Global Alliance for Vaccines and Immunization

PROPOSAL

for Support to
Health System Strengthening (HSS)
in
Azerbaijan Republic

2008

Table of Contents

Abbreviations and Acronyms

AEFI	Adverse Events Following Immunization
ANC	Antenatal Care
APR	Annual Progress Reports
BBP	Basic Benefits Package
BCG	Bacillus Calmette-Guerin (tuberculosis vaccine)
cMYP	Comprehensive Multi Year Plan
DHIS	Department of Health Information and Statistics under MOH
DSSES	Department of State Sanitary Epidemiological Service
DTP	Diphtheria-Tetanus-Pertussis Vaccine
FAP	Feldsher-Midwife Point
GAVI	Global Alliance for Vaccines and Immunization
GoAz	Government of Azerbaijan
HSRP	Health Sector Reforms Project
HSCC	Health Sector Coordinating Committee
ICCIP	Intersectional Coordination Committee on International Projects
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
MOEG	Ministry of Economic Growth
MOH	Ministry of Health
MOF	Ministry of Finance
NGO	Non Governmental Organization
NIP	National Immunization Program
PHC	Primary Health Care
PHCSP	Primary Health Care Strengthening Project
PHRC	Public Health and Reforms Centre
PIU MOH/WB	Health Sector Reforms Project Implementation Unit
RHEC	Republican Hygiene and Epidemiological Center
SMMIA	State Mandatory Medical Insurance Agency
SSC	State Statistical Committee
SVA	Village Doctor Ambulatory
SUB	Village Hospital
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WG	Working Group
WHO	World Health Organization

Executive Summary

In Azerbaijan, broader health system characteristics constrain the effective and efficient delivery of health services. The health system is in need of restructuring with a reorientation of public health interventions and service delivery in line with the current and emerging disease burden.

The overall health goal of the proposed activities is to better prevent and treat the primary causes of morbidity and mortality amongst infants, children and mothers.

To achieve this goal the proposal suggests the following objectives:

OBJECTIVE ONE: Over the next three years improve the capacity of eight training institutes, 42 educators and 640 mid-level health workers (feldshers, midwives, and nurses) through a strengthened postgraduate education system.

The need for retraining is paramount and with over 25,000 nurses, midwives and feldshers it is essential to introduce a sustainable retraining program for the development of these critical staff. The current educational provision to train mid level health workers is inadequate and focuses on a medical model with knowledge that appears to be largely outdated and not relevant for use within PHC practice. The major aim of the Objective ONE is to improve the skills and expertise of mid level staff who work at the primary health care level.

OBJECTIVE TWO: Over the next three years strengthen the health information system for better monitoring of child and maternal health services.

Lack of coordination within both internal and external information systems hinder effective resource planning, appropriate data interpretation and effective use of data for immunization and health sector management purposes. To strengthen the health information system, activities under the Objective TWO will be focused on developing mechanisms for the supply of immunization passport cards; modernization of registration of pregnant women to ensure continuity of care for mother and child; decentralization of selected data entry and analysis to the district level; development of a strategy on health information systems and their integration into national information resources.

OBJECTIVE THREE: Over the next three years strengthen the capacity and tools to plan cost and budget for the immunization program.

Assessments of immunization program performance and the recent multi-year planning for immunization have revealed insufficient capacity and need to strengthen simple planning tools and procedures to support adequate planning and budgeting for the implementation of the immunization program. To address this need, under the Objective THREE guidelines on management of immunization programs will be developed and a training on program planning and budgeting will be conducted for the staff responsible for immunization program implementation.

The main activities to be undertaken, the expected results, the duration of support and total amount of funds requested are provided in Table 1 below.

Table 1: Major interventions, expected results, priority indicators and total amount of funds

Objectives	Main activities, expected results, and output indicators	Duration and level of support	Total amount of requested funds
Objective ONE: Over the next three years improve capacity of eight training institutes, 42 educators and 640 mid-level health workers through a strengthened postgraduate education system	1.1. Identify and select core working group to develop trainers curriculum, supporting materials and tools **Expected results:** ➢ **Increased capacity of the nursing education system to incorporate new approaches to learning and teaching and concepts associated with health reform.**	**2009-2010** National level	**Total amount** **$473,928**
	1.2. Carry out training program for 42 educators **Expected results:** ➢ **Improved capacity amongst educators to teach skills and competences of family practice according to modern methods**	**2009-2011** Central level and district level through six decentralized nursing schools	
	1.3. Carry out training program for mid level workers **Expected results:** ➢ **Improved level of competence in family practice among mid-level workers** ***Indicator:*** % of mid level workers successfully completed the training program and actively working in PHC	**2010-2011** National level. Outreach to districts through decentralized nursing schools	
	1.4 Equip seven Nursing Schools with essential requirements for teaching the program, including learning materials, a best practice manual and clinical laboratory for simulated practice. **Expected results:** ➢ **Learning materials of nursing schools upgraded to support modern training approach**	**2009-2011** National level. Outreach to districts through decentralized nursing schools	

Objective TWO: Over the next three years strengthen the health information system for better monitoring of child and maternal health services	2.1. Develop a mechanism for the provision of immunization passports in 5 pilot districts **Expected results:** ➢ **Increased awareness of families on immunization schedule** ➢ **Increased immunization coverage** ***Indicator:*** % of children provided with paper immunization passports at their birth relative to the number of children for which personalized data on immunization is available through E-health card 2.2. Modernization of registration of pregnant women to ensure continuity of care for mother and child in five pilot districts **Expected results:** ➢ **Increased number of registered pregnant women** ➢ **Improved continuity of maternal and perinatal care** ***Indicator:*** % of pregnant women registered within first 12 weeks of pregnancy 2.3. Strengthen decentralized data entry system for the district level, including forms no 103, 106 and 66 **Expected results:** ➢ **Improved data collection, entry and analysis at district level** ***Indicator:*** % of forms from pilot districts demonstrating use of contemporary coding (ICD 10, etc.) 2.4. Develop a strategy of integrating separate information sub-systems into a single information system (e-health card, RCHE, health statistics, and SSC) **Expected results:** ➢ **Improved data management and analysis at the district and national level** ***Indicator:*** **%** discrepancy between the number of newborns provided by the SSC and MOH	**2009-2011** Five pilot districts **2009-2011** Five pilot districts **2009** Five pilot districts **2009** National level	**Total amount** **$541,536**

Objective THREE: Over the next three years strengthen the capacity and tools to plan cost and budget for the immunization program.	3.1 Identify and select core working group to develop SOP and tool on planning, costing and budgeting **Expected results:** ➢ **Developed tools and procedures for planning, costing and budgeting** 3.2 Carry out workshop on planning, costing, and budgeting **Expected results:** ➢ **Improved capacity of staff to plan, cost, and budget** ***Indicator:*** % of managers trained on planning and budgeting	**2009-2011** National level	**Total amount** **$35,000**

The proposed interventions under GAVI HSS initiative have been carefully synchronized with existing Government policies and strategies on health care reform and activities implemented by international partners. The activities support the improvements in health care system as a whole and will lead to better coverage and improved quality of services.

The GAVI HSS Proposal combines activities that will be implemented both at central and district level. The district level activities related to health information system strengthening will be implemented in the five pilot districts of the MOH's Health Sector Reform Project, i.e. Agdash, Ismailli, Sheki, Absheron, and Gakh (referred to hereafter as five pilot districts) while the activities to strengthen nursing schools will focus on the eight existing nursing schools of which two are located in Baku and 6 in districts. Respective investments in training equipment will start with the two schools in Baku and the schools of Lenkaran, Sheki and Ganja in 2009. In 2010, training equipment will be bought for 2 additional schools in Mingechavir and Sumgait. For the nursing school in Sheki and Nakhichevan only complementary investments will be made as main investments are made by the Health Sector Reform Project and Executive of the Nakhichevan Autonomous Republic accordingly.

The total budget of the program is $1,362,775 for 3 years (2009-2011) out of which $1,182,175 is supposed to be financed through the GAVI HSS support (financial support by Executive of the Nachichevan Autonomous Republic are not included as provided prior to project start date).

The preparation of GAVI HSS application was coordinated by the Public Health and Reform Center of the Ministry of Health. The application was developed by joint efforts of the working group established by the MOH, local and international experts in close collaboration with MOF and MOEG. Technical support was provided by WHO, the PIU MOH/World Bank, UNICEF, UNFPA, USAID, and other partners. The Proposal drafts were timely introduced to the Intersectional Coordination Committee on International Projects (ICCIP) for comments and approval. The ICCIP (the HSCC country equivalent) is a stand-alone committee established by the MOH to provide policy-level coordination of initiatives and projects related to health sector reform and health system strengthening.

The implementation and monitoring of the GAVI HSS project will be managed by the Public Health and Reform Centre of the MoH. The PHRC interacts with all structures involved in the project implementation. The Intersectional Coordination Committee on International Projects will be responsible for agreeing high level policy decisions related to the GAVI HSS, ensuring coordination with non GAVI health system strengthening activities and approving any potential changes to the GAVI HSS plan and budget.

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of Health Sector Coordinating Committee (or equivalent):

Intersectional Coordination Committee on International Projects (ICCIP)

HSCC operational since:

ICCIP was established according to the Order #70 of MOH dated 15th of May 2008. The main role of ICCIP chaired by the Deputy Minister of Health is to provide policy-level coordination of initiatives and projects related to health sector reform and health system strengthening (see Annex A).

Organizational structure (e.g., sub-committee, stand-alone):

ICCIP is a stand-alone committee under the MOH

Frequency of meetings:

The normal frequency of ICCIP meetings is once every two months. To discuss GAVI HSS proposal and approve the final application ICCIP had three meetings within May-August 2008 (see Annex B).

Overall role and function:

- Identifying and coordination of main strategic trends of international assistance in healthcare sector, including health system strengthening and health reforms
- Revision and authorization of international projects, including their implementation plans
- Policy level synchronization of international projects with main terms of Azerbaijan Healthcare Reform Concept, National health policies and State Programs
- Ensuring appropriate and cost-effective allocation of resources available through international projects
- Provision of ongoing monitoring and evaluation of international projects' implementation

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

According to the MOH's Order #5 of February 5, 2008 the Public Health and Reforms Centre was responsible for coordination of and provision oversight to the application development process (see Annex C).

Who led the drafting of the application and was any technical assistance provided?

The drafting of the application was led by the Working Group established by the MOH's order #5 of February 5, 2008. The WHO country office assisted the WG and PHRC with arranging international missions and provision of technical support. Two local consultants were recruited to conduct comprehensive assessment of existing healthcare system, develop suggestions on application strategy and activities, and prepare a final draft of proposal. The Working Group benefited from the technical assistance provided by a Workshop on GAVI HSS Application Development in August 2007 in Kyrgyzstan. The technical assistance was also provided by PIU MOH/World Bank, USAID, UNICEF, and other partners.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

During the period of February-July 2008 Working Group, MOH held 27 weekly meetings with participation of international partners such as WHO, USAID, UNICEF, and others. Also, members of WG and local consultants had working meetings with key officials in MOH, RHEC, MOF, MOEG, and other stakeholders. It should be emphasized that WG and consultants worked in close collaboration with PIU MOH/WB and all proposed activities were synchronized with the Health Sector Reform Project and the updated Concept for health care reform (2008).

Within February-April 2008 WG identified the main problems and barriers of health system. Meanwhile, local consultants conducted a comprehensive assessment of the existing Healthcare System. The results of the assessment were further submitted to the WG and international experts.

The first international mission was arranged on April 21-25th, 2008. During the mission Pim de Graaf and Alexander Katsaga, WHO experts met with key officials of MOH, Ministry of Justice, State Statistical Committee, PIU MOH/WB, and international partners. WHO experts, in close collaboration with WG analysed main problems and barriers; identified barriers to be covered by GAVI HSS funds; and proposed interventions to overcome those barriers.

Per approval of proposed interventions by ICCIP on May 20th, 2008 the WG started working over major activities, impact/outcome/output indicators, and implementation schedule. During the 2nd international mission, July 1-10, 2008 Barbara Parfitt and Alexander Katsaga, WHO experts proposed an action plan, developed a detailed implementation schedule, specified application indicators, and M&E mechanisms. To achieve that the experts met with key officials of MOH, PIU MOH/WB, SSC, directors of nursing schools, and other stakeholders. On July 7th 2008 experts participated in round-table discussions on nursing education system, particularly, post-graduate education. The proposed action plan and implementation schedule was presented to and authorized by the ICCIP on July 10th, 2008.

July 21-25th, 2008 in frame of the 3rd international mission, Victor Galayda, WHO expert and local consultants developed budget based on previously approved activities; identified mechanisms for channeling GAVI HSS funds into the country and, further, to the periphery, specified procurement mechanisms; and determined management issues. These suggestions were presented to and agreed on at the ICCIP meeting of July 25th, 2008.

Further, the final draft of application was submitted to the Ministry of Health and the Ministry of Finance to obtain their comments and recommendations. It was also shared with international partners and local NGOs involved into the healthcare reform process.

In September 2008 the application was endorsed by MOH and MOF.

Who was involved in reviewing the application, and what was the process that was adopted?

ICCIP provided the overall revision of the application development process at all stages. Key stakeholders involved into application reviewing process are as follows:

- Members of the WG, MOH
- UNICEF
- WHO
- PIU MOH/World Bank
- USAID-funded projects
- Local NGOs

Who approved and endorsed the application before submission to the GAVI Secretariat?

The application was endorsed by ICCIP on July 25, 2008 and further on signed by the Ministry of Health and the Ministry of Finance of Azerbaijan (see Annex D).

