in all oblasts working under the single payer system, and, by April 2003, it was functioning in all rayons of the country except two in Osh oblast. As of 1 October 2004, there were 703 family group practices and 612 pharmacies working under the additional drugs package scheme. The additional drugs package forms part of the State Benefits Package. In 2004, the additional drugs package consisted of 53 generic (including syringes) and about 250 trade names, based on the essential drugs list. Pharmacies that conclude a contract with the MHIF sell the specified drugs to insured patients at lower prices. The MHIF reimburses pharmacies in arrears using a reference price system and a computer-processed prescription form. The average reimbursement rate is 50% of the price. Even though the issue of physical access to 70 types of drugs, including tablets, unguents, galenicals and herbal raw materials, has largely been solved, their affordability remains a major problem. Budgets of health facilities are limited and a large proportion of the population lives in poverty and cannot afford necessary drugs. Access has been gradually improved: 10% customs duty on drugs was removed in 2001 and 20% value-added tax on drugs was cancelled in 2003. These measures, especially the removal of value-added tax, have resulted in a decrease of prices in the retail network, amounting to 21.7% in late 2003. Foreign aid has been very important for the pharmaceutical sector. When the supply of drugs was interrupted after independence, foreign loans and grants were used to import emergency drugs, and additional drugs were donated as humanitarian aid. A special warehouse for storing the drugs received was established.

Financial resource allocation

Current situation

At present, health care budgeting and resource allocation take place in the single payer system, which means that budgetary and mandatory health insurance funds for health care are consolidated in one pool and the resources are subsequently allocated to health providers through a single channel. Fig. 18 shows how revenues for health care are collected, pooled and allocated to providers.

Fig. 18. Financial flows in the single payer system



Case-based Capitation Mandatory health insurance fees for the employed (2% payroll tax)
Republican budget subvention for
a) Children under 16 and students under 18
b) Pensioners
c) Unemployed
d) People with disabilities since childhood
e) Social beneficiaries
f) Military
Local budget Categorical grants Mandatory health insurance funds Sanepid Line item. Other Mandatory health insurance fees are collected by the Social Fund and then transferred to the MHIF at national level. Transfers are annually approved by the Law on the Social Fund Budget. In reality, however, they depend on the collections by the Social Fund and its compliance with the law, and the actual levels to be received by the MHIF are therefore difficult to forecast. Transfers from the republican budget to the MHIF are approved each year by the Law on the Republican Budget. Regional finance departments prepare a forecast of local budgetary health financing, categorical grants and grants from the republican budget. Given these expected volumes of budgetary financing, the territorial departments of the MHIF prepare a budget in accordance with the budget classification. The Ministry of Finance and regional finance departments transfer the collected revenues to territorial departments of the MHIF in line with the adopted budgets. The territorial departments of the MHIF allocate these resources to the health providers of their territories on a contractual basis using new provider payment methods. The budgets of health facilities are then planned on the basis of the State Benefits Program and the following new financing norms: the number of ambulance brigades for ambulance and emergency care providers; the size of the enrolled population for family group practices; the size of the population of the service area for specialized outpatient care providers, including outpatient departments of hospitals, and for san-epid services providers; the average cost of treatment for hospitals. These new norms apply equally to budgetary and mandatory health insurance funding; the only differences are in base rates and calculation formulas. Hospitals providing extended periods of inpatient care and providers of rehabilitation and some

other forms of care are exempt from these norms, and they continue to plan their budgets according to the old budget classification methods. Co-payment was introduced as part of the single payer system. The levels of co-payment are determined by the State Benefits Package, which is calculated each year (see the section on *Health care financing and expenditure – health care benefits and rationing*). At the outpatient level, the co-payment levels depend on the prices of diagnostic tests and procedures, which are developed by the Ministry of Health and approved by the Anti-Monopoly Commission. At the hospital level, the co-payment depends on the average cost of treatment – a projected indicator of spending per treated patient from budgetary and mandatory health insurance funds and co-payments. Co-payment is administered directly by health facilities and regulated by the Statute "On the population's co-payment for drugs, meals and certain types of health services provided by public health facilities working in the single payer system". In 2004, 206.3 million som were collected as co-payments. The collected co-payments are allocated in health facilities in the following way: 20% are used to increase salaries, including social contributions; 60% are allocated to the purchase of drugs, medical supplies, and laboratory and diagnostic tests; and 20% are used for the purchase of additional food, disinfectants and detergents, paper forms, bank fees and other support services. The mandatory health insurance funds are allocated in health facilities as follows: in hospitals, 25% are used to increase salaries, including social contributions; 70% are used for the purchase of drugs and medical supplies, and diagnostic and laboratory tests (covering no more than 35% of laboratory needs); and 5% are used for other purchases, repairs and technical support, paper forms, bank fees and other support services, and travel expenses in the framework of the contract with the territorial department of the MHIF. In family group practices and family medicine centers, 35% of mandatory health insurance funds (30% in Bishkek) are used for additional salary and social contributions, accrued monthly on the basis of the size of the enrolled population; 12% (10% in Bishkek) are used for the purchase of basic and laboratory equipment, drugs and medical supplies; 43% (50% in Bishkek) are used for drug provision under the additional program of mandatory health insurance; and 10% are used for repairs, technical support, paper forms, bank fees and other support services. Health facilities maintain separate reporting for funds coming from the state budget, the MHIF and co-payments. Funds received from these three sources are not subject to taxation or inclusion in the state budget.

Payment of providers

Hospitals

For both budgetary and mandatory health insurance funding, hospitals are paid on the basis of the number of cases treated. Cases are categorized according to clinical expenditure groups, which are a version of diagnosis-related groups, based on Kyrgyz hospital utilization and cost data. Co-payments are paid directly to the hospital's cash desk.

Outpatient facilities

Outpatient facilities (outpatient departments of hospitals and family medicine centers) are paid from both budgetary and mandatory health insurance funds according to a capitation method. They receive funds per person living in the service area. Like hospitals, they administer co-payments, which are paid directly to their cash desk.

Primary care

The allocation of funds to family group practices is also based on a capitation method and applies to both budgetary and mandatory health insurance funds. Family group practices receive funds for each person enrolled with them. Providers of ambulance and emergency care are paid on the basis of a maintenance norm per ambulance brigade. In 2004, one ambulance brigade was estimated to serve on average 12 500 people.

Payment of physicians

During the entire period of 1993 to 2003, the average salary in the health sector was lower than the average salary in all sectors combined. While in 1992 the average salary in the health sector was 92% of the national average, by 2003 it had declined to only 49%. The average salary in the health sector is now the third lowest of all economic sectors, after forestry and agriculture. Public sector employees in the health sector have been paid according to a national pay scale for public employees, under the system of "tarification". Since 1993, their salaries have been supplemented by official premiums from paid

services. Physicians have also charged or accepted unofficial under-the-table payments from patients. Since the introduction of the mandatory health insurance system, physicians have received additional salaries from the mandatory health insurance funding. Since the introduction of the single payer reform, salaries have improved considerably. One of the most prominent changes is that the groups used to calculate the bonuses of managers of health facilities are now tied to output, such as the number of treated cases per year for hospitals, the enrolled population for family medicine centers, the service area population for providers of ambulance and emergency care, the amount of plasma per year for transfusion facilities, and the amount of milk portions per day for dairy kitchens. In the single payer system, health care facilities form a consolidated salary pool from four sources: budgetary means, special means, mandatory health insurance funds and co-payments. Budgetary means and special means are determined according to planned budget limits, while mandatory health insurance funds and co-payments are determined according to rates set by the Ministry of Health (25–35% and 20%, respectively, in 2004). No less than 85% of the consolidated salary pool is used for health personnel and no more than 15% for management, administrative and support staff. The salary in the single payer system consists of two components: the guaranteed salary and the additional salary. While the guaranteed salary is calculated according to tarification, in accordance with the regulations applying to remuneration in health care facilities, the additional salary is calculated according to the guaranteed salary and two coefficients: the additional salary coefficient and the labour participation coefficient. The labour participation coefficient is calculated by expert commissions in health facilities, taking account of the staff workload. Recommended workload norms and labour participation coefficients, including a detailed methodology, have been developed by the Ministry of Health. The salary pool of providers of san-epid services includes budgetary means and special means. Thirty-five percent of the salary pool is used for laboratory personnel and 65% for other personnel.