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Sanan Kerimov/Deputy Minister of Health	Ministry of Health	Yes	o Overall revision of the application development process o Chairman of ICCIP
Jeyhun Mammadov/Director	PHRC, MOH	Yes	o Coordination of the overall application development process externally and internally including other HSS activities in Azerbaijan o Chair of the WG o Participation in the expert missions
Sultan Aliyev/Head of Health Services Department	Ministry of Health	Yes	o Advice and consultations on PHC policies and strategies o Deputy Chairman of the ICCIP
Viktor Gasimov/Head of Sanitary-Epidemiological monitoring Department	Ministry of Health	Yes	o Supervision on application development process o Technical support and consultations on immunization policies o Support in establishment ICCIP
Samir Abdullayev/Deputy Head of International Affairs Department	Ministry of Health	Yes	o Coordination with international partners o Support in establishment ICCIP
Elmira Aliyeva/Deputy Head of Health Services Department	Ministry of Health	Yes	o Technical advice and consultations on Mother and Child Health
Adil Karimov/Deputy Head of Health Service Department	Ministry of Health	No	o Technical advise and consultations on PHC current structure and scope of services o Linking of HSS planning with the current reforms on PHC
Svetlana Zmitrovich/Deputy Director	RHEC	Yes	o Technical advice and consultations on Immunization issues
Abulfaz Abdullazade/Director	Centre of Medicines' Analytical Expertise	Yes	o Technical advice and consultations
Kamran Garakhanov/Head of WHO Country Office	WHO Azerbaijan Country Office	Yes	o Technical support on GAVI HSS application development process o Consultations on WHO input
Shafag Rahimova/PO Adolescent Development	UNICEF Azerbaijan Country Office	Yes	o Provision of information on current UNICEF activities o Technical support on mother and child related issues

			o Review of the draft application
Tara Milani/Health Programs Coordinator	USAID	Yes	o Provision of information on on-going activities in health sector under USAID programs
Soltan Mammadov/Director	Vishnevskaya-Rastropovich Foundation, INGO	Yes	o Technical advice and consultations on immunization issues
Elvira Anadolu/Health Programs Coordinator	WB	Yes	o Technical advice and consultations o Coordination of activities under HSRP and GAVI HSS projects
Javid Mammadov/Deputy Head of Department	Ministry of Finance	Yes	o Technical advice and consultations
Jamalatdin Guliyev	Ministry of Economic Growth	Yes	o Technical advice and consultations
Lutfi Gafarov/Head of PHC Department	PHRC, MOH	No	o Facilitation of the WG meetings o Secretarial support to WG o Member of the WG o Participation in the expert missions
Azad Ahmadov/Head of Healthcare Workforce Department	PHRC, MOH	No	o Technical advice and consultations o Member of the WG o Participation in the expert missions
Emin Babayev/Head of Epidemiology Department	RHEC, MOH	No	o Technical advice and consultations o Member of the WG o Participation in the expert missions
Afag Aliyeva/Head of Immunoprophylaxis Department	RHEC, MOH	No	o Technical advice and consultations o Member of the WG o Participation in the expert missions
Oleg Salimov/Adviser on Sanitary-Epidemiological monitoring	Ministry of Health	No	o Technical advice and consultations o Member of the WG o Participation in the expert missions
Oktay Akhundov/Head of HIS Department	Ministry of Health	No	o Technical support on health data collection and analysis issues o Coordination of HIS activities
Kamala Mekhtiyeva/Head of HR Department	Ministry of Health	No	o Policy support and coordination on HR related strategies o Consultations on post-graduate education of mid-level health workers
Rauf Agayev/Deputy Head of HR Department	Ministry of Health	No	o Sharing information on educational policy related documents of the MoH o Consultations on post-graduate education of mid-level health workers
Jabrail Asadov/Deputy Director/E-health card Program Coordinator	PHRC, MOH	No	o Sharing information on E-health card Program o Coordination of activities under E-health Card and GAVI HSS projects o Technical support
Rza Allahverdiyev/Head of Demography and Social Statistics Department	State Statistical Committee	No	o Sharing information on data collection and analysis o Support in coordination of activities on information system between SSC and MoH

Agakerim Samedov/Chief	Ministry of Justice/State Population Register Service	No	o Provision information on National Registry Project o Technical support
Jahangir Ali-zadeh/Deputy Chief	Ministry of Justice/State Population Register Service	No	o Provision information on National Registry Project o Technical support
Faiza Aliyeva/Director/Reproductive Health National Coordinator	Obstetrics and Gynaecology Research Institute, MOH	No	o Updating on Reproductive Health Program o Coordination of activities under Reproductive Health Program and GAVI HSS project o Policy and technical support in development of pregnancy register
Tarana Tagizade/Maternity and Child Health National Coordinator	Ministry of Health	No	o Updating on Child Health Program o Technical support
Willcox Gillian/Deputy Representative	UNICEF	No	o Provision of information on UNICEF-funded on-going activities
Farid Babayev/Assistant Representative	UNFPA	No	o Coordination and technical discussions
Olga Zues/Chief of Party	Abt. Associates, INGO	No	o Coordination and technical discussions on PHC and health financing issues
Shirin Kazimov/Deputy Chief of Party	Abt. Associates, INGO	No	o Coordination and technical discussions
Aybeniz Ibrahimova/Public Health Policy Manager	Abt. Associates, INGO	No	o Coordination and technical discussions
Akif Hasanov/Deputy Chief of Party	EngenderHealth/ACQUIRE, INGO	No	o Coordination and technical discussions on Reproductive Health issues
Dilara Velikhanova/Head of PH Department	PHRC, MOH	No	o Problems/barriers assessment o Technical support in preparation of the application o Coordination and technical discussions with partners
Farkhad Mekhtiyev/Director	Project Implementation Unit, MOH/WB	No	o Technical support in preparation of the application o Coordination of activities under PIU MOH/WB and GAVI HSS projects
Zakiya Mustafayeva/Health Surveillance Coordinator	Project Implementation Unit, MOH/WB	No	o Coordination and technical discussions
Sakina Ismaylova/PHC Coordinator	Project Implementation Unit, MOH/WB	No	o Coordination and technical discussions
Fariz Akhundov/HR	PIU, MOH/WB	No	o Coordination and technical discussions

Coordinator			
Gulara Efendiyeva/ Health Financing Coordinator	Project Implementation Unit, MOH/WB	No	o Coordination and technical discussions
Dilara Mammadaliyeva /Director	Baku Base Nursing School #2	No	o Consultations on post-graduate education of mid-level health workers o Technical support and coordination
Rafael Eyvazov/Director	Sumgait Nursing School		o Consultations on post-graduate education of mid-level health workers o Technical support and coordination
Fikret Zeynalov/Director	Mingechevir Nursing School	No	o Consultations on post-graduate education of mid-level health workers o Technical support and coordination
Nariman Nagdaliyev/Consultant	PHRC, MOH	No	o Consultations on post-graduate education of mid-level health workers o Technical support and coordination
Natig Ibrahimov/Senior Adviser on Secondary and High Education	Ministry of Education	No	o Coordination and technical discussions o Linking of HSS planning with the current educational reforms MoE
Vusala Allahverdiyeva/ National Professional Officer VPD&Immunization	WHO	No	o Technical support in preparation of the application o Coordination and technical discussions with partners
Jenni Kehler/Technical Officer	WHO	No	o Technical support in preparation of the application o Coordination and technical discussions with partners
Malik Abbasov/Deputy President	Savab, local NGO	No	o Technical support and consultations
Nariman Safarly/President	Azerbaijan Medical Association, local NGO	No	o Technical support and consultations
Naila Aliyeva/Senior Consultant	Assistance to Healthcare Development, local NGO	No	o Problems/barriers assessment o Coordination and technical discussions with partners o Participation in the expert missions o Drafting of the application

1.4: Additional comments on the GAVI HSS application development process

Local NGOs, as representatives of civil society, were involved into application development process through meetings and discussions held by the WG, international experts, and local consultants.

Currently public health issues aren't properly addressed by private sector due to various socio-economic reasons though the situation has been improving in recent years.

Section 2: Country Background Information

Azerbaijan is located on the western coast of the Caspian Sea. About 50% of the land is mountainous. In most places the climate is dry and 70% of the cultivated land is irrigated. The country is divided into two parts, the autonomous republic of Nakhichevan and the main territory of Azerbaijan, that are separated by Armenian territory. Azerbaijan is divided into 78 districts, 11 cities, and one autonomous republic of Nakhichivan subdivided into 8 districts and a city[1]. In 2007, the population of Azerbaijan was 8,532,400 where 51.5% urban and 48.5% rural[2].

Azerbaijan continues to be plagued by an unresolved 15-year-old conflict with Armenia over the Nagorno-Karabakh region of Azerbaijan. A ceasefire accord was signed between Armenia and Azerbaijan in 1994, following two years of armed conflict. As a result of the conflict, there are 1 million refugees and internally displaced persons (IDPs) in Azerbaijan, of whom about 650 000 are IDPs from Nagorno-Karabakh and the nearby territories[1].

Source: United Nations Cartographic Section, 1997.

The collapse of the Soviet Union had a major impact on economic and social indicators in Azerbaijan. Intense political, military and financial turmoil in the early years of independence alongside the inefficient and often crumbling remains of the Soviet-era state systems prevented the implementation of reforms in most areas and made any prospect of immediate economic prosperity almost impossible[1].

[1] Sources: Health care systems in transition: Azerbaijan, WHO/EURO, 2004
[2] State Statistical Committee of Azerbaijan Republic, 2007, www.azstat.org

For years health protection in Azerbaijan had been managed administratively. Financing allocated to the health care system was based on quantitative indicators, principally the bed stock, number of medical and pharmaceutical personnel and other subjective characteristics. The scarce money allocated to the health care sector were used to build and commission new facilities, provide resources, procure and supply new equipment and technologies, upgrade personnel qualifications and increase the number of health care professionals. As a result, the health care sector's resources were used extremely ineffectively, with medical personnel developing a rather non-professional attitude with respect to their duties and delivering medical service way below the required level[1].

Within recent years the demographic indicators have been improving where the birth rate increased from 14.0 (2003) to 18.0 (2007)[2]. According to SSC 2007 life expectancy is 72.4 years, 69.7 for males and 75.1 for females[2].

Since 2003 infant mortality rate has been decreasing from 15.5 to 12.1 in 2007. The leading causes of infant death are respiratory diseases (49.1%), certain conditions originating in perinatal period (21.7%), congenital anomalies (21.2%), and infectious and parasitic diseases (9.6%) respectively[2]. Meanwhile, the official statistics indicates an increase from 18.5 to 35.5 in maternal mortality per 100 thousand live-births during the period from 2003 through 2007[2].

Azerbaijan is an economy in transition in which the state continues to play a dominant role. It has important oil reserves and a significant agronomic potential based on a wide variety of climatic zones. In 2007 Azerbaijan's gross domestic product increased by 24.7%, with growth in 2008 estimated at 16.1%. Increases in oil production have largely driven this rapid growth as the oil sector accounted for 52.8% of GDP in 2007.

The government budget for health in 2008 is AZN 331 million as compared to AZN 162 million (2006) and AZN 278 million (2007). This represents a nominal increase of 104% between 2006 and 2008 (Ministry of Finance) while the real increase is lower due to inflation. According to latest WHO estimates, 3.6% of total government expenditure was allocated to health in 2006, which corresponds to 1.13% of GDP (http://www.who.int/nha/country/aze.xls). The share of health in total government budget expenditure increased to 4.2% in 2007 (Ministry of Finance). Yet, despite recent increases in health budget, health system performance experience problems because of both financial and inherent system constraints[3].

2.1: Current socio-demographic and economic country information

Information	Value	Information	Value
Population, 2007	8,532,400[1]	GDP per capita, 2007	$3,642[3]
Annual Birth Cohort, 2007	151,963[1]	Under five mortality rate, 2006	50/ 1000[2]
Surviving Infants*, 2007	150,207[1]	Infant mortality rate, 2007	12.1/ 1000[1]
General government health expenditure as share of GDP, 2006	1.13%[2]	Percent of Government expenditure allocated to Health, 2006	3.6%[2]

* Surviving infants = Infants surviving the first 12 months of life
[1] The State Statistical Committee of the Republic of Azerbaijan, www.azstat.org
[2] AzDHS, 2006
[3] World Development Indicators, World Bank

[3] WHO country information - http://www.who.int/nha/country/aze.xls

2.2: Overview of the National Health Sector Strategic Plan

Health Reform Context

In Azerbaijan, broader health system characteristics constrain the effective and efficient delivery of health services.

After gaining independence, the government has managed to preserve the health system network despite economic constraints and scarcity of resources. The current structure of the health system is still characterized by structures and financing mechanisms inherited from the Soviet era not now suitable to meet the current and emerging disease burden and resulting for instance in fragmentation, inefficient resource allocation and inherent inequalities. Also, according to modern standards, the system is overly oriented towards inpatient care which causes inefficiencies. Most primary health institutions are staffed and still provide certain basic services. However, there has been little change in the distribution and service mix of these institutions and they continue to deliver only a narrow scope of services. Hence, the health system is in need of restructuring with a reorientation of public health interventions and service delivery in line with the current and emerging disease burden.

Recent Commitments and Strategies towards Health Sector Reform

The Ministry of Health formulated its health strategy in a Concept for Health Care Reform in 2006. In early 2008, an updated and expanded version of this Reform Concept has been finalized by the Ministry of Health based on a stakeholder consultation process. While it has not been formally signed, it is accepted as a working document on directions and principles for health system reform for Azerbaijan and was used to orient the process of prioritizing interventions for this HSS proposal.

The proposed Concept for Health Care Reform is structured around the following broad priorities of health system reform:

A. Strengthening health system governance and regulation
B. Strengthening health care financing
C. Increasing the effectiveness of health service delivery
    C1. Strengthening and prioritizing primary health care
    C2. Increasing the efficiency of secondary, tertiary and social care provision
    C3. Strengthening of Public Health Services
    C4. Improve access and rational use of drugs
D. Aligning human resources for health to population health needs
E. Health information systems, monitoring and evaluation

The Concept for Health Care Reform outlines directions for strengthening primary health care involving the development of adequate skills, organizational forms and new structures. A new approach to primary care service delivery will be developed which broadens the scope of services provided at the primary level while making best use of existing capacities and structures of ambulatory care, including polyclinics. By this, access to a broad range of preventive and curative services of adequate quality shall be ensured also during the transitional phase. Other parts of the Concept outline reform directions for specific parts of the health system which will enable a shift towards strengthened PHC provision, including reforms of physical and human resources new incentives through health financing reforms.

In terms of implementation, the Ministry of Health, with support from the government and

international organizations (World Bank, USAID, WHO, UNICEF), launched the Second Health Sector Reform Project (2006-2012) under World Bank loan agreement in 2006. The Project gives an opportunity to pilot new principles in organizing and financing health services in five districts. While certain reform measures are immediately planned and implemented at the national level, a substantial share of the reforms outlined in the overall health care reform concept and the health financing concept will be initially piloted in these five districts.