Reform implementation

Developed and implemented in the context of transition, the health care reform in Kyrgyzstan has depended heavily on domestic political support and the assistance of external donors. The Kyrgyz government has provided the necessary institutional arrangements, while international organizations have provided technical expertise and financial assistance. The step-by-step approach to health reform has proved to be beneficial. Innovations were first tested in pilot regions, with the support of external donors. Successful experiences were then rolled out to the rest of the country, provided that they were compatible with the existing infrastructure, capacities and resources. The effective coordination of the activities of donors in the health sector and continuity in health reform management have also been important factors in the successful implementation of health care reform. Originally, the Department of Health Care Reform coordinated donors' activities, but the Ministry of Health subsequently took over this function. Continuity in the management of health reform has been partly due to the fact that little rotation in the top management of the Ministry of Health has taken place, in spite of a change of health minister in 2002. The main successes and failures, risks and future plans of health reform are discussed below in a breakdown of the four key elements of health reform: health delivery restructuring; health care finance reform; medical education and human resources; and drug policy and quality assurance.

Lessons learnt

Health care reform in Kyrgyzstan provides important lessons relevant to other health care systems in transition. The key lessons of the Kyrgyz experience are the following: Development of the health sector depends to a large degree on the economic and democratic development of the whole society. Health financing reforms are extremely difficult if they are not embedded in a reform of the financial system of the country. Successes in health sector reform should not be punished by decreased levels of financing. All attempts to introduce mechanisms to ensure the more efficient use of resources while financing levels are declining risk losing public trust in the reforms. Restructuring of the health care delivery system is impossible to achieve without strong political commitment and new economic instruments, just as such restructuring is impossible to achieve solely through administrative methods. Coordination of donors' activities is crucial to the successful implementation of reforms. There has to be a professional and committed team of reformers who understand the essence of the reforms and are guided by the same

vision. One of the main obstacles to successful health care reform can be the health personnel. It is therefore essential to ensure that health care workers are extensively educated and informed. These measures should be combined with financial and other incentives to enhance the motivation of health personnel, improve the quality of care and reduce demands for under-the table payments.
It is also essential to raise awareness of the population and civil society about the content of the reforms. It is very difficult to develop a new legislative framework at an early stage of program development. Laws therefore tend to lag behind the reform process. New reform elements should be piloted and then rolled out to the whole country. A system of monitoring and evaluation is crucial to controlling and correcting the reform process.

Materials brought:
Hard copies:

1. Report on quality monitoring of family group practices performance and implementation of state drug policy in the Kyrgyz Republic (April-June, 2003) English & Russian version.
2. List of reimbursed additional drugs package. MOH Kyrgyz Republic, Mandatory Health Insurance Fund. Russian version 2004.
3. State guarantee on ensuring Primary Health Care for Kyrgyz Republic citizens. Russian version 2006.
4. TOT Curriculum, 2003-2004, Russian version.
5. Curriculum for the retraining of FGPs on Family Medicine, phase I, 2006, Russian version.
6. Curriculum for the retraining of FGPs on Family Medicine, phase I, before 2006, Russian version.
7. Curriculum for the retraining of FGPs on Family Medicine, phase II, 2000, 2001, 2002, 2003, Russian version.
8. Changes and additions included into FM education Programs (TOT and Retraining), 200-2003, Russian version.
9. Review of Experience of Family Medicine in Europe and Central Asia (Volume 1), Russian.

E-copies:

1. Health and health financing related Laws and prikazes Bishkek Republic (Eng & Russian)
2. PHR*plus*/Albania Toolkits for Strengthening Primary Health Care *January 2005*
3. ZdravPlus' Strategy for EBM Promotion, CPG Development and Implementation in Central Asian Countries (Eng)
4. All Curriculums for the retraining of FGPs on Family Medicine (PhaseI & II), English & Russian.
5. All Curriculums for TOT, English & Russian.
6. Quick Reference Guide for Primary Care Providers, which includes all modules taught on FM programs (Eng & Russian)
7. The future of family medicine education in Kyrgyzstan, 2004, English.
8. The Role of Pilot Programs Approaches to Health Systems Strengthening, PHR*plus, Abt associates Inc*, 2004, English.
9. Health Policy Analysis Project Policy brief #5 Policy issues in providing outpatient specialist care, WHO/DfID Manas
10. Family medicine in the Kyrgyz oblast health care system, mission report, 2003, English.
11. Perceptions of the co-payment policy among patients and health personnel: rapid appraisal study in the pilot area of Chui and Issykkul oblasts, November 2001, WHO, MOH, Department of Reform Coordination and Implementation and Swiss Development Corporation, English.
12. Case Study on Piloting Complex Health Reforms in Kyrgyzstan, 2004, English.
13. Moving from First Generation of FM Training to a Model for National Retraining and Reorganization of Primary Care Delivery, Armenia.
14. HIT Kyrgyzstan (Eng & Russian)
15. Samples of Clinical Protocols (CP) and Clinical Guidelines (CG)
16. Review of Experience of Family Medicine in Europe and Central Asia (1-5 volume), English.
17. Single payer system, Bishkek, Ibrahimova, PP presentation flagship course, Russian.

18. Examples from Kyrgyzstan of how to use purchasing tools to promote policy objectives, Kutzin, PP presentation flagship course, English.
19. The Introduction of Family Medicine Into Kyrgyzstan, Post-graduate training in Family Medicine, Current Status (Sept. 2002), Paul Fonken, M.D., PP presentation (Russian & English).
20. Models for Foreign Assistance, A Comparison of the Partnership Model with the Long-term Technical Assistance Model in Kyrgyzstan, PP presentation (Russian & English).
21. Evidence Based Medicine Course Materials, October 2005, Bishkek (4-day training material and all presentations)
22. Distance Education Course (CD-Rom based interactive course)

AI Quarterly Report

TOT and District Level Training for the Healthcare Providers

Training of Trainers (TOT): A four day TOT was organized between 30 June and 4 July. The training was facilitated by PHC staff. The training was designed to provide 16 “master trainers” with the knowledge and skills necessary to conduct AI training for health personnel (district hospital and SES) at the district level. Additionally, these master trainers will lead discussions regarding AI planning and preparedness with the District Emergency Response Committees in the same districts.

The participation and level of engagement of the master trainers was lively and active. Their participation identified a number of areas of concern in the MoH AI detection and reporting protocols and forms, which required clarification prior to the district trainings. These master trainers now represent an important resource for the MoH to continue to support and strengthen AI preparedness in the country’s health sector.

Revision of training materials: The TOT experience identified a number of areas of ambiguity within the protocols and forms which required clarification before their introduction to district level staff. The PHC team worked with MoH officials to incorporate changes into the official forms and protocols. The district level training materials and methods were modified to reflect and incorporate those changes. The level of interaction between PHC staff and MoH officials appears to be strong and highly collaborative.

In addition to these changes, a pre/post test was developed to help the team to measure initial knowledge transfer to district staff as a result of the training. It is suggested that this same instrument be re-administered to district staff at some point in the future to assess knowledge retention by the staff.

Several other instruments were developed for use by the master trainers to standardize and focus their feedback to PHC on the training experience. These instruments were designed to highlight district level reaction to the training and material and to identify obstacles to strengthened AI surveillance and response. PHC will sue this feedback to continue dialogue with MoH and donor partners as to next steps and future support to AI preparedness and response planning.

District Emergency Response Committee meetings: MTs conducted meeting with the District Emergency Response Committee in all 11 selected districts prior to the start of training for health staff. The objective of these meetings was to facilitate a discussion of the AI threat and how the districts might mobilize their own resources to respond. During the meetings it quickly became clear that the committees have taken the AI threat seriously (despite having detected no cases yet) and have been active in planning and response activities. In each district the committee brings the agricultural and the health sector together and promotes communication between the sectors. The result of the discussion was a number of ideas as to how the committee might be supported to improve their state

of readiness and capacity to respond to AI if needed. Feedback from master trainers in all districts suggested a similar level of active engagement on the part of the committees.

District level training in districts: Jim Setzer (Abt Associates Inc.) visited district level training of health staff in Devechi, Xizi and Salyan Districts. He did so in order to gage the effectiveness of both the mater trainers and the training materials to improve the knowledge of health staff with respect to AI detection, reporting and response protocols. According to Setzer in all three cases the training seemed to be going extremely well. The trainers were clearly in command of the material and seemed at ease leading the groups through the modules observed. The participants were actively engaged (following along in their folders, taking notes, asking/answering questions, asking for clarification, etc.). PHC had done a good job organizing the sessions and all three seemed to be running smoothly and on schedule/track. Setzer's main conclusion from his observations (and discussions on the side with trainers and monitors about how other sessions/modules had gone) is that the project seems to be: "doing the right thing AND doing it right".

Through their experience with these trainings, the master trainers will also be much better supervisors of AI preparedness and activities in these districts. This affirms the wisdom of the PHC AI plan.

Next Steps: The following next steps have been identified for the PHC project support to AI surveillance and response strengthening:

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Analysis of feedback/information collected during district level training and District Emergency response Committee meetings: This includes scoring of the pre and post tests administered to health staff training participants. This analysis can be based largely on the forms that Master trainers were given to complete at the end of each module. They may provide other feedback and commentary as well and that should be duly noted and integrated into the analysis and report. This analysis will be completed after the second round of districts trainings is carried out.

Continued dialogue with MoH and donor partners related to support to AI surveillance and response strengthening in all sectors: The trainings will provide important, evidence-based insight into the current level of AI preparedness and the obstacles and needs to strengthen preparedness. This information must be shared with all stakeholders so that they might better define and coordinate their inputs and support.

(Possible) Modify training materials: Based upon the experience of the first round of trainings major revisions of the training materials dos not appear warranted. After the training is completed however, the materials should be reviewed and "fine tuned" so that the MoH has the best and most up to date versions available should it decide to expand its AI preparedness activities to include training in additional districts.

Other Issues:

Training of district level clinicians: The PHC supported training has targeted staff responsible for strengthening district level AI surveillance and response. It has included some of the clinical staff from the district hospital. A key to the success of the system however is the correct, consistent and universal use of the standard case definition by all health care providers seeing patients in the district.

These personnel were not (by design) included in the trainings conducted by the project. This next step is assumed to be the responsibility of the district SES team. The project should, however, pay careful attention as to whether the districts are able to carry out this training. This should be part of the supervision and support to be provided to the districts by the PHC project. The project should work closely with the district teams to identify and overcome whatever obstacles there are to ensuring that all district health care providers understand their roles and responsibilities and have the knowledge and skills to fulfill them as their part in responding to AI in their district.

Minutes from the
Workshop of master trainers

Monitoring and evaluation plan

Workshop for master trainers

On July 24, the PHC project held meeting with master trainers. The main purpose was to review experience with conducting first round of district level trainings in 5 districts. Based upon the discussions held with the master trainers, the overall impression was that there was no need in major revisions of the training materials, and this was in line with the recommendation made by Jim Setzer (Abt Associates Inc.)

The major concern the master trainers had was that in the module 4, while describing lab samples and how to collect them, they are unable to demonstrate sample collection procedures since equipment for specimen collection is not available. It was obvious this problem could not be solved for the second round training given that the equipment was not still available.

It seems that this problem can be only addressed during subsequent monitoring visits to every district SES providing that the MOH makes these equipment available to the master trainers (small quantity that is needed for demonstration purposes only). Equipment for specimen collection has been recently handed over to the Republican Anti-Plaque station through the lab strengthening project implemented by US DoD/ DTRA (confirmed by Dr Yingst, NAMRU-3, during the meeting with HAI project team). This issue has been discussed with Dr Gassimov, who supported this idea and confirmed that the MOH is ready to provide this equipment to the master trainers.

Finalized monitoring and evaluation plan

In cooperation with HAI project team and the master trainers, Mamuka Djibuti(**Curatio International Foundation)** has developed a detailed plan for monitoring visits in 10 districts targeted by the project. The plan also defines the monitoring format, i.e. what has to be done during these monitoring visits.

First monitoring visit

As emphasized in Setzer's report a key to the success of the system is to ensure that all health care providers starting from the grass root level (including FAPs and village ambulatories) correctly and consistently use the standard case definition for HAI. It is critically important that all providers know the case reporting procedures as defined by the HAI surveillance protocol.

In order to make sure that health care providers are knowledgeable about the standard case definitions and the case reporting procedures, it is recommended to organize one day meeting with all district providers including feldshers and ambulatory doctors who have not attended the initial district level trainings. For this meeting, it is proposed to use the venue of routine district health personnel meeting (so called "Med Sovet"), which usually takes place once a month and is attended by all health personnel working in a district. This idea was discussed with district Chief

Doctors and SES Directors, who have strongly supported it (This idea was also supported by Dr Gassimov).

The format of the first monitoring visit will be the master trainers traveling to each of 11 targeted districts and assisting local SES epidemiologists to instruct district providers on HAI standard case definition and case reporting procedures. For this meeting, it is recommended to print and distribute **the primary health care (PHC) provider's instructions** which will focus on standard case definition and case reporting procedures (short version of the HAI surveillance protocol tailored to the PHC providers needs). Djibuti has developed a first draft of the PHC provider instructions (see attached to this report), which needs to be reviewed first by the HAI project team members and then submitted to MOH (Dr. Gassimov) for their approval. Printing and distribution of the PHC provider's instructions among providers is conditional to the MOH official approval. It is recommended to print one or two pages laminated sheets and make sure that at least one copy is available in each PHC facility in a district (ideally, one sheet per PHC provider).

The HAI project local team has to prepare a detailed schedule for all 11 districts (see Table 1 below). The dates should be set to conduct "Med Sovets", and the monitors (i.e. master trainers) should be selected for going to each district. Number of PHC facilities/ providers needs to be obtained from the MoH to estimate the quantities of materials to be printed (PHC provider instructions and HAI case report form).