Development of the healthcare sector and protection of public health have been identified by the President of Azerbaijan as one of the priorities for the country's long-term development. On December 27th 2007, the President approved the establishment of a "State Mandatory Medical Insurance Agency" under the Cabinet of Ministers and issued a decree on approval of a "Concept for Reforming Health Financing System and Introduction of Mandatory Medical Insurance in the Republic of Azerbaijan" on January 10th 2008. The latter represents a major commitment to system reform as it involves the implementation of the purchaser/provider split, a reduction of fragmentation in financing and the piloting of new provider payment schemes – all of which are likely to become important drivers of change. The gradual introduction of output-based payment schemes starting from pilot districts (per capita payments for primary care and case based payments for inpatient care) represents a critical step towards successfully implementing a redefined package of state guaranteed services as outlined in the Concept for Health Care Reform. On 30 January 2008, the Minister of Health signed a National Reproductive Health Strategy 2005-2015 including a detailed plan of actions.

In terms of educational reforms with relevance to health workforce, Azerbaijan has joined the Bologna process in May 2005. A country action plan until 2010 stipulates standardizing diplomas, introducing a multi-tier system of higher education, transfer to a credit accumulation system, recognition of foreign documents on higher education abroad, quality assurance of higher education, and increasing mobility of students and teaching staff between specialties. In addition, the upgrade of nursing schools to colleges is currently under consideration.

Azerbaijan's strong economic growth and increased government revenues fuelled by high oil prices, have created favorable conditions for developing the social sector and for achieving the much needed increase in public revenue allocations for health. Currently the Ministry of Health is building a momentum for a systemic health sector reform based on those economic opportunities.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments

Title of the assessment	Participating agencies	Areas / themes covered	Dates
European Observatory on Health Systems and Policies. Health Systems in Transition	European Observatory on Health Systems and Policies	▪ Organizational structure and management ▪ Health care financing and expenditure ▪ Health care delivery system ▪ Financial resource allocation ▪ Health care reforms	2004
Evaluation of the Health Information System (HIS) in Azerbaijan Republic and working out recommendations for further development	MOH Azerbaijan and WHO Euro	▪ Legislative framework ▪ Participants in the HIS ▪ Data and information sources ▪ The flow of routine data and information within and outside the health system ▪ Use of health information and databases developed by international organizations	2005
Azerbaijan Health Sector Review Note (in two Volumes) Volume II: Background Papers	World Bank	▪ Demand for and utilization of healthcare services ▪ Health system stewardship ▪ Health financing ▪ Resource generation ▪ Healthcare organization and service delivery	2005
Primary Health Care Assessment	USAID	▪ Health sector assessment ▪ Health system reforms ▪ Primary Health care in Azerbaijan ▪ Health Care financing	2005
Azerbaijan Demographic and Health Survey	UNICEF/USAID/MOH	▪ Reproduction ▪ Contraception ▪ Fertility ▪ Maternal Care ▪ Child Health/Nutrition ▪ HIV/AIDS ▪ Adult health and life style	2006
Rapid assessment of surveillance system	WHO/MOH	▪ National management system ▪ Detection and notification ▪ Reporting and data management ▪ Event-based investigation and analysis ▪ Laboratory proficiency ▪ Supportive activities for surveillance	2007
Effective Vaccine Store Management Assessment of the National Store	WHO/MOH	Assessment of following indicators: ▪ Pre-shipment and arrival ▪ Temperature monitoring ▪ Cold store capacity ▪ Building, equipment and	2007

		vehicles ▪ Effective maintenance ▪ Stock management ▪ Human and financial resources	
National Vaccine Regulatory System Assessment	WHO/MOH	▪ National Regulatory System ▪ Marketing authorization and licensing activities ▪ Laboratory access ▪ Post-marketing activities including surveillance of AEFI	2007
Assessment of the situation in Perinatal/Neonatal Care in Azerbaijan, 2008	WHO/UNICEF	▪ Evaluation and analysis of the existing situation in perinatal/neonatal care ▪ Plan of action for improvement/strengthening/ reorganization of perinatal/neonatal care for 2008-2010	2008
Training Needs Assessment Report of Pre-service and In-service Training Institutions in Azerbaijan	WHO/MOH	▪ Overview of existing pre-service and in-service training institutions (focus on mid-level workers) ▪ Needs and capacity assessment (focus on mid-level workers) ▪ Recommendations	2008
White Paper on the health sector workforce capacity and planning implications, MoH, Interim Report	Health Sector Reform Project of the Ministry of Health, World Bank supported.	▪ Overview of staffing capacity and supply ▪ Hospital sector medical staffing ▪ Staffing at the primary level	2008

3.2: Major barriers to improving Immunization coverage and Maternal and Child Health Outcomes identified in recent assessments

Service delivery

Inadequate scope and quality of care provided at the primary level

The health system currently lacks effective mechanisms to direct patients and resources to the most appropriate level of care. Attempts to shift service provision to the primary care level have been mainly targeted to rural areas. Most primary health institutions are staffed by mid-level workers and still provide certain basic services. However, there has been little change in the service mix of these institutions and many patients seek outpatient services in secondary care facilities. Currently, there is little incentive to use primary care as first level of access (no strict referral system in place and few resources and capacities available). Hence, the primary health services continue to have a narrow scope. Efforts to reform the health system over recent years did not create the systemic changes required for expanding the role of primary level. However, the current health financing reform agenda suggests a more favorable environment for PHC reforms in the future, starting from pilot districts (Report on Health System Assessment Mission for GAVI HSS 2008, White Paper on the health sector workforce capacity and planning implications, MoH, 2008, Azerbaijan Health Sector Review World Bank 2005).

Comprehensive and updated clinical protocols for maternal and child health are not yet available. Use of available clinical protocols or guidelines is uncommon, leading to individual habits and preferences in terms of diagnostics and interventions. Consequently, guidance on delivery of

quality health service and clarity on the scope of services to be performed by mid-level staff is insufficient. There is no systematic approach on providing health education to families, to encourage antenatal care visits and to distribute child immunization passport to parents. (Report on Health System Assessment Mission GAVI HSS 2008, Assessment of the situation in Perinatal/Neonatal Care in Azerbaijan, WHO/UNICEF 2008, Azerbaijan Demographic and Health Survey, UNICEF, USAID, MOH).

Coordination and monitoring of health care is hampered by weaknesses in the information and reporting system

Technical issues on reporting from the Primary Care level, like shortage of reporting forms, inadequate reporting forms, unclear reporting requirements and an unduly heavy reporting system, have been observed. At the level of FAPs, SVAs and SUBs lists of children that have to be immunized do exist, but individual histories (medical files) of the population covered by the health facility are usually not kept. The current quality assurance system is limited to maternal and child death, immunization status and serious adverse events. However, monitoring and reporting on services provided at the PHC level (FAP, SVA) is not sufficient to inform broader quality improvements strategies (Report on Health System Assessment Mission GAVI HSS 2008).

Comparison of surveys and data gathered by official statistical authorities undertaken as part of the GAVI HSS assessment mission revealed a substantial divergence and there is indication of incomplete collection and reporting. Official statistics provided by different agencies sometimes show substantial deviations from survey findings. While a significant part of the discrepancy for example in live births can be explained through the incomplete transfer from the Soviet to the internationally used WHO live birth definition, issues of data quality and reliability constrain the monitoring of service provision and health outcomes (Report on Health System Assessment Mission for GAVI HSS 2008, Evaluation of the Health Information System (HIS) in the Azerbaijan Republic and working out recommendations for further development, MoH/WHO 2005).

- *The registration process of newborns* is based on a Form #103 issued by a Maternity/secondary care facility. This Form is a basis for the civil registration process. However, there is no certainty on the complete registration of children born outside health facilities, though there are efforts to register these newborns at the nearest hospital. There are indications that the current low levels of reported home births may be an under estimation and that real numbers may be much higher.

- *Registration of maternal and infant mortality*: similar to the possible undercounting of home births by medical statistics, there might be underreporting on child deaths. In addition, there might be reasons for prioritizing other causes of female death than maternal mortality in official reports.

- *Reporting on immunization coverage rates*: The Republican Centre for Hygiene and Epidemiology (RCHE) receives reports on actual vaccinations from the medical facilities at PHC level which are service providers. A significant deviation of demographic information provided by the State Statistical Committee and the Statistics of the Ministry of Health suggests that the official immunization target group used for measuring and monitoring coverage might undercount the actual number of newborns. The comparatively very high DTP coverage rate of 95% may indicate a low number of children in the denominator. Since the number of children is used by the RCHE as a target group to ensure immunization coverage, any understatement of the actual number of children undermines the systematic monitoring and increase of immunization coverage through RCHE.

The facility visits during the GAVI HSS assessment mission indicated an insufficient availability of immunization passports to be distributed to parents. UNICEF supported to the MoH for the printout of immunization passports in the past. Today, providers face an important shortage of such passports for distribution to parents, partly related to the practice of keeping them at health facilities as respective forms. Importantly, UNICEF is not supplying the health system with

immunization passports any more given the increasing role of the Ministry of Health in organizing and financing the immunization program. However, the printing and distribution of immunization passports has not been budgeted into the current national immunization program. Hence, parents of children have little or no information on the opportunities for immunization and an important tool for increasing the parent's role in managing child vaccination remains underutilized.

Resource Generation

Health sector workforce planning is not systematically aligned to health needs and reform strategies

Resulting from little efforts on integrated human resources planning in the past decade, insufficient adjustment of human resource capacities to the demand has taken place. The health system is burdened by an inappropriate skill-mix in certain areas, and imbalances in the distribution between urban and rural areas persist (White Paper on the health sector workforce capacity and planning implications, MoH, 2008).

The retraining system is not adequate to scale up the capacities of mid-level workers in line with the objectives of PHC reform

As part of the state education system, nursing schools provide both, basic and postgraduate trainings of middle level workers according to officially approved curricula and under government budget. As a result of transition, the nursing schools have faced a shortage of resources and capacities. Even if over the past decade, intensive retraining of mid-level workers took place under donor-funded PHC strengthening projects in limited number of districts, sustainability of these efforts and impact at the national level were obstructed by the lack of investments into the national system of nursing education and its capacity to outreach to regions. Donors' projects, given their project nature and time limitations have prioritized direct training of staff as an emergency response to health needs and have not emphasized on strengthening the education system as such. The direct trainings of PHC workers initiated under donor projects have not been sufficient in terms of national coverage and sustainability. In addition, the investments into an alternative, project-based system have to some extent discouraged efforts to strengthening the functionality of official system (Report on Health System Assessment Mission for GAVI HSS 2008).

The training methodology and conditions for learning and teaching within the nursing schools are insufficient against modern teaching approaches. Curricula currently consist of separate training modules for each specialty (e.g. feldsher, nurses and midwifes) which to some extent contradicts the provision of a universal scope of family-focused care through each mid-level worker. At the same time, the training programs developed under donor projects so far represent a large number of very specific components which are not harmonized and therefore cannot be integrated to fill this gap. In addition, a number of resources are needed to increase the training capacity of the national education system, such as learning materials and a clinical laboratory for simulated practice (Training Needs Assessment Report of Pre-service and In-service Training Institutions in Azerbaijan, WHO/MoH 2008, Report on Second Mission for GAVI HSS 2008).

Stewardship

Inadequate efficiency of Health Information System Management

National statistics are under the responsibility of the State Statistical Committee (SSC). Health information is provided to the SSC through the Ministry of Health which is responsible for overall health information and the Ministry of Justice which provides information based on civil registration of births, deaths and civil status. Apart from official data collection, there is a multitude of smaller information channels linked to national health programs (Report on Health System Assessment Mission for GAVI HSS 2008, Evaluation of the Health Information System (HIS) in the Azerbaijan Republic and working out recommendations for further development, MoH/WHO 2005).

Comparison of data gathered by official statistical authorities in recent years revealed inconsistencies between different official sources and there is indication of incomplete collection

and reporting. For example, comparison of child births in 2007 indicates 30,000 more newborns according to SSC statistics as compared to Ministry of Health statistics. This has implications on the estimation of the birth cohort for immunization and planning for other health services (Report on Health System Assessment Mission for GAVI HSS 2008).

Insufficient information sharing and feedback to providers and other health care planners
Currently, the Ministry of Health relies on a centralized system for data entry, i.e. medical records collected on paper at district level are entered into the electronic database at the national level. While this was quite appropriate for the initial period of establishing the new system, this should be changed now as providers loose the opportunity to analyze the data they report as a basis for monitoring service delivery and quality improvement strategies. Also, opportunities for improving the accuracy of data are not fully exploited if there are no tools and procedures for electronic data checks at the district level. Despite recent efforts to decentralize data entry, capacities to report and the level of computerization for entering and monitoring health information at the district level remain insufficient (Report on Health System Assessment Mission for GAVI HSS 2008).

The limited access to tools for conducting targeted data analysis and evaluation represents another weakness of the health information system. Public health reports are still constructed around the production of traditional lengthy statistical tables on a limited number of topics compared to the bulk of data which is collected, with no multivariate analysis, insufficient construction of indicators, and no dissemination plan (Report on Second Mission for GAVI HSS 2008).

Health Financing

Health financing arrangements do not promote equitable access to services and efficient service provision
The performance of the health financing system is constraint by a number of features inherited from the Soviet budgeting system, such as rigid line item budgets, fragmentation in the financing of the health care sector between the republican and district levels which does not allow for optimizing service delivery structures across districts or for redistributing funds between. In addition, inefficient budget allocation practices sustain inefficiencies in resource allocation by relating it to input categories such as the number of beds rather than the quantity and quality of services actually provided (outputs). As a consequence, there are inherent inequalities and inefficiencies in the distribution of public resources which contribute to lower accessibility of health services in areas of low health facility density (Azerbaijan Health Sector Review World Bank, 2005).

Financial access to health care services remains a barrier according to surveys. The inpatient admission rate was 62 per 1000 population in 2007 compares low to EU and CIS levels of 180-190 per 1000 population. This may suggest insufficient financial access to quality health services important for maternal and child health. According to WHO estimates, almost 60% of total health expenditure was paid out of pocket at the time of service use in 2006. Given the fact that the government budget has doubled between 2006 and 2008, this ratio might have decreased since 2006.

Insufficient capacity in planning and budgeting for immunization programs
Assessments of immunization program performance and the recent multi-year planning for immunization have revealed insufficient capacity and need to strengthen simple planning tools and procedures at national and sub-national level to support adequate planning and budgeting for the implementation immunization programs. The latter, besides underfunding, can be an important cause of problems with the supply of vaccines, cold chain equipment, and surveillance (Report on Health System Assessment Mission for GAVI HSS 2008).

3.3: Barriers that are being adequately addressed with existing resources

Service delivery

Improving scope and quality of care provided at the primary level
Over the past decade, several attempts have been made to improve the delivery of primary healthcare services with financial support not only from World Bank, but also from other UN agencies, most notably UNICEF, and USAID-funded INGOs such as International Medical Corps, AIHA, and Mercy Corps. However, these remain confined to a few select districts and have not resulted in a redefined approach to PHC at the national level.

Supported by the World Bank and other partners, the Ministry of Health's HSRP will pilot new models of PHC provision. Lessons from the five pilot districts are expected to inform the national reforms, including a revised scope of service for the different levels of service provision, referral requirements and standards of accreditation and licensing.

Public Health and Reforms Centre/MOH and PIU MOH/WB are synchronizing their efforts in updating clinical protocols for primary care providers. Meanwhile, UNICEF and other partners are providing support for the development of clinical protocols mainly in the area of ante-natal, perinatal, and post-natal period as specified in the National Reproductive Health Strategy for 2008-2015 approved by the Ministry of Health in 2008.

Efforts to better coordinate and monitor of health care through improving the information and reporting system
Since 2004 the State Population Register Service established by the President's decree under the Ministry of Justice has been implementing the project on developing the Population Register with the aim to assign appropriate identification number to every person who is permanently living in Azerbaijan. To synchronize the individual data entry State Population Register Service is collaborating with the Health Information and Statistics Department under the Ministry of Health. This partnership will help to avoid the duplication of individual data entry and decrease divergence of information provided by the two agencies. However, implementation of the project is constrained due to financial limitations.

The E-Health Card Project, the other example of MOH's efforts to improve data collection and reporting, is aimed at development of data base and introduction of plastic Cards with a chip for the registration of data on health status, including conducted vaccinations and other medical information. E-health cards have been issued to newborns in Baku and some districts since December 2007 with plans to provide universal coverage by 2010**.**

Resource Generation

Aligning health sector workforce planning to reform strategies
Supported by the World Bank and other partners, the Ministry of Health's HSRP has a component on strengthening the planning capacity for long term human resource needs of the health sector. So far, national staffing levels and profiles have been assessed against current and future needs. Based on this, the distribution and profiles of medical personnel will be gradually reformed in the five pilot districts. Lessons on adequate staffing norms and the composition and roles of different staff profiles will inform an update in national regulation and the implementation of related reforms across the Republic. Furthermore, efforts have been initiated by the government to control the overproduction of medical personnel in certain areas.

Improving the retraining system to scale up the capacities of mid-level workers in line with the PHC reform objectives

The Ministry of Health's HSRP will focus training on the development of Family Doctors and Family Health Nurses in five pilot sites. The HSRP will focus on training trainers who will train a large number of health workers in pilot districts using project funds directly. In terms of strengthening the national re-training system, the HSRP will contribute via training materials development and the training of trainers that could potentially be hired by the government for teaching at nursing schools in the future.

Stewardship

Improving efficiency of Health Information System Management

The E-health Card Project initiated by the government within the Ministry of Health has quite ambitious goals to have an electronic database with information on health status for children up to 14 years of age and to provide all newborns starting from 2008 with plastic cards as a medical passport including selected information on mother and child health, conducted vaccinations and other medical information. However, benefits of integration between the e-health card system and the general health information systems have not been fully exploited yet in the current design and could be increased if more linkages were established to the health information system reform undertaken by the Department of Health Information and Statistics.

Increasing information sharing and feedback to providers and other health care planners

The State Statistical Committee with support from UNICEF and UNDP is developing an online database on child and maternal health which will use and analyse administrative and survey data.

The Department of Health Information and Statistics has installed a piece of software for entering the patient discharge form (Form #66) at district hospitals. This provides a basis for increasing the service provider's role in electronic data entry and in monitoring data accuracy and service provision.

Some activities to strengthen information and reporting systems are also planned under the HSRP and will be partly implemented by USAID PHCS. However, they are mainly concentrated on the discharge information of inpatients (Form #66) and will complement well with the health information system strengthening activities proposed for GAVI HSS funding which aim at gradually expanding the scope and integration of information entered at the provider level (complementarity of investments has been ensured through a joint field trip, planning and the use of the same consultant for GAVI HSS and USAID PHCS).

Health financing

Developing output-based health financing arrangements to promote equitable access to services and efficient service provision

Once established and staffed, the "State Mandatory Medical Insurance Agency of the Republic of Azerbaijan" shall serve as a pool of funds and as a single purchaser of a benefit package. To increase equity in distribution of services and resources, new allocation formulas will be developed according to population needs. It is planned under the HSRP to develop and pilot output-based provider payment schemes with support from the USAID PHCS project.

A basic package of state guaranteed services will be specified to be provided for free and financed through the State Mandatory Medical Insurance Agency, based on the new provider payment schemes. It will be initially piloted in a few districts. It is expected that the redefinition of benefits, increased allocations by the state based on the estimated price of the benefit package and improved monitoring of service delivery and quality through the purchasing agency will improve access to a broader scope of outpatient level and improve financial access to inpatient care. Importantly, the planned shift to output based payments will be an important driver for more complete reporting from inpatient providers, given the direct link to financing while data accuracy will improve over time supported through monitoring systems.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

Service Delivery

Coordination and monitoring of health care is hampered by weaknesses in the information and reporting system

Centralized data entry of main statistical forms (103, 106, and 66) is among the factors contributing to observed weaknesses on the quality of information, its efficiency, and reliability. Healthcare providers lack opportunity to analyze data and make appropriate decisions. Thus, it is important to shift data entry from central to district level. Improving capacities of statisticians and providing technical support at district level will allow strengthening information base, monitoring capacity, and competences to manage and coordinate prevention and care.

There are a few positive examples from former Soviet Union countries in development and implementation of Pregnant Women Registry. In Kazakhstan, the Pregnant Women register was implemented in Karaganda oblast with ZdravPlus (USAID funded project) technical assistance in 2006. Within the project, a methodology, reporting forms, and information system were developed. In Russia, the Pregnant Women Register was implemented in several Russia's regions, including Tomsk oblast (www.mednet.ru/conference/files/29-05-07/druginina2.ppt), Yaroslavl oblast, Altaic oblast and others. In Kyrgyzstan, the Healthcare Development Center in collaboration with CDC/USAID implemented a "newborns registry" and is currently expanding it to pregnant women. The introduction of such a formal Register of Pregnant Women in Azerbaijan would allow a closer monitoring of care against agreed standards on frequency and deliverables of antenatal care visits and represent a new data source to verify the registration of newborns and maternal and child deaths at the district level. By this, it is expected that the immunization target group would be more accurately defined in the future. This is something not foreseen in the HSRP and therefore would add to the piloting of the improved Health Information System a valuable component with direct benefits on coordination, awareness by mother on entitlements, monitoring of birth outcomes, etc. Hence, it would be important to increase monitoring and reporting from primary care facilities on pregnant woman so that this can be used to cross check the number of newborns registered and immunized.

In light of the existing E-Health Card Project, it is proposed to link the distribution of **immunization passports** to parents to the E-health card system through a printout showing registered vaccination and the schedule of outstanding vaccinations for a specific child. However, an electronic feature to print such forms is not yet part of the software package and requires additional investment to address the current shortage of the plastic cards.

Resource Generation

The retraining system is not adequate to scale up the capacities of mid-level workers in line with the objectives of PHC reform

Currently, the basic care level is mainly staffed with mid-level workers who perform services within a relatively narrow scope. To improve health services within the PHC sector it is essential to raise the standard and level of competence of all medical staff including nurses, midwives and feldshers. The current educational provision to train mid-level workers is inadequate and focuses on a medical model with knowledge that appears to be largely outdated and not relevant for use within PHC practice. Meanwhile, the expected transition towards a modern family medicine approach will increase demand on skills and knowledge of mid-level workers as family focused care and the family nurse in particular will become responsible for providing a broader scope of services.

The current gaps in skills and knowledge will be addressed through enhanced provision of postgraduate nursing education and a new curriculum on family focused care. The new curriculum will be comprehensive in order to cover the full scope of mother and child care, assessment of family health risks and improved preventive services (incl. immunization).

A major aim of GAVI HSS funding will be to improve the skills and expertise of mid level staff who work in the primary health sector. The need for retraining is paramount and with over 25,000 nurses, midwives and feldshers working in this sector it is essential to introduce a sustainable program of retraining that can allow for the development of these critical staff. Hence, the core objective is to improve capacity and capability amongst both educators and mid-level health workers through a strengthened post-diploma education system.

Coordination of the activities under the GAVI HSS and those of the MOH HSRP on development Family Doctors and Family Nurses in five pilot sites has been agreed and provides an opportunity to maximize resources while at the same time providing the added value of incorporating a similar approach nationally. Agreement has been reached that both projects will share materials and seek to adopt common principles for the education and training of the PHC staff.

Stewardship

Inadequate efficiency of Health Information System Management
Although E-health Card Project initiated by the government within the Ministry of Health has quite ambitious goals it lacks integration with the general health information systems and this worsens the data flows, analysis, and sharing. Moreover, fragmentation weakens the monitoring and evaluation of the system. Benefits of integration between the e-health card system and the general health information systems are obvious. The integration of health information system components through establishing more linkages between key stakeholders will ensure identification of complete target groups for maternal and child care, improve monitoring and evaluation system, and increase immunization coverage.

Insufficient Information sharing and feedback to providers and other health care planners
Although different components of health information system have been implementing projects on various aspects of improving the overall system functioning they lack information sharing with key stakeholders of the healthcare system as a whole. As result, the information chain healthcare provider – healthcare planners is missing a feedback point so important in reporting, data accuracy and analysis, and decision-making procedures, particularly, at district level. Thus, the GAVI HSS project components will be allocated for development of functions and capacities of different levels and institutions of the health system in collection, flow, sharing, and M&E of information within the system in general including antenatal care, delivery and birth outcomes.

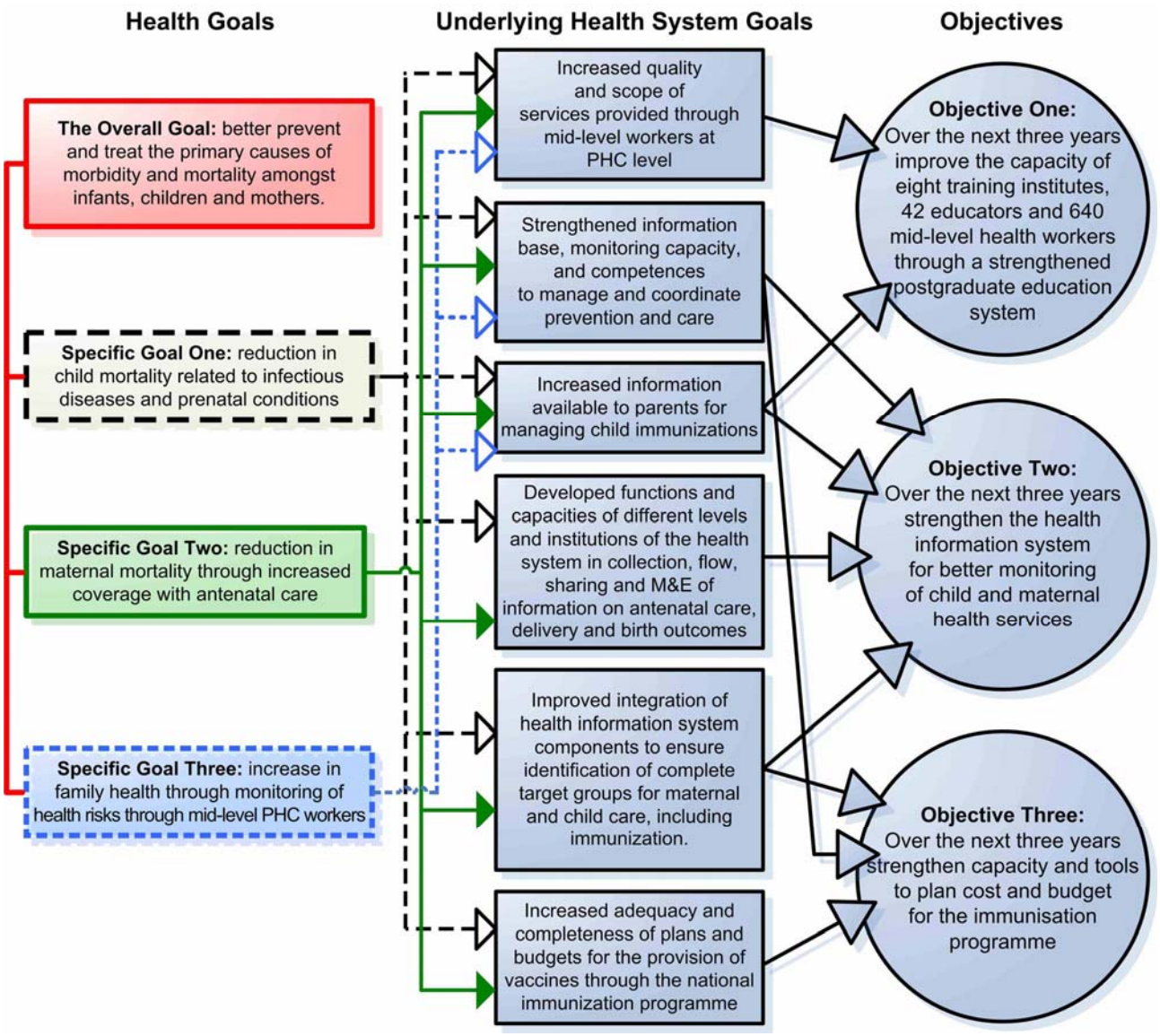
Health financing

Insufficient capacity in planning and budgeting for immunization programs
The activity proposed for GAVI HSS funding addresses the need to increase the adequacy of plans and budgets for the provision of vaccines through the national immunization program. Strengthening of capacities in the use of planning tools is considered critical to avoid shortages in supply of vaccines, cold chain equipment, and forms and systems for reporting and surveillance that result from insufficient planning and budgeting. It is also anticipated that the lessons and tools developed under this activity will inform similar exercises of other parts of the health system.