Table 1. The plan for first monitoring visits

District	Med Sovet Date	Number of PHC Facilities/ providers	Monitor/ Master Trainer	Activities
				• Instructing providers on HAI standard case definitions and case reporting procedures • Distribute the PHC provider's instructions among all district providers including FAP and village ambulatory staff (at least one manual per facility)

<u>Second monitoring visit</u>
By employing similar approach, the HAI project local team is advised to prepare the schedule for the second monitoring visits (see Table 2 below). The format of the second visit is also described in the Table 2.

Table 2. The plan and format for the second monitoring meeting

District	Date	Monitor/ Master Trainer	Activities
			First day • Meet with SES epidemiologists to demonstrate them a sample collection equipment and how to use them • Fill out the district SES evaluation form (see below) [1] Second day • Select 2 or 3 facilities, travel to them with local SES epidemiologist and fill out facility performance evaluation form [2] General format Monitoring visits in both district SES and health care facilities need to be conducted according to supportive supervision guidelines, which was presented during the ToT and district level training

1. Sample district SES evaluation form

The table below provides simple questions for the evaluation of a district SES's performance in the area of HAI surveillance by the monitors/ master trainers. The aim of such evaluations is to:

- Identify problem areas, and
- Provide on the job technical assistance and plan adequate interventions aimed at addressing these issues.

Supervision and evaluation should be carried out in an encouraging atmosphere. The monitor should provide needed clarification, explanations, and support as necessary, and should find reasonable and acceptable solutions to improve the system. The questions provided in the below table also can be used by the district SES epidemiologists themselves in self-monitoring their work.

Availability of Surveillance Documentation, Registers, and Forms	
1. Does the district SES use the standard infectious diseases journal 60?	Yes ☐ No ☐
2. Has the district SES lacked urgent notification cards at any time in the last 2 months?	Yes ☐ No ☐
3. Has the district SES lacked monthly reporting forms at any time in the past 2 months?	Yes ☐ No ☐
4. Does the district SES have the MoH protocol for HAI surveillance?	Yes ☐ No ☐
Adherence to Notification and Reporting Requirements	
5. Prepare a list of probable HAI cases for which urgent notifications were sent by this district SES in the past 2 months. Check journal 60 randomly for the corresponding information. Has this SES always forwarded urgent notifications about probable HAI to	Yes ☐ No ☐

apprpriate authorities according to protocol for HAI surveillance?	
6. Has submission of an urgent notification of an HAI probable case been ever delayed for more than 6 hours?	Yes ☐ No ☐
7. Have the weekly notifications for possible cases for the past 2 months been always submitted prior to the established deadline?	Yes ☐ No ☐
8. Are all of the weekly notifications for possible cases for the past 2 months complete? Verify using the journal 60 and copies of forms submitted by facilities.	Yes ☐ No ☐
9. Are all of the weekly notifications for possible cases for the past 2 months accurate? Verify using the journal 60 and copies of forms submitted by facilities.	Yes ☐ No ☐
10. Have case report forms been submitted for all cases of probable HAI?	Yes ☐ No ☐
Adherence to Laboratory Confirmation Requirements	
11. Does the district hospital have the capacity to transport specimens to a higher level lab?	Yes ☐ No ☐
12. Has this district reported cases of probable HAI requiring lab testing in the past 2 months? Check case notifications and register 60. If answer is “yes” go to Q13, if “no,” go to Q15.	Yes ☐ No ☐
13. Were specimens collected for all reported probable HAI cases? If answer is yes go to 14, If no go to 15	Yes ☐ No ☐
14. Were test results received for all specimens?	Yes ☐ No ☐
Data Analysis	
15. Does this SES analyze timeliness and accuracy of emergency notification forms received from facilities? Observe.	Yes ☐ No ☐
16. Does this SES analyze case confirmation rates (lab) for HAI?	Yes ☐ No ☐
17. Does this SES have appropriate demographic data at site?	Yes ☐ No ☐
18. Does this SES analyze timeliness and accuracy of possible HAI (influenza-like illness) case reports received from facilities? Observe.	Yes ☐ No ☐
Case Outbreak Preparedness, Investigation, and Response	
19. Is the case/outbreak investigation rate in this rayon higher than 90%? Check the last 2-month period.	Yes ☐ No ☐
20. Has the start of investigation ever been delayed beyond the recommended period in the past 2 months?	Yes ☐ No ☐
21. Does the district have a permanent commission for HAI preparedness and response?	Yes ☐ No ☐
22. Can the district SES give fresh examples of delivering community education materials and messages based on the current epidemiological situation with HAI?	Yes ☐ No ☐
23. Has the district been always able to implement HAI case/outbreak control protocols recommended by the MOH HAI protocol in the past 2 months? (If “No” specify a reason: shortage of drugs or supplies?, lack of funding?, no means of transport?)	Yes ☐ No ☐
24. Has the district SES carried out a formal training for district providers in the HAI surveillance protocol?	Yes ☐ No ☐
Feedback and Supervision	
25. Can the district SES provide examples of mechanisms it uses to provide routine/ regular feedback to health facilities and other district stakeholders? If yes, specify:	Yes ☐ No ☐
26. Does the district SES have evidence of making supervisory visits to more than 80% of the facilities involved in the HAI surveillance work in its service territory?	Yes ☐ No ☐

Answering “No” to any of the questions requires clarification and discussion about what exactly is wrong and a provision of recommendations that will allow district SES to correct the mistakes quickly.

2. Sample facility performance evaluation form

The second monitoring for facilities is mainly conducted with district SES epidemiologists with technical assistance provided by the master trainers. The table (below) includes questions for SES evaluation of facility performance in the area of HAI surveillance in order to accomplish the following:

- Identify problem areas, and
- Provide on the job technical assistance and plan adequate interventions to address these issues

To prepare for a supervisory visit, it is recommended that district SES staff review and bring with them relevant copies of the journal 60 and copies of reports received from facilities. Supervision and evaluation should be carried out in an encouraging atmosphere. SES personnel should provide clarification, explanations, and support as necessary, and should assist in finding reasonable and acceptable solutions to improve the system. The questions addressed in the below Table also can be used by the facilities themselves to self-monitor their work.

Availability of Surveillance Documentation, Registers, and Forms	
1. Does the facility use the standard infectious diseases register journal 60 ?	Yes ☐ No ☐
2. Does the facility have at least one copy of the emergency notification form?	Yes ☐ No ☐
3. Does the facility have the standard HAI surveillance protocol?	Yes ☐ No ☐
4. Does the facility have the HAI case report form? (consider different levels)	Yes ☐ No ☐
5. Does the facility have the lab request form? (for district hospitals only)	Yes ☐ No ☐
6. Does the facility have the lab shipment form? (for district hospitals only)	Yes ☐ No ☐
7. Does the facility have the contact tracing form? (for district hospitals only)	Yes ☐ No ☐
8. Does the facility have the contact monitoring form? (for district hospitals only)	Yes ☐ No ☐
9. Does the facility have the the health care worker monitoring form? (for district hospitals only)	Yes ☐ No ☐
10. Does the facility have the animal worker monitoring form? (for district hospitals only)	Yes ☐ No ☐
Adherence to Notification and Reporting Requirements	
11. Prepare a list of probable HAI cases for which urgent notifications were sent by this facility in the past 2 months. Check clinical registers randomly for the corresponding information. Has this facility always sent urgent notifications about HAI?	Yes ☐ No ☐
12. Has submission of an urgent notification been ever delayed for more than 6 hours? Verify using clinical records.	Yes ☐ No ☐
13. Have HAI case report forms for the past 2 months been always submitted prior to the established deadline?	Yes ☐ No ☐
14. Are all of the HAI case report forms for the past 2 months complete? Verify using the clinical records.	Yes ☐ No ☐
15. Are all the HAI case report forms for the past 2 months accurate? Verify using the clinical records.	Yes ☐ No ☐
16. Have possible HAI (influenza-like illness) case reports always been submitted to the district SES weekly by the established deadline?	Yes ☐ No ☐
17. Are all of the possible HAI (influenza-like illness) case report forms for the past 2 months complete? Verify using the clinical records.	Yes ☐ No ☐
18. Are all of the possible HAI (influenza-like illness) case report forms for the past 2 months accurate? Verify using the clinical records.	Yes ☐ No ☐