Section 4: Goals and Objectives of GAVI HSS Support

4.1 and 4.2: Goals and objectives of GAVI HSS Support

Figure 1: Goals and Objectives of GAVI HSS Support



OBJECTIVE ONE. Over the next three years improve the capacity of eight training institutes, 42 educators and 640 mid-level health workers (feldshers, midwives, and nurses) through a strengthened postgraduate education system.

Strengthening (re)training of feldshers, midwives and nurses through strengthening of the national nursing education system

Preparing Curricula for Trainers and Trainees. The National Concept for Health Care Reform (2006) and its 2008 revision both emphasize the necessity for strengthening the quality and scope of services provided at the primary health care level. Given that the current educational provision to train mid level workers is inadequate and appears to be largely outdated, it is essential to invest in the state structures and institutions for retraining that can allow for the development of these critical staff. To ensure a sustainable resource of well prepared health professionals at the Primary Health Care level (FAPs, SVAs and SUBs), an increase in the capacity of the training institutions (Nursing Schools) is required to provide a training program that is fit for purpose to meet the demands of the changing PHC environment.

A short term working group will be established to prepare both the curricula for trainers and trainees, to identify standards for practice and to develop the tools for the supervision of students quality control and evaluation. They will also prepare the program for implementation of the training courses. To ensure a sustainable process beyond the life span of this project the new course will be incorporated into the current timetable of post graduate courses offered at the Nursing Schools and teachers currently teaching the specific subject areas will have the opportunity to retrain in preparation for the new curriculum.

It is proposed to consolidate four courses currently offered for the advanced training of feldschers, nurses and midwives and replace them with an updated family focused curriculum for PHC mid level workers. This program will incorporate modern teaching methods and will use the evidence base for practice effectively within the PHC environment. The new course will be 6 month in total and will be taught over 2 years in three parts. Each part will consist of one month theory and one month supervised practice. Students will be supervised in practice by nurses who have completed the trainers program. Students working in rural areas will have first priority to access the course. Once the course is integrated into the portfolio of approved courses by the Ministry of Health all mid level healthcare providers who work in PHC will be expected to complete the course as part of their retraining five year schedule. All mid level workers in PHC will be eligible for the courses both those who are experienced and those who are new to the profession and recently graduated. This mix of experience and newly qualified staff will add richness to the learning environment enabling an exchange of ideas with the experienced staff sharing their expertise while the newly qualified staff will be fresh and open to new ideas without being constrained by traditional practices.

It is expected that the training course and the training materials developed for the new curricula will continue to be used after the project and in addition will provide the foundation for the further development of improved education for primary health care staff. The materials developed to support the course can also be used within the basic nursing program to develop early awareness of community health care issues amongst mid level health care workers. It is also expected that the principles used in this post basic course will be incorporated into development of the new basic program and teachers will have the opportunity to benefit from the new teaching and learning methods introduced.

The focus of the new course will be on Family Health Care. Family focused care provides a holistic approach to community health provision and is especially dependent upon the skills of midlevel workers who are able to apply the principles of health promotion and health education with leadership and decision making skills. Mid level workers working within a family focused model are able to identify the key health risks to the family particularly mothers and young children and to provide appropriate interventions such as the management of child hood disease, surveillance of

chronic disease, nutrition and prevention of infectious diseases through properly managed immunization schedules and monitoring at the community level. A key skill to be acquired will be the ability to carry out an effective community risk assessment and subsequently plan for effective intervention. This approach requires that these health workers work either in partnership with the physician with clearly defined areas of responsibility and accountability or when there is no physician they are able to maintain quality provision independently for the local community. (Kutzin April 2008).

Strengthening Teaching Capacity and improving the learning environment. It will be necessary to improve the quality of the teaching provision amongst the current teaching staff. The training course for teachers will be held once a year. Educators in the Nursing Schools will have the opportunity to not only advance their knowledge of family focused care principles but also they will be exposed to modern approaches to education, new learning and teaching methods and curriculum development techniques. There is a recognition that by doing so the competence and level of the education of mid level workers within the current system will improve and consequently MCH care at the PHC level and the uptake of immunizations and effective surveillance of the health of mothers and children amongst rural communities will also increase.

Nurses will be recruited in order that there will be an increase in the teaching capacity of the staff. Potential nurse teachers will have the opportunity to advance their knowledge and skills and will undertake a teaching role taking leadership responsibility and working in collaboration with their medical colleagues. This will be important as there is a recognition internationally that doctors work from a different paradigm than nurses and in the long term well educated nurses are best able to teach their own profession and equip them with the levels of competence and expertise required. It will also ensure that a future cohort of nurse leaders can be prepared in anticipation of changes in the education of nurses to higher education and the development of a professional nursing workforce.

To deliver the new curriculum effectively, upgrading the learning environment for students undertaking this new training program and providing resources for teachers to utilize modern teaching approaches will be required. These resources will remain available for the continuing cohorts of students who will undertake the program after the GAVI funding has ceased. The resources include an e-granary system containing necessary learning materials in each school, the development of a practice manual with best practice statements for PHC intervention and a clinical laboratory for simulated practice.

Improving access to postgraduate training for mid-level workers. In addition to improving the quality and content of the educational course, it is also necessary to increase the numbers of feldschers, midwives and nurses who have access to the course annually. Currently training courses are primarily offered in Baku city, the capital and it is often not possible for staff in rural and remote areas to easily access the training provided. It is proposed that in addition to the two schools in Baku the six Nursing Schools across the country will be able to offer the necessary course so making access to retraining easier for those living out of reach of Baku. This along with the delivery of the program in three parts spread over two years will provide a more flexible opportunity for access by those from the remote and rural areas. The involvement of the Nursing Schools will be phased - in the first year four schools will be involved while the remaining schools will be included the following year.

Motivating Medical Staff. Because sufficient staff is already in place and there is evidence that there are adequate numbers to meet the immediate needs, it will be possible to sustain current workforce levels without additional costs (Cochrane and Crilly 2008). It is expected that students will be motivated by the opportunity to learn new knowledge and gain status within their communities. Financial incentives will not be introduced as this may not be sustainable at this early stage of health financing reforms. Still, with advanced knowledge, trainees will be better placed to take the necessary exams for advancement and consequent increased salary. Hence,

the training will be an incentive for staff to be motivated, advance in their careers and obtain better salaries.

As a result, improved awareness of new approaches to learning and teaching and concepts associated with health reform will provide a template for other courses and facilitate the move into modern educational practices and approaches in medical education.

It is expected that the improved level of competence and expertise of mid level workers as well as availability of a full range of services to mothers and children including health education, health promotion, support and advice will lead to an improvement in infant mortality and a reduction in adverse effects of immunization.

OBJECTIVE TWO. Over the next three years strengthen the health information system for better monitoring of child and maternal health services.

Developing mechanism for the supply of immunization passports

According to international experience, introduction of immunization passports ensures better immunization coverage through improved record-keeping of vaccinations, increased awareness of parents about timelines and types of immunization, and ensured continuity of immunization process in case of internal and international migration.

Introduction of Immunization Passports in Azerbaijan through the MOH's E-health Card Project will include personalized electronic registration of vaccinations, which will result in improving data accuracy and providing opportunities for development of a vaccination planning and monitoring system.

Upon the GAVI HSS project completion, sustainability and further roll-out of the provision of Immunization Passports will be ensured through governmental funding in the framework of the E-health Card Project, one of the Ministry of Health's priorities officially included into the national project "Electronic Azerbaijan". Expansion of the E-health Card Project through adding Immunization Passports will increase the efficiency of public investments into the Health Information System, including the E-health Card Project. The introduction of Immunization Passports will also play an important role in implementation of the cMYP for the Immunization Program approved by the Cabinet of Ministers' Decree #177 of July 19th 2006.

Implementation of this project will be supported by UNICEF, which has already had an experience of launching similar projects in Azerbaijan and other countries.

Furthermore, Vishnevskaya – Rostropovich Foundation, together with DTRA and WHO, is currently planning to implement a project on "Electronically Integrated Disease Surveillance System". In the long-term perspective, synchronization of this project with Immunization Passports will allow to develop a unique analytical tool to monitor effectiveness of immunization and track AEFI.

Modernization of registration of pregnant women to ensure continuity of care for mother and child

Mother and child health is the main priority of the Ministry of Health and the Government of Azerbaijan Republic. In 2008 the Ministry of Health, together with WHO, UNICEF and other international organizations developed a "National Strategy for the Protection of Reproductive Health of the Population of Azerbaijan Republic for 2008-2015".

Based on examples and experience from other countries, it is proposed to develop a Pregnant Woman Registry and to pilot it in the five districts of the MoH's Health Sector Reform Project. A formal Register of Pregnant Women will allow a closer monitoring of care against agreed standards on frequency and deliverables of antenatal care visits. Besides direct benefits for the coordination and completeness of antenatal care, awareness of mother about entitlements, and a monitoring of

birth outcomes, such register also allows to verify the registration of newborns and maternal and child deaths at the district level and thereby contribute to a more accurate definition of the immunization target group in the future.

The anticipated transition of Azerbaijan to the life birth definition recommended by WHO makes a modernization of the registration of pregnant women especially important. The transition to the new criteria will create fundamentally new requirements to registration and management of pregnancies, planning of preventive measures and ensuring continuity between primary care and hospital sectors.

Implementation of the project implies the development of a unique, country-specific technology of data collection, analysis and evaluation based on existing document flow system, level of information technology development and managerial capacity at the local level. The suggested outlines of the model to be implemented in Azerbaijan include:

a) Project coordination at district level will be carried out by Chief Ob/Gyn, or, as an option, by Head of regional obstetric-gynecological centers (OGC) that are being established to cover several districts.
b) Data entry on newborns based on 103 and 106 forms is provided at maternity houses (E-health Card Project). Data entry on primary registration of pregnant women is done by Statistics Department at central district hospital. In framework of the project it is planned to use existing forms (log-books) that will be updated to ensure electronic processing of data and possibility to change the set of variables if required[4].
c) Information from both sources will be transferred to E-card server where it will be processed and, further, shared with stakeholders.

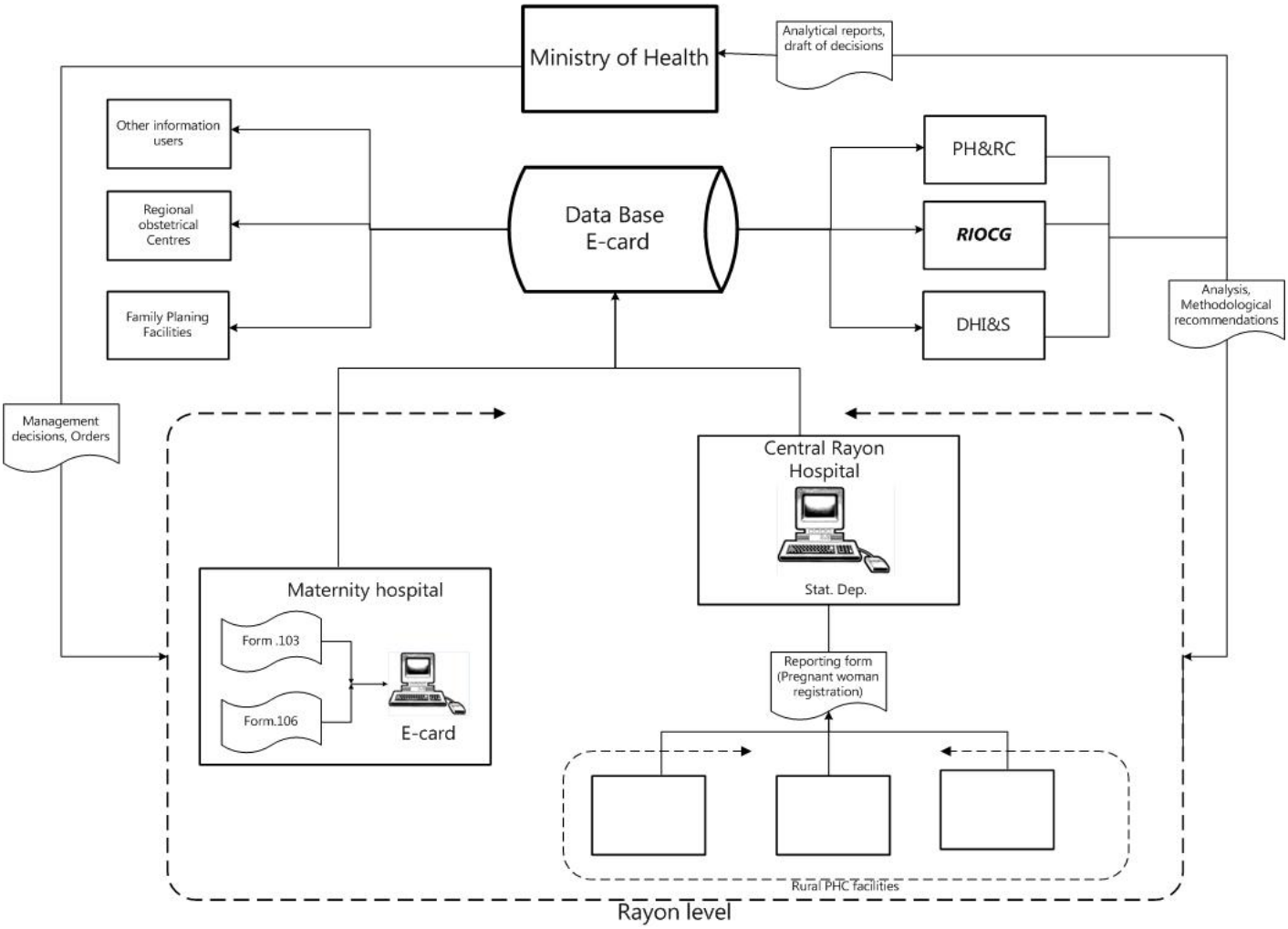
The roles of the National institutions will be distributed in the following way:

Research Institute of Obstetrics and Gynecology is a main methodological and analytical body, which monitors the system, generates analytical reports, submits them to the Department of Maternal and Child Health of MOH for managerial decision-making, and shares with other stakeholders (including OGC) ;
Public Health and Reforms Center (PHRC) develops specific proposals and projects aimed at reaching the population and health workers on issues identified in the process of data analysis.
E-Card Project ensures technical implementation and provides access to data for stakeholders.
Department of Health Information and Statistics (DHIS) utilizes the data in order to generate state statistical reports.

Figure 2. illustrates a simplified scheme of the flow of information and documents involved. The data collection is initially done at the level of Rural Health Facilities through a paper-based Pregnant Woman Registry which is used to report to the district hospital. The district level, the data can be compared to existing electronic reports (forms) on birth outcomes, patient discharge forms and the data reported through the E-health card system.

[4] From a methodological point of view it is important to divide data collection process from the primary level on registration of pregnant women and from the hospital level on registration of newborns. This all allow making information more objective and to create internal control mechanism.

Figure 2. Simplified Scheme of the Proposed Flow of Information and Documents



Implementation of the Pregnant Woman Registry will be carried out in close collaboration with the "National Strategy for the Protection of Reproductive Health of the Population of Azerbaijan Republic for 2008-2015". "Improvement of data collection, analysis and reporting systems" is one of the main objectives of this strategy. To this end, the Action Plan for the National Strategy Implementation (article 1.5.1) includes development of a reproductive health register. Technical implementation of the project and the scheme of data collection are also in line with the MOH Decree #74-S dated May 15th, 2008 on «Creation of a System of Monthly Monitoring of Main Health Indicators».

After implementation of the GAVI HSS project, the Ministry of Health will expand this experience throughout the country using funds to be allocated by the GoAz for implementation of the National Strategy. Implementation of the project is supported by UNICEF and UNFPA as part of their technical assistance to countries in transition to the new life birth criteria.

Decentralization of selected data entry and analysis to the district level

The centralized data entry of main statistic reporting forms at the level of the Department of Medical Information and Statistics of the Ministry of Health has resulted in a range of issues related to inadequate level of information quality, timeliness and accuracy. Providers cannot use this information as the basis for analysis and managerial decisions given that the consolidated information is not available to them in a user friendly format. Overload of information that is to be collected by providers and submitted in a manual mode distracts managers from their direct

responsibilities of managing their district health care system. This problem is one of the reasons why health statistics do not always reflect the real situation and can significantly differ from statistics from alternative sources of information (surveys, expert assessments, etc.).

The Concept of Reforming Health Financing System and Introduction of Mandatory Medical Insurance Introduction in Azerbaijan, approved by Presidential Decree on January 10, 2008, provides basis for introduction of new provider payment systems (using case-based payment method in hospitals and capitation payment principle in primary care). Implementation of these reforms implies the introduction of new statistical reporting forms for providers and subsequent development of billing forms and other documents of financial statistics. In addition, there is a number of health care programs and projects, such as the National Reproductive Health Strategy, that stipulate collection of information on a primary level, in order to introduce modern approaches to development of monitoring and evaluation systems.

Decentralization of selected forms will be supported through a range of activities including fine-tuning of the software for entering forms at providers' level; providing personnel of statistic departments and doctors with appropriate manuals; training doctors on coding diagnoses and surgical interventions; setting up software and organization of data entry and transfer; demonstration of examples of using information for decision making; training for providers' management on how to use medical information for management decision-making; national level review of the pilot use of information for monitoring and evaluation of the health care system efficiency.

Decentralization of data entry is a priority that is supported by the World Bank and USAID funded Primary Care Reform Project. Therefore sustainability of the data entry decentralization project will be ensured by consolidated resources of the Government and other donor organizations.

Developing a strategy of integrating separate information sub-systems into a single information system (e-card, RCHE, health statistics and statistics agency)
Lack of coordination within both internal and external information systems and discrepancies between the data from the Committee on Statistics and the Ministry of Health (e.g. on the number of life births) hinder effective resource planning, appropriate data interpretation and effective use of data for immunization and health sector management purposes. Functions of various government bodies are overlapping which results in structural inefficiency and irrational utilization of public investments.

Development of a strategy on health information systems and their integration into national information resources are in accordance with the National Program on "Development of Communication and Information Technologies in Azerbaijan Republic" (Electronic Azerbaijan) and this will ensure commitment for the project objectives and sustainability for the longer term.

OBJECTIVE THREE. Over the next three years strengthen capacity and tools to plan cost and budget for the immunization program.

Under the framework of healthcare reforms, the Ministry of Health has launched re-organization of some institutional structures involved with implementation of the immunization program since 2006. As result of those reforms the Baku Center for Hygiene and Epidemiology responsible of planning and implementation of immunization in Baku was merged with the Republican Center for Hygiene and Epidemiology (RCHE). The department of RCHE responsible for purchase and supply of equipment, injection materials, and medicines including vaccines for immunization was transformed into a separate agency, Center for Innovation and Provision that ensures material and technical provision of all institutions under the Ministry of Health. In 2007 the department of Laboratory on Drug Quality Control established on the basis of RCHE was enlarged to the Center for Analytical Expertise of Drugs with status of the National Regulatory Body. Thus, nowadays three agencies under the Ministry of Health are authorized to facilitate the implementation of the

immunization program. Despite the significance of aforementioned reorganizations there are still plenty of opportunities for further improvement.

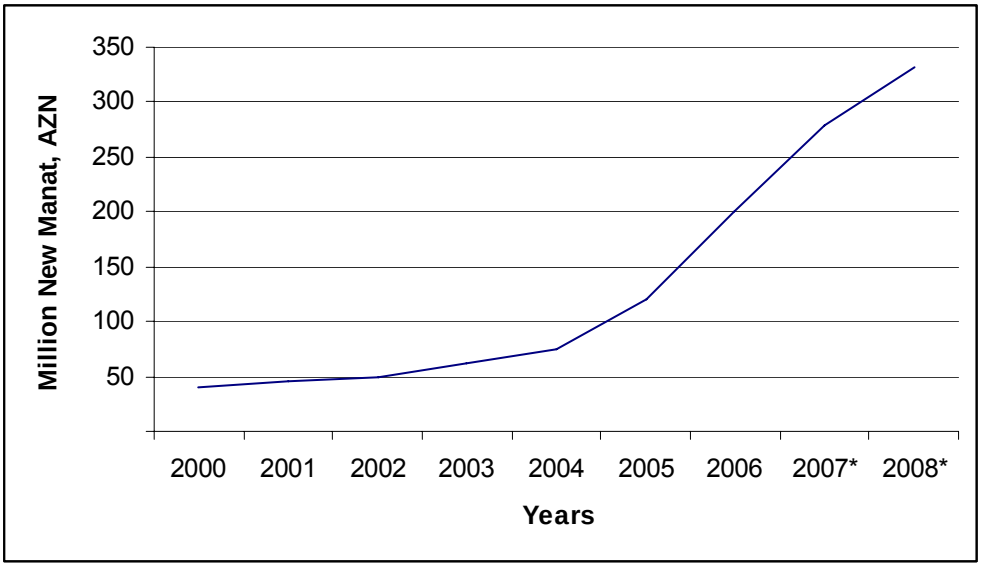
To synchronize and make effective a collaboration of these agencies it is crucial to develop guidelines on management of the immunization program with clear definitions of functions and responsibilities of each agency. It is especially important to determine the role, participation, and ways of interaction between the agencies at the stage of program planning and budgeting. As many of agencies were established newly, tools and mechanisms for planning and budgeting of the program haven't been developed yet. Thus, it is essential to develop a detailed model and precise guidelines on planning and budgeting schemes that would furthermore take into consideration problems identified while developing cMYP. To strengthen capacity of key stakeholders involved into the process of program planning and budgeting, it is crucial to conduct trainings for the staff of all agencies responsible for immunization program implementation. Tools and lessons from this will be shared within the wider health system as appropriate.

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

The economy of Azerbaijan has been rapidly growing in recent years, mainly due to the oil and gas sector (In 2007, Azerbaijan's gross domestic product increased by 24.7% and is estimated to be at 16.1% in 2008). In addition to increased state oil revenues, tax collection has increased from 15% of GDP in 2003 (the lowest indicator in CIS) up to 26% in 2006. Supported by this growth in government budget, the government health budget for 2008 amounts to AZN 331 million as compared to AZN 162 million budgeted for 2006 and AZN 278 million for 2007. This represents a 104% nominal increase between 2006 and 2008 (Ministry of Finance) (see also Figure 3 below). However, between 2005 and 2007, the cumulative inflation was about 40%, which means that the real growth of public expenditures on health was lower.[5]

Figure 3: WHO estimates of government health expenditure for years 2000-2006, approved health care budget for years 2007 and 2008, in Million AZN



Source: WHO estimates of national health expenditure for 2000-2006, Ministry of Finance, Approved Health Care Budget for 2007 and 2008

*Since budgeted amounts according to the Government health budget are provided for 2007 and 2008, these years are not fully comparable to the WHO expenditure estimates (2000-2006) as these also include estimated health expenditure by other Ministries than the MoH.

[5] The State Statistical Committee of the Republic of Azerbaijan, State budget revenues and expenditures, 2008 (http://www.azstat.org/publications/azfigures/2008/en/020.shtml)

Despite these important increases, the share of public expenditures for health in total government expenditure still remains low in Azerbaijan compared to other countries. This has contributed to a rather high share of private out-of-pocket expenses for health care. According to WHO estimates, almost 60% of total health expenditure was paid out of pocket at the time of service use in 2006.

Given the country's significant economic capacity and the Government's recent increase in government financing for health, the constraint posed on the health system by insufficient financing is likely to decrease. The "Concept of Reforming Health Finance System and Introduction of Mandatory Medical Insurance in Azerbaijan Republic" approved on January 10th 2008 by President Decree, apart from expenditure increases, stipulates implementation of comprehensive health financing reform, including the establishment of a Mandatory Medical Insurance fund as a single payer and transition to new health care provider payment methods – initially in pilot districts. Hence, additional state funding for health will be supported by a range of reforms targeting a more efficient utilization of investments. Overall, the planned increases in government funding in the coming years and the range of health care provider reforms introduced in the five pilot districts of the Ministry's health sector reform project create very favourable conditions for the continuation and roll-out of the proposed GAVI HSS activities from government funds in the future.

Specific reference to the institutionalisation and sustainability of each of the proposed activities against ongoing and planned government reforms was made in Section 4 in the description of activities under each objective.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2009)				Year 2 (2010)				Year 3 (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1. Over the next three years improve the capacity of eight training institutes, 42 educators and 640 mid-level health workers through a strengthened postgraduate education system												
Activity 1. Strengthening (re)training of feldshers, midwives and nurses through strengthening of the national training institute												
1.1 Identify and select core working group to develop trainers curriculum, supporting materials and tools												
1.1.1 Identify members and establish working group including international expert	X											
1.1.2 Undertake initial preparation workshop for working group	X											
1.1.3 Prepare Trainer Curriculum and learning materials *Curriculum to include in addition to syllabus and module guides, learning and teaching support materials and methods, practice arrangements, entry criteria, plan of delivery and assessment requirements*. Identify course evaluation tools Identify quality assurance mechanisms Approval of curriculum from Minister of Health	X X	X X	 X									
1.1.4 Prepare curriculum for Trainees and learning materials *Curriculum to Include in addition to syllabus and module guides, learning and teaching support materials and methods, practice arrangements, entry criteria, plan of delivery and assessment tools and requirements*. Identify course evaluation tools Identify quality assurance mechanisms Approval of curriculum from Minister of Health		X X X	X 	 X								
1.1.5 Prepare guidelines for Family focused practice Review existing guidelines on IMCI, reproductive health,												

immunization conducted by different agencies and develop unified guidelines for PHC and use by mid level workers.												
Activity 1.2 Carry out training program for trainers												
1.2.1 Select and recruit key participants			X				X				X	
1.2.2 Conduct training program				X				X				X
1.2.3 Supervise teaching practice				X				X				X
1.2.4 Successful completion by all trainers of the trainer program.					X			X				X
1.2.5 Evaluate trainers experience of the course and their learning outcomes.						X			X			
1.2.6 Monitor the quality of the program using the quality assessment tools.							X				X	
Activity 1.3 Carry out training program for mid level workers												
1.3.1 Recruitment of a minimum of 80 students in each school over one year.				X	X	X	X	X	X	X	X	X
1.3.2 Successful implementation of the theoretical program				X	X	X	X	X	X	X	X	X
1.3.3 Supervision and monitoring of Students in practice					X	X		X	X	X		X
1.3.4 Monitor the quality of the course using a quality assessment tool							X				X	
1.3.5 Evaluate the students experience of the course and learning outcomes					X	X	X	X	X	X	X	X
Activity 1.4 Equip seven Nursing Schools with essential requirements for teaching the program												
1.4.1 Identify and purchase support materials needed for each learning component of the course	X	X			X				X			
1.4.2 Install seven egranary storage boxes with downloaded essential materials	X	X			X	X						
1.4.3 Equip simulation laboratories with identified supplies	X	X			X	X						
1.4.4 Provide Additional Equipment /learning resource needs	X	X			X	X						

Objective 2. Over the next three years strengthen the health information system for better monitoring of child and maternal health services												
Activity 2.1 Develop mechanism for the supply of immunization passports												
2.1.1 Development of Immunization Passport Cards concept note, their use and integration to other information systems	X											
2.1.2 Development of the TOR for information sub-system, including reporting forms and document flow model (on the basis of Activity 2.1.1)		X										
2.1.3 Software development in accordance with the TOR (Activity 2.1.2)			X	X								
2.1.4 Conducting training sessions with representatives of primary care facilities, personnel of statistic services and RCHE on the use of the new system (5 pilot districts, 2 days, 3 persons from each district)				X								
2.1.5 Printing of immunization passports for five pilot districts				X								
2.1.6 Launch, testing and adapting of Immunization passport issue system in five pilot districts. Providing all children up to two including newborns with the immunization passports in these districts					X	X	X	X				
2.1.7 Carry out a review seminar with representatives of all five districts on the results of pilot testing (1 day, 1 person from each district)								X				
2.1.8 Printing and distribution of immunization passports for the remaining districts (funded through another budget)								X	X			
2.1.9 Setting up and maintenance of the system in all districts (funded through another budget)								X	X	X	X	X
2.1.10 Methodological and technical assistance in setting up the passport system (telephone consultations, recommendations, etc.)	X	X	X	X	X	X	X	X	X	X	X	X
Activity 2.2 Modernization of registration of pregnant women to ensure continuity of care for mother and child												
2.2.1 Development of 'Register' concept and document flow model	X											
2.2.2 Development of TOR for the software that ensures the register functioning at the primary care level and its synchronization with the newborn registration information system (Form 103)		X										