Adherence to Laboratory Confirmation Requirements (District Hospitals)	
19. Is this facility able to collect lab samples (throat swab, blood)?	Yes ☐ No ☐
20. Does this facility have the capacity to handle the lab sample appropriately and safely until shipment?	Yes ☐ No ☐
21. Does this facility have the capacity to ship specimens to a higher level lab (e.g., presence of packing materials, cold chain)?	Yes ☐ No ☐

District SES supervisors should make a clear decision ("yes" or "no") with regard to every question listed. Whenever the answer is "no," they should indicate what exactly is wrong and provide recommendations that will allow a facility to correct the mistakes in the future.

It is recommended to conduct one day refresher training on the monitoring tools and methodology for the monitors/ master trainers before going to the second monitoring visits. The main objective would be to make sure that the monitoring is conducted in most encouraging atmosphere by employing supportive supervision methodology and providing on-the-job technical assistance to address the problems and correct mistakes.

Long term strategy for monitoring and evaluation

More rigorous monitoring/ on-the-job technical assistance will be provided to those districts where the probable HAI cases would be recorded during September – November, 2006. The monitors/ master trainers will be mobilized to travel to the district SES and health care facilities to provide on-the-job technical assistance as needed.

By the end of November, when two and more monitoring visits are conducted in all 11 districts, it is recommended to conduct qualitative assessment of HAI surveillance standards, forms, and procedures among providers, district SES epidemiologists, and national level experts. Based on the results of this assessment, the system will be refined as needed.

Debriefing meeting with master trainers and Dr Gassimov

July 29, HAI project team had a wrap up meeting with the master trainers who have completed the second round district level trainings. The main objective was to discuss the monitoring and evaluation plan and give detailed instructions for the first monitoring visit. The same day PHC AI team met with Dr Gassimov to inform him on the project progress and next steps to be undertaken for the next period (August – September, 2006). The schedule and format for monitoring visits, the idea of using "Med Sovet" meetings and development and distribution of the provider's instructions was strongly supported by Dr Gassimov.

Plan of action for the next period

Action	Completed by the Date
1. Develop the plan for the first monitoring visits (Table 1 above)	By August 4

2. Develop the draft PHC provider instructions and submit it to the MOH for their approval	By August 4
3. Print PHC provider instructions and HAI case reporting forms	By August 11
4. Conduct first monitoring visit according to predefined plan and format	August 14 – September 8
5. Conduct one day refresher training to prepare for the second monitoring visit	By September 15
6. Conduct second monitoring visit according to the predefined plan	By October 15

USAID
FROM THE AMERICAN PEOPLE

INTERNEWS AZERBAIJAN

"Reporting the news without fear or favor and holding sacred the trust bestowed upon the media by the public"

MEDIA TOOLS WORKSHOP FOR JOURNALISTS REPORTING ON AVIAN INFLUENZA

Funded by the United States Agency for International Development (USAID), the Primary Heath Care Strengthening Project (PHC Project) provides technical assistance to the Government of Azerbaijan (GoAz) in a collaborative effort to strengthen the country's primary healthcare system. The project is implemented by International Medical Corps with support from Abt Associates, Johns Hopkins University Center for Communication Programs (JHU CCP) and Curatio International Foundation. In the framework of the Avian Influenza component of the PHC Project, JHU CCP approached Internews Azerbaijan to conduct the Avian Influenza Journalism Workshop. The workshop has been successfully conducted by [1]Internews Azerbaijan Public Association (hereinafter refereed as "IAPA") for the purpose to emphasize media coverage on the Avian Influenza across Azerbaijan. On 16th of September, for journalists who have achieved a certain level of skills in the relevant field, the IAPA conducted a 1-day seminar in the venue IRSHAD HOTEL Baku, Azerbaijan in an effort to strengthen the overall communication and reporting skills on the Avian Influenza.

Today, as reportedly, the Azerbaijan media lacks an experienced journalists specialized in this specific sphere. Therefore Internews with a funding provided by the USAID PHC Strengthening Project offered such an excellent opportunity to improve the

[1] Internews Azerbaijan Public Association is a local organization that supports open media within country. It fosters independent media in emerging democracies, trains journalists in the standards and practices of professional journalism, produces innovative television and radio programming and internet content, and uses the media to reduce conflict within and between countries. It is eligible member of Internews International, which has offices in 25 countries worldwide funded primarily by grants from foundations, governments and individuals.

quality of Azerbaijani media by working with journalists in this particular field, namely the Avian Influenza, from different media outlets around the country.

Essentially, the accomplished training focused on raising professional level of journalists in reporting on AI in times of disease pandemic crises within country. As such, the key step of the seminar was provision of broadcast and print media outlets with knowledge how to behave in extreme cases, increase the awareness of the AI and also introducing effective ways of delivering the relevant message in media.

Both regional and Baku-based journalists applied for the training and the majority of participants were working professionals from Baku and local private broadcasters and newspapers from Sumgait, Mingachevir, Zagatala, Guba, Ganja and Lankaran. This way, in total of twenty six (26) journalists had been trained on professional skills to highlight AI issues on media in a timely and appropriate manner *(please see APPENDIX A for greater training details).*

The training combined both theory and practice were led by three highly skilled local trainers, namely (1) Zeynal Mammadli, the media expert/member of the Press Council/ PhD Baku State University, journalism faculty, as well as Internews media experts, (2) Kenan Guluzade, television expert, Internews producer and (3) Ayaz Salayev, famous cinematography expert, Internews filmmaker those are considerably experienced and famous in the broadcast and print media field. Working languages of the seminar was Azerbaijani.

Workshop Structure

The training program consisted of lectures and discussions, which made the seminar more involving for the participants. Following the enrollment of participating journalists there was an opening ceremony of the training.

The first part of the training was theoretical sessions followed by practical cases whereas the trainees were split up into four groups (six/seven persons per each group) to work out necessary action plan in case "if any illness symptoms or the illness itself

occurs, how to prevent and treat Avian Influenza". As such, the teamwork groups under the so called *"officials, owners, journalists and suffers"* imitated real case studies/situations as if the pandemic influenza has already been occurred within country. Particularly, this part of the training was highly welcomed from the participants and donors sides.

Non-local participants were provided with transportation, lodging and meals as initially outlined in the proposal.

Sessions breakdown:

- **10:00-12:00;** İMC expert provided succinct and clear-cut explanation to the journalists upon how to protect, what to do when sick and how to treat Avian Influenza in a timely and appropriate manner
- **12:00-14:40;** Ayaz Salayev, Internews filmmaker having produced variety of documentaries and PSAs on social topics – provided instructions on how to professionally avoid panic dissemination. On the basis of PSAs there had been introduced possible ways of media coverage as relevant to the given problem through practical sessions.
  11:30-11:45 coffee break
  13:00-14:00; lunch break

- **14:00-15:30;** Zeynal Mammedli, media expert, member of the Press Council, PhD of the Baku State University, journalism faculty. Topic – how to highlight the problem arisen, work with informational sources and the technique of the storytelling/news production.
  15:30-15:45 coffee break
- **15:45-17:30** Kenan Guluzade, Internews producer of pan-Caucasus conflict resolution project "Perekrestok" (Crossroads) - Background of Avian Influenza in Azerbaijan, "hi quality news" and "low quality news" – review of the stories, news blocks, discussion.
- **17:30-18:00** – conclusion, post testing/questionnaire

Workshop Attendees

This time Internews Azerbaijan invited 26 (14 female, 54%) participants representing 11 TV stations, 1 Press Center, 8 newspapers and 2 news agencies from 8 regions across Azerbaijan *(please see APPENDIX A for greater training details).*

The official certificates were presented to participants in the official closing ceremony.

Press Coverage:

Acknowledging that efficient press coverage is a key instrument for raising public awareness, there was organized proper media highlight of the accomplished training on ANS TV, Space TV, Lider TV, ATV, Public TV, AzTV and STV in a timely and appropriate manner.

Furthermore, the relevant articles were also published on local newspapers and news agencies, including "Zerkalo" (#173 dated on Sep 19, 2006), as well as"day.az" (Sep 17, 2006), "APA" Azeri Press Agency (Sep 16, 2006), "Media Forum" (Sep 19, 2006) and more.

Feedback:

- *"Thanks to this training, I was lucky to get direct information and tips about the Avian Influenza issues and its media coverage as required. The knowledge I grasped of herein was tremendously useful for me personally to further applying the gained skills in my workplace. Now I am pretty well aware how to professionally presenting the fact-based AI messages to the readers so that the public is not frightened in panic. My hope is that such specialty-reporting trainings are offered more often in future, this time in much more extended timeframe in an effort to give the Azerbaijani journalists an opportunity to access AI background information easing its accurate coverage in media afterwards. Special thanks go to Internews for organizing such an effective training.*
  Lala Mursalova, journalist, "Echo" newspaper
  Baku, Azerbaijan
  16/09/2006

NOTE: The trainees' feedback details (pre/post tests) are enclosed in the separate package.

Appendix A

A breakdown of the Internews Azerbaijan specialty-reporting seminar held on September 16, 2006:

NAME OF COURSE: 1-day seminar on "Media Tools for Journalists Reporting on Avian Influenza in Azerbaijan"
DATE AND PLACE CONDUCTED: Aug 1-2, 2006, Baku, Azerbaijan
CONSULTANTS:

- Zeynal Mammadli, media expert, member of the Press Council, PhD Baku State University, journalism faculty
- Kenan Guluzade, television expert, Internews producer
- Ayaz Salayev, cinematography expert, Internews filmmaker

ATTENDEES: 26 attendees (14 female-54%) from 11 TV stations, 1 Press Center, 8 newspapers and 2 news agencies from 8 regions across Azerbaijan.

#	NAME	POSITION	TV/ NEWSPAPER	CITY	COUNTRY
1	Sabina Aliyeva	Journalist	"Zerkalo"	Baku	Azerbaijan
2	Lala Mursalova	Journalist	"Echo"	Baku	Azerbaijan
3	Elkhan Salahov	Journalist	"Gun Seher"	Baku	Azerbaijan
4	Irina Parfionova	Journalist	"Obozrevatel"	Baku	Azerbaijan
5	Durna Safarli	Journalist	"Express"	Baku	Azerbaijan
6	Mursal Aliyev	Journalist	"Turan"	Baku	Azerbaijan
7	Ayten Mamedova	Journalist	"Azadlig"	Baku	Azerbaijan
8	Vasila Zeynalova	Journalist	"ITV"	Baku	Azerbaijan
9	Gunel Aliyeva	Journalist	"ATV"	Baku	Azerbaijan
10	Magsad Rahimov	Journalist	"GIJC"	Ganja	Azerbaijan
11	Ilham Mamedov	Journalist	"Alternativ TV"	Ganja	Azerbaijan
12	Madina Nik-Najat	Journalist	"ATV"	Ganja	Azerbaijan
13	Samira Samedova	Journalist	"Kapaz TV"	Ganja	Azerbaijan
14	Ehtiram Muradov	Journalist	"Mingachevir TV"	Mingachevir	Azerbaijan
15	Makhbuba Gourbanova	Journalist	"Aygun TV"	Zagatala	Azerbaijan
16	Polad Aliyev	Journalist	"Gutb TV"	Guba	Azerbaijan
17	Khayala Kelbiyeva	Journalist	"LTV"	Lankaran	Azerbaijan
18	Konul Nouriyeva	Journalist	"Dunya TV"	Sumgait	Azerbaijan
19	Zahir Amanov	Journalist	"Jenub Kheber"	Masalli	Azerbaijan
20	Tariyel Jalalli	Journalist	"Media Forum"	Baku	Azerbaijan
21	Vugar Safarov	Journalist	"Internews"	Baku	Azerbaijan
22	Idris Jafarov	Journalist	"Space"	Baku	Azerbaijan

23	Aynoura Ahmedova	Journalist	"Ayna Press"	Baku	Azerbaijan
24	Ilhama Isabalayeva	Journalist	"APA"	Baku	Azerbaijan
25	Javanshir Gouseynov	Journalist	"Internews"	Baku	Azerbaijan
26	Rustam Houseynov	Journalist	"Space"	Baku	Azerbaijan

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PHC Strengthening in Azerbaijan

PROJECT PHOTOS

September, 2005- October, 2006

Submitted to:

United States Agency for International Development

October 30, 2006. Baku

Health sector reform project launch workshop in Sheki, October 2006

Project photos Year One

Training for Trainers (TOT) on Human Avian Influenza, July , 2006

1

2

A trainer from IMC tells about Human Avian Influenza

3

4

Through PHC project, Azerbaijan now has a team of master trainers on avian influenza

5

6

Questions and Answers session

Flagman course on PHC in Bishkek

1

Representatives of Azerbaijani delegation

2

Azerbaijani delegation along with international trainer

3

PHC course participants' group photo

4

Members of Azerbaijani delegation along with international trainer

Bishkek, May 20-25, 2006

USAID FROM THE AMERICAN PEOPLE

Media Workshop for Journalists Reporting on Avian influenza

1

2

Avian Influenza Prevention Program Manager Azer Melikov makes his presentation

3

Regional media reporters took active part in workshop

4

Famous journalist Ayaz Salayev makes his presentation

September, 2006
Baku

Workshop for journalists and government spokesmen reporting on avian influenza October 2006, Baku

Project photos Year One

Media workshop for journalist and government spokesmen reporting on AI

1

2

The workshop was jointly organized by PHC Project and UNICEF

3

4

Journalists make their group presentations

5

A spokesman of the Ministry of Agriculture explains his point of view

6

A representative of the influential media outlet listens to the government spokesman

Project photos Year One

Communication Strategy workshop

Representatives from Government and Private sectors and NGO community participated in the workshop

Officials from the MOH and USAID attended opening session

Group discussion

Baku, September 2006

Avian Influenza Information

Consumer AI FAQs

General information on AI

What is Avian Influenza?

Avian influenza, is a contagious disease of animals caused by viruses that normally infect only birds and, less commonly, pigs. Avian influenza viruses are highly species-specific, but have, on rare occasions, crossed the species barrier to infect humans.