2.2.3 Development of software and a system of data transfer from the district level to the national level		X	X									
2.2.4 Public awareness campaign through local mass media in pilot districts to explain to women the goals and objectives of the register and the importance of early registration of pregnancy. Printing posters and displaying them in places attended by women (shops, polyclinics, markets)			X									
2.2.5 Procurement of computers (1 computer for each district and 2 computers for E-health Card Project)			X				X					
2.2.6 Printing new reporting forms, registration log-books, pregnancy record forms for the pilot districts			X									
2.2.7 Conducting a training seminar with health professionals from obstetric and gynecological services and primary care facilities of the pilot districts (2 days, 2 persons from each district)				X								
2.2.8 Setting up and testing information system in the regions				X	X	X	X					
2.2.9 Training for representatives from the national level on the use of the Register for the purposes of monitoring, evaluation and making managerial decisions (1 day, 15 people.)						X						
2.2.10 Workshop to analyze the results of the project implementation in pilot districts (for representatives from other districts; 1 person from each district)							X					
2.2.11 Expanding the system to other districts (funded from another budget).								X	X	X	X	X
2.2.12 Methodological support in setting up the system in other regions								X	X	X	X	X
Activity 2.3 Decentralization of selected data entry and analysis to the district level, including forms no 103, 106 and 66												
2.3.1 Fine-tuning of the software for entering forms at providers' level	X	X										
2.3.2 Providing personnel of statistic departments and doctors of pilot areas with appropriate manuals		X										
2.3.3 Training doctors on coding diagnoses and surgical interventions (ICD 10, and ICD 9CM, 3 persons from each pilot district, 1 day)			X									
2.3.4 Setting up software in pilot districts and organization of data entry and transfer			X	X	X	X						
2.3.5 Database analysis and generation of reports showing examples of using information for decision making						X						

2.3.6 Carry out training for providers' management on how to use medical information for management decision-making (2 days, 2 people from each district)							X					
2.3.7 Carry out a review seminar for representatives of the national level on the pilot use of information for monitoring and evaluation of the health care system efficiency (1 day, 30 people)							X					
2.3.8 Distributing software to other districts (funded from another budget)								X	X	X	X	X
Activity 2.4 Develop an integration strategy, based on existing system and plans (e-health card, RHEC, health statistics, and SSC)												
2.4.1 Studying and describing technological processes within information systems (E-cards, RCHE, Department of Statistics' system and Agency of Statistics' system) in regards to newborn registration and demographic statistics	X	X										
2.4.2 Development of strategy for integration of information systems and coordinating the strategy with stakeholders		X	X									
2.4.3 A seminar for representatives of the national level on modern approaches to development and functioning of Integrated Health Information Systems				X								
Objective 3. Over the next three years strengthen capacity and tools to plan costs and budget for the immunization program												
Activity 3.1 Identify and select core working group to develop guidelines and tools on planning, costing and budgeting												
3.1.1 Identify members and establish working group	X											
3.1.2 Conduct assessment of planning, costing and budgeting tools currently used within the health system		X										
3.1.3 Review the organization and information availability among the agencies involved in the implementation of the immunization program		X										
3.1.4 Develop guidelines on immunization program management, including tools on planning, costing and budgeting			X	X								
Activity 3.2 Carry out workshop on planning, costing and budgeting												
3.2.1 Select and recruit key participants				X								
3.2.2 Undertake workshop on planning, costing and budgeting					X				X			

Section 6: Monitoring, Evaluation and Operational Research

As has been outlined above the validity of statistical information is one of the health system bottlenecks this proposals aims to contribute to reducing. We therefore highlight that baseline data on impact indicators is presented with caveats on reliability.

Within the project, efforts are made to also include output indicators on the proposed actions assuming that the actions will contribute to a change in outcome and impact indicator values over time.

The selection of indicators for project monitoring and evaluation and the identification of their baseline value were made under data validity constraints related to most statistical data. These can be to some extent explained by yet incomplete implementation of international standards and definitions. The proposed activities for GAVI HSS funding and ongoing efforts to strengthening the health information system described further above include a variety of activities aimed at improving the accuracy of data for improved management and monitoring of service provision.

Based on official information, Azerbaijan has already achieved very high results on most of impact indicators while alternative sources of information (surveys) do not always confirm these levels. For example, according to official statistical data, perinatal mortality in Azerbaijan during the last five years was 9-11 cases per 1000 newborns. This compares low to regional and international averages and there are few alternative data sources and systems of medical data analysis available to verify the accuracy of this data. Also, according to official statistics, infant mortality is around 10.1 per 1000 newborns (2006). Meanwhile, according to the health household survey conducted by UNICEF and USAID (2002-2006), infant mortality was 43 per 1000 life births[6].

A similar situation is observed in the area of immunization coverage. The coverage rate was 95% in 2007 based on official reports. According to the DHS Survey (2006), the majority of children, about 80 percent, have received vaccinations for BCG and the first doses of DPT and polio while incomplete vaccination was frequent among the surveyed population. For example, 80 percent of children received the first dose of DPT compared with 66 percent who received the third.

Consequently, the "baseline' and 'target' values for some indicators are the same or similar for some indicators in the following table. This reflects the expectation that the value of these indicators will converge to more real levels during the reporting period given all ongoing and planned efforts targeted at adopting the WHO live birth definition and improved completeness of reporting. Hence, maintaining the currently reported level of achievement despite these changes is considered a target as such.

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	State Statistical Committee of the Azerbaijan Republic	95	STATISTICAL YEARBOOK OF AZERBAIJAN	2007	95	2011
2. Number / % of districts achieving ≥80% DTP3 coverage	State Statistical Committee of the Azerbaijan Republic	64	STATISTICAL YEARBOOK OF AZERBAIJAN	2007	65	2010
3. Under five mortality rate (per 1000)	AzDHS	50	AzDHS	2007	40	2010
4. Maternal mortality rate (per 100 000 births)	State Statistical Committee of the Azerbaijan Republic	35.5	STATISTICAL YEARBOOK OF AZERBAIJAN	2007	25	2011

[6] National strategy for the protection of reproductive health of the population of the Azerbaijan Republic 2008-2015

6.2: Output Indicators

Objective	Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
Objective 1. Over the next three years improve the capacity of eight training institutes, 42 educators and 640 mid-level health workers through a strengthened postgraduate education system	1) % of mid level workers successfully completed the training program and actively working in PHC	Number of midlevel workers who complete the new program	Total number of PHC mid level workers eligible to attend courses for retraining within 5 years.	Cochrane and Crilly HS report 2008	0*	Nursing Schools' records	2007	10%**	2010
Objective 2. Over the next three years strengthen the health information system for better monitoring of child and maternal health services	2) % of pregnant women registered within the first 12 weeks of pregnancy	Annual number of women registered within the first 12 weeks of pregnancy	Annual number of registered pregnant women	MOH	To be determined when the registry fully functioning	Register of Pregnant Women	2011	To be determined end of 2011 when registry fully functioning	2012
	3) % of children provided with paper immunization passports at their birth relative to the number of children for which personalized data on immunization is available through E-health card	Annual number of newborns provided with the passports	Annual number of newborns registered in E-health card system	MOH	0	E-card system	2007	80	2010

	4) % of forms with correctly used contemporary coding (ICD 10, etc.)	Number of correctly coded entries in the database	Total number of entries in the database	MOH	50%	Database of treated cases	2007	90%	2010
	5) Discrepancy between the number of newborns provided by the Committee of Statistics and MOH (%)	Annual number of newborns according to MOH data	Annual number of newborns according to the SSC	MOH SSC	14%	DHIS SSC	2007	<3%	2010
Objective 3. Over the next three years strengthen capacity and tools to plan costs and budget for the immunization program	6) % of managers trained on planning and budgeting	Number of managers from immunization program who complete trainings	Number of national level managers from immunization program involved in planning and budgeting	MOH, RCHE	0	MOH	2007	100%	2009

* 4% of middle level medical workers of 5 pilot districts
** 10% of middle level medical workers of whole Republic

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%) 2. Number / % of districts achieving ≥80% DTP3 coverage	Through existing monthly routine reporting system. No additional measures needed to collect required data.	The data will be analyzed quarterly at the national level	The results of the analysis will be used to identify the major problems that hinder improvement of these indicators, and develop specific measures to improve the situation. The results of this work will be regularly conveyed to the district level to ensure feedback to local providers. The analyzed data will be presented at semi annual HSCC meetings and recommendations of HSCC will be forwarded to MoH to take/implement necessary actions. Annual progress reports will present the analyzed data and recommendations to share the implementation progress with all stakeholders.
3. Under five mortality rate (per 1000)	Mortality data is collected through DHS surveys conducted every 5 year. Next one is scheduled for the year 2010 and will be funded by international partners.	The surveys provide only mortality data at the national level. They give overall information on the impact of interventions targeting reduction of child mortality. Therefore, no specific data analysis is planned on mortality reduction before the year 2010.	Mortality data that will be obtained from the year 2010 survey will be used in final evaluation (completion report) of HSS Plan implementation at national level.
4. Maternal mortality rate (per 1000)	Data source – statistical data of the State Statistics Committee and DHIS	Analysis will be performed by the MOH Mother and Child Health	The data will be used to evaluate effectiveness of the National

		Department	Reproductive Health Strategy, as well as the components of this project and for the development of specific measures to improve the situation.
Output			
1. % of mid level workers successfully completed the training program and actively working in PHC	Baku Nursing School will retain a list of all those who complete the course and monitor their working position following the course completion. Supervisors will have the opportunity to observe students in practice and so confirm the location of their work. MoH currently hold all the information on location of PHC staff and those who have completed the necessary 5 year refresher course requirement. These records will continue.	Records will be maintained by the MoH Baku Nursing School 2 will return data to HR department in MoH where the information will be analysed and stored according to current monitoring systems.	Data will be used to monitor progress towards retraining of all PHC staff and can be used to plan for future training programs as they are implemented avoiding replication.
2. % of pregnant women registered within first 12 weeks of pregnancy	Data will be received by PH&RC through analysis of the information contained in the Register	The analysis will be performed by the Institute of Obstetrics and Gynecology with subsequent submission of materials to the MOH for decision making	The analysis will help to identify the districts with low coverage of pregnant women, and as a result, to develop measures to increase awareness among women
3. % of children provided with paper immunization passports at their birth relative to the number of children for which personalized data on immunization is available through E-health card	Data will be received from the E-card system	On a monthly basis at the national level	The data will be used to evaluate the efficiency of immunization passports by district
4. % of forms with correctly used contemporary coding (ICD 10, etc.)	Data will be received from DHIS	Analysis will be carried out on a monthly basis by DHIS	The analysis will help to identify the districts that don't pay adequate attention to the use of the data and to develop measures to improve the situation

5. Discrepancy between the number of newborns provided by the Committee of Statistics and MOH	DHIS SSC	The analysis will be carried out on an annual basis at the national level	Based on the results of the analysis joint activities will be planned to ensure birth rate data accuracy
6. % of managers trained on planning and budgeting	GEM	After each training workshop	Based on the results, further trainings for national level managers from immunization program involved in planning and budgeting can be scheduled

6.4: Strengthening M&E system

While developing the project, a special effort was made to minimize introduction of new forms of statistical reporting. The majority of data for the project will be collected through the existing forms and information systems without additional inquiries to providers. Still, various workshops and seminars will be provided on both national and local levels in order to strengthen analytical capacity of the Ministry of Health and its subordinate divisions.

Monitoring and evaluation of educational program for both trainers and trainees will be strengthened through improving capacities of teaching staff and students. Questionnaires for students and evaluation of student performance in both theory and practice will be introduced. This evaluation by students can be introduced as a long term process for all courses in the Nursing School and be incorporated as part of the monitoring system. All reports will be returned to the HR department MoH for collation and, further, decision-making.

It is proposed to strengthen technical capacity and human resources of the Public Health and Reforms Center as this institution will be responsible for overall monitoring of the project, data collection, and coordination of stakeholders activities.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	The Public Health and Reforms Center under the Ministry of Health is proposed to manage GAVI HSS implementation and M&E. Given the broad range of project components, the PHRC is the most appropriate institution to take this responsibility as it interacts with all structures involved into the project implementation. The Center coordinated and provided oversight to the application development process; it possesses the required capacity and thus can become an effective integrator of the project.

Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	The Intersectional Coordination Committee on International Projects (the HSCC country equivalent) will do the following: · monitor timely implementation of planned GAVI HSS activities and take high level policy decisions in order to assist in solving any issues that may arise during the implementation, · ensure coordination between GAVI HSS activities and non GAVI HSS activities in order to harmonize implementation of country wide HSS activities, · review and approve changes to the GAVI HSS POW and budget, · provide a mechanism for coordination of activities and dissemination of information on the process of implementation (progress achieved & remaining challenges) to all HSS related stakeholders.
Mechanism for coordinating GAVI HSS with other system activities and programs	Coordination between GAVI HSS Plan activities and other HSS programs and/or activities will be established through the ICCIP (the HSCC country equivalent). The functions of the ICCIP are not limited to GAVI HSS. ICCIP is established to coordinate all HSS related activities within the country. ICCIP will be convened at least twice a year to coordinate HSS activities among all HSS related stakeholders within the country.