In domestic poultry, infection with avian influenza viruses causes two main forms of disease, distinguished by low and high extremes of virulence. The so-called “low pathogenic” form commonly causes only mild symptoms (ruffled feathers, a drop in egg production) and may easily go undetected. The highly pathogenic form is far more dramatic. It spreads very rapidly through poultry flocks, causes disease affecting multiple internal organs, and has a mortality that can approach 100%, often within 48 hours.

What causes it?

H5N1 virus

Is there more than one type of avian flu?

Yes. The H5N1 avian flu gets a lot of attention because it is so widespread and because many of the people unlucky enough to catch it from poultry have died.

Other avian flu germs have spread to humans. One is the H7N7 avian flu that in 2003 infected a number of people in the Netherlands. This virus usually caused pinkeye in infected people. However, one unlucky veterinarian died from the virus. Fortunately, Dutch authorities stamped out the virus before it learned to spread widely in humans.

Avian flus have, in the past, infected poultry. So far, all of these germs have been eradicated before spreading among humans.

How do outbreaks of AI spread?

The role of migratory birds in the spread of highly pathogenic avian influenza is not fully understood. Wild waterfowl are considered the natural reservoir of all influenza A viruses. They have probably carried influenza viruses, with no apparent harm, for

centuries. They are known to carry viruses of the H5 and H7 subtypes, but usually in the low pathogenic form. Considerable circumstantial evidence suggests that migratory birds can introduce low pathogenic H5 and H7 viruses to poultry flocks, which then mutate to the highly pathogenic form.

In the past, highly pathogenic viruses have been isolated from migratory birds on very rare occasions involving a few birds, usually found dead within the flight range of a poultry outbreak. This finding long suggested that wild waterfowl are not agents for the onward transmission of these viruses.

Recent events make it likely that some migratory birds are now directly spreading the H5N1 virus in its highly pathogenic form. Further spread to new areas is expected.

What is being done to stop AI?

Rapid elimination of the virus among infected birds and other animals is essential to preventing a major outbreak. The World Health Organization recommends that infected or exposed flocks of chickens and other birds be killed in order to help prevent further spread of the virus and reduce opportunities for human infection. However, safety measures must be taken to prevent exposure to the virus among workers involved in culling.

Where can I get more information?

Call your local heath district office for information or check the Ministry of Health website.

Health related inquiries

How do people become infected?

Direct contact with infected poultry, or surfaces and objects contaminated by their feces, is presently considered the main route of human infection. To date, most human cases have occurred in rural or peri-urban areas where many households keep small poultry flocks, which often roam freely, sometimes entering homes or sharing outdoor areas where children play. As infected birds shed large quantities of virus in their feces, opportunities for exposure to infected droppings or to environments contaminated by the virus are abundant under such conditions. Moreover, because many households in Asia depend on poultry for income and food, many families sell or slaughter and consume birds when signs of illness appear in a flock, and this practice has proved difficult to change. Exposure is considered most likely during slaughter, plucking, butchering, and preparation of poultry for cooking.

How can I prevent AI in my family?

Practice good hygiene at home and in public. Wash your hands often with ash, soap and water or hand sanitizers. Cover your nose and mouth with a tissue when coughing of sneezing. If possible stay home from work, school and errands when you have any symptoms of respiratory illness, including a bad cold.

What are the signs and symptoms of AI?

Generally the symptoms are similar to those for people infected with human Flu virus, although the severity of the illness may differ. Symptoms generally appear 3 - 7 days after exposure and can last up to 7 days.

Symptoms of the flu include: a high fever, chills, nasal congestion, headache, muscle aches and pains, tiredness and fatigue, cough, sore throat, a runny nose and conjunctivitis. It may take up to three days to feel symptoms after you catch the flu (the incubation period). Cases of Bird Flu are also likely to experience breathing problems, pneumonia and can be fatal,

Anyone can get the flu – being fit, active and healthy does not protect you from getting this virus.

Anyone can die from the flu.

What is the treatment?

Most H5N1 viruses that have caused human illness and death appear to be resistant to amantadine and rimantadine, two antiviral medications commonly used for treatment of patients with influenza. Two other antiviral medications, oseltamivir and zanamavir, would probably work to treat influenza caused by H5N1 virus, but additional studies are needed to demonstrate their current and ongoing effectiveness.

Is there a vaccine?

(ARE WE SAYING ANYTHING ABOUT GLAXOSMITHKLINE?)

No. Currently available vaccines will not protect against disease caused by the H5N1 strain in humans. WHO is urgently working together with laboratories in the WHO Global Influenza Surveillance Network to develop a prototype H5N1 virus for use by leading vaccine manufacturers.

An available vaccine prototype virus, developed using the 2003 strain of H5N1 (which caused the two human cases in Hong Kong), cannot be used to expedite vaccine development. Initial analysis of the 2004 virus, conducted by laboratories in the WHO network, indicates that the virus has mutated significantly.

Should I go to the hospital if I think I have it?

If you suspect that you or someone in your family has avian influenza, go to a healthcare provider immediately. See your doctor immediately if you develop flu symptoms, including a fever, cough and body aches, and have recently traveled to a part of the world where bird flu occurs. Be sure to let your doctor know when and where you were traveling and whether you visited any farms or open-air markets.

Can I get sick from eating chicken or eggs?

You cannot get avian influenza from properly handled and cooked poultry and eggs.

There currently is no scientific evidence that people have been infected with bird flu by eating safely handled and properly cooked poultry or eggs.

Most cases of avian influenza infection in humans have resulted from direct or close contact with infected poultry or surfaces contaminated with secretions and excretions from infected birds. Even if poultry and eggs were to be contaminated with the virus, proper cooking would kill it. In fact, recent studies have shown that the cooking methods that are already recommended by the U.S. Department of Agriculture (USDA) and the Food and Drug Administration (FDA) for poultry and eggs to prevent other infections will destroy influenza viruses as well.

So to stay safe, the advice is the same for protecting against any infection from poultry:

- Wash your hands with soap and warm water for at least 20 seconds before and after handling raw poultry and eggs.
- Clean cutting boards and other utensils with soap and hot water to keep raw poultry from contaminating other foods.
- Use a food thermometer to make sure you cook poultry to a temperature of at least 165 degrees Fahrenheit Consumers may wish to cook poultry to a higher temperature for personal preference.
- Cook eggs until whites and yolks are firm.

I am pregnant, should I be concerned?

Pregnancy doesn't appear to increase the risk of developing avian influenza. Currently, specific information about the effect of the illness on pregnancy is unavailable. Make sure you get your seasonal flu shot, even though it will not protect you from H5N1 it will still protect your from the seasonal flu. Keep all appointments with your doctor. At the first onset of flu symptoms, go see your doctor.

Are children more vulnerable?

While it is not known why so many children are being infected by the virus, one potential explanation may be that children, especially girls, often care for domestic poultry by feeding them, cleaning pens and gathering eggs. Children may also have closer contact with poultry as they often treat them as pets. Children should also use preventive measures.

Who is most vulnerable to bird flu?

Flu is usually most dangerous to infants, pregnant women, the elderly, and people with immune suppression (such as transplant patients or people with AIDS). It's also dangerous to people who have previously been hospitalized for flu or pneumonia.

Am I at a greater risk for being infected with H5N1 if my immune system is already weakened due to HIV, cancer treatment, or other health problems?

People with weakened immune systems are at greater risk of H5N1 related complications and, if infected, may be capable of spreading the virus for longer periods of time.

Animal related inquiries

What kinds of birds can get AI?

All kinds of birds can get avian influenza—chickens, ducks, geese, quails, turkeys, pigeons, wild birds and even pet birds. Some birds such as ducks can be infected even when they don't look sick.

How can I prevent AI in my flock?

The most important control measures are rapid destruction ("culling" or "stamping out") of all infected or exposed birds, proper disposal of carcasses, and the quarantining and rigorous disinfection of farms.

The virus is killed by heat (56 degrees C for 3 hours or 60 degrees C for 30 minutes) and common disinfectants, such as fomalin and iodine compounds.

The virus can survive, at cool temperatures, in contaminated manure for at least three months. In water, the virus can survive for up to four days at 22 degrees C and more than 30 days at 0 degrees C. For the highly pathogenic form, studies have shown that a single gram of contaminated manure can contain enough virus to infect 1 million birds.

Restrictions on the movement of live poultry, both within and between countries, are another important control measure.

If my farm is disease-free, how do I keep it that way?

Make sure you brush or wash off your shoes and the wheels of your bicycle or motorcycle if you visit another farm or the poultry market so that you don't carry the virus home on your clothing, shoes or tires.

Where should I keep my flock?

Do not let poultry in your house. If you have to keep them indoors, keep them in a specific area away from where the family sleeps and eats. It is best to keep them in a closed pen (coop).

How do I clean the area?

Clean or sweep the feces and unconsumed feed from the yard everyday. Wear a mask while sweeping the farmyard. Burn or bury feathers and other waste away from the farmyard. Bury waste deep and with lime so that scavengers do not dig it up. Allow manure to decompose for several weeks to allow any virus to die before using the manure as fertilizer. Clean small farm equipment daily.

How does it spread?

Infected birds shed influenza virus in their saliva, nasal secretions, and feces. Susceptible birds become infected when they have contact with contaminated excretions or with surfaces that are contaminated with excretions or secretions. Domesticated birds may become infected with avian influenza virus through direct contact with infected waterfowl or other infected poultry or through contact with surfaces (such as dirt or cages) or materials (such as water or feed) that have been contaminated with the virus.

Within a country, the disease spreads easily from farm to farm. Large amounts of virus are secreted in bird droppings, contaminating dust and soil. Airborne virus can spread the disease from bird to bird, causing infection when the virus is inhaled. Contaminated equipment, vehicles, feed, cages or clothing – especially shoes – can carry the virus from farm to farm. The virus can also be carried on the feet and bodies of animals, such as rodents, which act as “mechanical vectors” for spreading the disease. Limited evidence suggests that flies can also carry it.

Droppings from infected wild birds can introduce the virus into both commercial and backyard poultry flocks. The risk that infection will be transmitted from wild birds to domestic poultry is greatest where domestic birds roam freely, share a water supply with wild birds, or use a water supply that might become contaminated by droppings from infected wild-bird carriers.

So called “wet” markets, where live birds are sold under crowded and sometimes unsanitary conditions, can be another source of spread.

What are the signs and symptoms of AI in poultry?

Wild birds don’t usually show symptoms of bird flu. However the avian influenza virus can kill domesticated birds, such as chickens and turkeys.

Symptoms in birds differ according to the species but can include diarrhea, breathing difficulties, swollen head and death. A sick bird sheds the virus in its feathers, mucous, saliva and feces.

What do I do if I find a dead or sick bird?
If you come across any dead or sick birds, do not touch them. Contact the proper authorities in your area immediately.

What do I do with dead chickens in my flock?

If you come across any dead or sick birds, do not touch them. Contact the proper authorities in your area immediately. Do not throw dead birds in a river, pond or other body of water. Place dead birds in a bag or container away from other animals until the authorities can inspect the situation. If you see any birds that look sick, don't leave them in the yard. Take them out of the flock using gloves and place them in a closed cage. Then contact the paravet (or other authorities) immediately.

Could my neighbor's birds infect mine?

Yes, AI can travel from farm to farm.

Can other animals get AI too?

In addition to humans and birds, we know that pigs, tigers, leopards, ferrets, and domestic cats can be infected with avian influenza A (H5N1) viruses. In addition, in early March 2006, Germany reported H5N1 infection in a stone marten (a weasel-like mammal). The avian influenza A (H5N1) virus that emerged in Asia in 2003 is evolving and it's possible that other mammals may be susceptible to infection as well. CDC is working closely with domestic and international partners to continually monitor this situation and will provide additional information to the public as it becomes available.

What if my pet eats a dead bird?

There is no evidence to date that cats can spread H5N1 to humans. No cases of avian influenza in humans have been linked to exposure to sick cats, and no outbreaks among populations of cats have been reported. All of the influenza A (H5N1) infections in cats reported to date appear to have been associated with outbreaks in domestic or wild birds and acquired through ingestion of raw meat from an infected bird.

While domestic cats are not usually susceptible to influenza type A infection, it is known that they can become infected and die (both experimentally and naturally) with avian influenza A (H5N1) viruses and, in a laboratory/research setting can spread the virus to other cats. It is not known whether domestic cats can spread the virus to other domestic cats under natural conditions.

There is not enough information available about avian influenza A (H5N1) infection in dogs to know how infection would occur. Affected domestic cats in Europe appear to have become infected by feeding upon raw infected poultry or wild birds. If dogs are susceptible to avian influenza A (H5N1), infection may be by the same route.

Health Care Provider AI FAQs

Are drugs effective in treating avian influenza in humans?

Data from the World Health Organization's Global Influenza Surveillance Network indicate that the recently circulating H5N1 strains are susceptible to two antiviral drugs—oseltamivir (sold as Tamiflu) and zanamivir (sold as Relenza). However, these medicines need to be started early enough—usually within the first two days of infection—to be effective. Relenza is sprayed in the nose. It is extremely effective at neutralizing flu viruses. But people who get bird flu from poultry tend to get infections deep in their respiratory tracts. It's not at all clear that Relenza could reach such deep-seated infections.

Many of the recently circulating H5N1 influenza viruses have been shown to be resistant to two older, inexpensive antiviral drugs, rimantadine and amantadine. Scientists are studying how the H5N1 viruses became resistant to these older drugs and carefully watching for any signs of resistance to the newer drugs.

Is there a vaccine?

Vaccines, not antiviral drugs, are the key to stopping the flu. An experimental H5N1 vaccine has been made -- a major scientific achievement. New ways of using it already are in the works.

But the first batch of this prototype vaccine likely will not be a good match for whatever bird flu virus eventually emerges to cause a pandemic. New batches of vaccine will have to be made. That process would take more than a year before most people can be immunized. And it will take two shots, weeks apart, before a person is protected. Meanwhile, experts suspect that modern transportation would carry flu around the world.

Since a vaccine won't immediately be available, flu drugs will be a major line of defense. But there won't be enough of the drugs to go around unless the next pandemic waits several years to strike.

Should my patients have medicine on hand?

No. Several flu experts say that they are not stocking up on flu drugs, and they strongly recommend that individuals follow their lead.

Why? First of all, the drugs are in short supply. In the event of a pandemic, public health workers will need all the flu drugs they can get in order to treat people actually exposed

to the virus. The drugs won't do nearly as much good sitting in people's medicine cabinets.

And even if you had the drugs on hand, when would you take them? Without a flu test, it's hard to know whether your symptoms are the flu or another respiratory infection. And the pills only work against the flu.