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Sanan Kerimov/Deputy Minister of Health	Ministry of Health	Yes	o Chairman of ICCIP o Coordination and monitoring HSS project activities
Jeyhun Mammadov/Director	PHRC	Yes	o Leading of the HSS project implementation o Coordination of HSS project activities with MOH and other partners o Monitoring and evaluation of HSS project implementation
Viktor Gasimov/Head of Sanitary-Epidemiological Monitoring Department	Ministry of Health	Yes	o Coordination and monitoring HSS project activities with focus on immunization issues o Technical support and consultations
Elmira Aliyeva/Deputy Head of Health Services Department	Ministry of Health	Yes	o Coordination and monitoring HSS project activities with focus on maternal and child health o Follow-up decision-making on improvement of mother and child health
Kamran Garakhanov/Head of WHO Country Office	WHO Azerbaijan Country Office	Yes	o Coordination and monitoring HSS project activities o Technical support and consultations

Shafag Rahimova/PO Adolescent Development	UNICEF Azerbaijan Country Office	Yes	o Coordination and monitoring HSS project activities o Technical support and consultations on implementation of immunization passports and pregnant woman registry components of HSS project
Tara Milani/Health Programs Coordinator	USAID	Yes	o Coordination and monitoring USAID-funded and HSS projects o Technical support and consultations
Soltan Mammadov/Director	Vishnevskaya-Rastropovich Foundation, INGO	Yes	o Coordination and monitoring HSS project activities on immunization component o Technical support and consultations
Elvira Anadolu/Health Programs Coordinator	WB	Yes	o Coordination and monitoring activities of HSRP/WB and HSS projects o Technical support and consultations
Oktay Akhundov/Head of HIS Department	Ministry of Health	No	o Leading technical implementation of pregnant woman registry and decentralized data entry on district level
Jabrail Asad-zadeh/Deputy Director/E-health card Program Coordinator	PHRC	No	o Leading technical implementation of immunization passports component of HSS project
Rza Allahverdiyev/Head of Demography and Social Statistics Department	State Statistical Committee	No	o Coordination of activities between MOH and SSC on improvement of newborns registration system
Faiza Aliyeva/Director /Reproductive Health National Coordinator	Obstetrics and Gynaecology Research Institute	No	o Leading methodological implementation of pregnant woman registry o Monitoring and evaluation of input/outcome indicators of HSS project
Olga Zues/Chief of Party	Abt. Associates, INGO	No	o Coordination of activities between PHCS/USAID and HSS projects with focus on decentralized data entry component
Farkhad Mekhtiyev/Director	Project Implementation Unit, MOH	No	o Coordination of activities between PIU MOH/WB and HSS projects
Vusala Allahverdiyeva/ National Professional Officer VPD&Immunization	WHO	No	o Technical support and coordination of HSS project activities o Technical assistance and consultations on implementation of immunization passports
Kamala Mehtiyeva/Head of HR Department	Ministry of Health	No	o Ensuring that all the necessary processes are followed to grant approval for courses and confirm the extended role of the mid level workers o Granting certificates o Confirming that the course will count as part of the retraining program for staff even if it is conducted earlier than the required 5 years
Dilara Mammadaliyeva /Director	Baku Base Nursing School #2	No	o Leading (chair) the working group who will prepare the curricula, materials and tools o Overseeing the introduction of the new curricula in all eight schools o Ensuring monitoring and quality processes

			are carried out and data collected and reported
Niyazi Ibrahimov/Director	Ganja Nursing School		o Participation in the working group that will prepare the curricula, materials and tools o Overseeing the introduction of the new curricula in Ganja nursing school
Elmira Haciyeva/Director	Sheki Nursing School	No	o Participation in the working group that will prepare the curricula, materials and tools o Overseeing the introduction of the new curricula in Sheki nursing school
Igbal Amerullayev/Director	Lenkaran Nursing School	No	o Overseeing the introduction of the new curricula in Lenkaran nursing school
4 Pedagogy methodologist's from the Nursing Schools	Nursing Schools	No	o Membership of the working group, four methodologist to be selected, one from each school participating during the first year of the project. They will be expected to contribute to the development of the curriculum, learning materials, monitoring and supervision tools and best practice statements.
Teachers undergoing the training program	Nursing Schools	No	o The first cohort of teachers to undergo the training will be expected to not only teach on the trainees course but also to teach further trainer courses

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channeling GAVI HSS funds into the country	GAVI HSS funds will be channeled into the country through MOH's official account
Mechanism for channeling GAVI HSS funds from central level to the periphery	GAVI HSS funds from central level to the periphery will be channeled through the subcontracted implementing agency for a given activity, such as a technical unit of the MoH or an in-country partner or an NGO
Mechanism (and responsibility) for budget use and approval	ICCIP will approve budget for the main activities semiannually/PHRC will be responsible for budget use
Mechanism for disbursement of GAVI HSS funds	MOH disbursement procedures will be applied
Auditing procedures	Auditing procedures applied to MOH will be applicable for the GAVI HSS funds

7.4: Procurement mechanisms

MOH procurement mechanisms will be applied. Procurement procedures of other international partner organizations will be applied if they will be subcontractors and/or direct recipient of GAVI HSS funds for procurement of goods.

7.5: Reporting arrangements

The major reporting arrangement will be submission of annual progress reports (APR) to the GAVI Secretariat by the Public Health and Reforms Center under the MOH, these will be shared with all relevant stakeholders. The MoH will be responsible for compiling and ensuring the quality of the APR, based on relevant inputs provided by project implementing agencies. Prepared APRs will be

reviewed by ICCIP (the HSCC country equivalent) and finalized according to ICCIP evaluation and comments.
ICCIP evaluation, comments, recommendations and decisions will serve as a reporting mechanism for HSS-related stakeholders, through the distribution of ICCIP minutes of meetings which will take place twice a year.
Besides the above arrangements, quarterly feedback will be issued by implementing units, based on received reports. These feedback reports will be open to all interested stakeholders.

7.6: Technical assistance requirements

Activities requiring technical assistance		Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
Activity 1.1 Identify and select core working group to develop trainers curriculum, supporting materials and tools	Preparation of nursing curriculum for Trainers including criteria for entry and assessment	6 weeks	Yr 1 Q 1 & 2	International consultant
	Preparation of nursing curriculum for Trainees including criteria for entry and assessment	6 weeks	Yr 1 Q 2 & 3	International consultant
	Identification of competencies and preparation of practice and supervision tool	6 weeks	Yr 1 Q 2	International consultant
	Preparation of quality assurance tools	3 weeks	Yr 1 Q 2	International consultant
	Preparation of student evaluation tool for both courses	2 weeks	Yr 1 Q 1 & 2	International consultant
	Preparation of planning schedule and timetabling	1 week	Yr 1 Q 1 & 2	Local partner
Activity 1.2 Carry out training program for trainers	Conducting first Trainers course	3/12	Yr 1 Q 3	International consultant
Activity 1.4 Equip seven Nursing Schools with essential requirements for teaching the program	Identification and procurement of key learning materials	6 weeks	Yr 1 Q 1 & 2 Yr 2 Q 1	Local partner
	Identification and procurement of technology for e-granary system	6 weeks	Yr 1 Q 1 & 2 Yr 2 Q 1 & 2	Local partner
	Identification, procurement of equipment list for simulation lab	6 weeks	Yr 1 Q 3	Local partner
	Installation of learning clinical lab	16 weeks	Yr 1 Q 2	Local partner

	Installation of technology for e-learning	8 weeks	Yr 1 Q 2	Local partner
Activity 2.1 Develop mechanism for the provision of immunization passports	Development of Immunization Passport Concept	1 month	Yr 1 Q 1	WHO, UNICEF GAVI
	Development of the TOR for information sub-system, including reporting forms and document flow model	2 month	Yr 1, Q 2	UNICEF, GAVI
	Software development in accordance with the TOR	6 month	Yr 1, Q 3 & 4	E-card
Activity 2.2 Modernization of registration of pregnant women to ensure continuity of care for mother and child	Development of a concept for the "Register of Pregnant Women'.	1 month	Yr 1, Q 1	Partners from the countries, where the similar registers have been introduced (Kyrgyzstan Kazakhstan, Russia) with involvement of UNICEF
	Development of TOR for the software that ensures the register functioning at the primary care level and its synchronization with the newborn registration information system (Form 103)	2 month	Yr 1, Q 2	Partners from the countries, where the similar registers have been introduced (Kyrgyzstan Kazakhstan, , Russia)
	Development of software and a system of data transfer from the district level to the national level	6 month	Yr 1, Q 3 & 4	E-card Project
	Conducting a training seminar with health professionals from obstetric and gynecological services and primary care facilities of the pilot districts and Training for representatives from the national level on the use of the Register for the purposes of monitoring, evaluation and making managerial decisions	2 X 1 week	Yr 1, Q 4 Yr 2, Q 3	International Expert
	Workshop to analyze the results of the project implementation in pilot districts (for representatives from other districts; 1	1 week	Yr 2, Q 3	International Expert

	person from each district)			
Activity 2.4 Develop a strategy of integrating separate information sub-systems into a single information system (e-card, RCHE, health statistics and statistics agency)	Studying and describing technological processes within information systems (E-cards, GEM, Department of Statistics' system and Agency of Statistics' system) in regards to newborn registration and demographic statistics Development of strategy for integration of information systems and coordinating the strategy with stakeholders A seminar for representatives of the national level on modern approaches to development and functioning of Integrated Health Information Systems	6 month	Yr 1, Q 1- 4 Yr 2, Q 1	International Expert
Activity 3.1 Identify and select core working group to develop SOP and tool on planning, costing and budgeting	Develop SOP on immunization program management and tool on planning and budgeting	2 weeks	Yr 1, Q 2 & 3	International expert
Activity 3.2 Carry out workshop on planning, costing and budgeting	Undertake the first workshop on planning, costing and budgeting	1 week	Yr 2, Q 1	International expert

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities

Area for support	*Cost per year in US$ (,000)*			
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	TOTAL COSTS
	2009	2010	2011	
Activity costs	***$581,790***	***$394,765***	***$205,620***	***$1,182,175***
***Objective 1.* Over the next 3 years improve the capacity of eight training institutes, 42 educators and 640 mid-level health workers through a strengthened postgraduate education system**	***$227,717***	***$204,861***	***$41,350***	***$473,928***
Activity 1.1 Identify and select core working group to develop trainers curriculum, supporting materials and tools	$44,687	$11,426	$10,307	$66,420
Activity 1.2 Carry out training program for 42 Trainers	$103,030	$110,683	$18,965	$230,678
Activity 1.3 Carry out training program for 640 mid level workers	$00,00	$6,752	$8,078	$14,830
Activity 1.4 Equip seven Nursing Schools with essential requirements for teaching the program	$80,000	$78,000	$4,000	$162,000
***Objective 2.* Over the next 3 years strengthen the health information system for better monitoring of child and maternal health services**	***$277,523***	***$146,341***	***$117,672***	***$541,536***
Activity 2.1 Developing mechanism for the supply of immunization cards	$69,803	$28693	$28,999	$127,495
Activity 2.2 Modernization of registration of pregnant women to ensure continuity of care for mother and child	$167,820	$77,837	$15,743	$261,400
Activity 2.3 Strengthen decentralized data entry system for the district level (forms no 103, 106 and 66)	$27,767	$39,811	$72,930	$140,508
Activity 2.4 Develop an integration strategy, based on existing system and plans (e-health card, RHEC, health statistics, and SSC)	$12,133	$00,00	$00,00	$12,133
***Objective 3.* Over the next three years strengthen capacity and tools to plan costs and budget for immunization programs**	***$20,000***	***$7,500***	***$7,500***	***$35,000***
Activity 3.1 Identify and select core working group to develop teaching pack for workshop on planning, costing and budgeting	$18,000	$00,00	$00,00	$18,000
Activity 3.1.2 Conduct assessment of planning, costing and budgeting tools currently used within the health system	$2,000	$00,00	$00,00	$2,000

Activity 3.1.3 Review the organization and information availability among the agencies involved in the implementation of immunization program	$00,00	$00,00	$00,00	$00,00
Activity 3.2 Carry out workshop on planning, costing and budgeting	$00,00	$7,500	$7,500	$15,000
Support costs				
Management costs	$43,550	$26,063	$26,098	$95,711
M&E support costs	$7,000	$6,000	$7,000	$20,000
Technical support	$6,000	$4,000	$6,000	$16,000
TOTAL COSTS	***$581,790***	***$394,765***	***$205,620***	***$1,182,175***

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation (GNI > $365 per capita)	**Allocation per year (US$)**				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2008	2009	2010	2011	
Birth cohort	150,207	153,300	157,450	162,120	
Allocation per newborn		$2.5	$2.5	$2.5	
Annual allocation		$383,250	$393,625	$405,300	**$1,182,175**

Source and date of GNI and birth cohort information:

GNI: World Bank

Birth cohort: State Statistical Committee of Azerbaijan Republic

8.3: Sources of all expected funding for health systems strengthening activities

Funding Sources	**Allocation per year (US$)**			
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2009	2010	2011	
GAVI	**$581,790**	**$394,765**	**$205,620**	**$1,182,175**
Government	**$00,00**	**$90,300**	**$90,300**	**$180,600**
Donor 1.				
Total Other				
TOTAL FUNDING				**$1,362,775**

Source of information on funding sources:	
GAVI:	See Section 8.2 on GAVI HSS country allocation as per guidelines
Government:	Financial planning of Public Health and Reforms Center, MOH
Donor 1:	.....
Total other:	.....

Section 9: Endorsement of the Application

9.1: Government endorsement

The Government of Azerbaijan commits itself to providing immunization and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:

Name: Abbas Valibayov

Title / Post: Deputy Minister

Signature:

Date: 05.09.2008

Ministry of Finance:

Name:

Title / Post:

Signature:

Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on July 25, 2008.The signed minutes are attached as Annex 1.

Chair of HSCC (or equivalent):

Name:
Sanan Kerimov

Signature:

Post / Organization:
Deputy Minister of Health/MOH

Date: 04.09.2008.

9.3: Person to contact in case of enquiries:

Name: Jeyhun Mammadov

Title: Director of PHRC

Tel No: 0099412-430-5267

Address: 96 Zardabi Avenue, Baku, AZ1122

Fax No. 0099412-430-5285

Email: jeyhun.mammadov@isim.az

ANNEX 1. Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan (or equivalent)	Yes		
cMYP	Yes		
MTEF	Yes		
PRSP	Yes		
Recent Health Sector Assessment documents	Yes		
WG meeting minutes, signed by Chair of WG	Yes		
HSCC minutes, signed by Chair of HSCC	Yes		