Document of
The World Bank

Report No: ICR00002977

IMPLEMENTATION COMPLETION AND RESULT REPORT
(IDA-4210-AZ)

ON A

CREDIT

IN THE AMOUNT OF SDR 34.3 MILLION
(US$50 MILLION EQUIVALENT)

TO THE

REPUBLIC OF AZERBAIJAN

FOR A

HEALTH SECTOR REFORM PROJECT

June 3, 2014

Human Development Sector Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective June 2014)
Currency Unit = New Azerbaijanian Manat (AZN)

AZN 0.7833 = US$1
US$1.55 = SDR 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing	MMR	Maternal Mortality Ratio
AIDS	Acquired Immunodeficiency Syndrome	MOED	Ministry of Economic Development
ALOS	Average Length of Stay	MOH	Ministry of Health
BBP	Basic Benefit Package	MOF	Ministry of Finance
CD	Communicable Disease	MS	Moderately Satisfactory
CPS	Country Partnership Strategy	MTR	Mid Term Review
ECA	Europe and Central Asia	MU	Moderately Unsatisfactory
EMP	Environmental Management Plan	NCD	Non-Communicable Disease
EU	European Union	NPV	Net Present Value
FM	Family Medicine	OOP	Out of packet payment
FSU	Former Soviet Union	PAD	Project Appraisal Document
GDP	Gross Domestic Product	PDO	Project Development Objective
GoA	Government of Azerbaijan	PHC	Primary Health Care
HBS	Household Budget Survey	PHRD	Policy and Human Resources Development Fund
HIV	Human Immunodeficiency Virus	PIU	Project Implementation Unit
HMIS	Health Management Information System	PRSC	Poverty Reduction and Support Credit
HR	Human Resources	S	Satisfactory
HSR	Health Sector Review	San-Epid	Sanitary Epidemiological Network
HSRP	Health Sector Reform Project	SDR	Special Drawing Rights
HPPU	Health Policy and Planning Unit	SPPRED	State Program for Poverty Reduction and Economic Development
HR LIL	Health Reform Learning and Innovation Loan	STI	Sexually Transmitted Infections
ICR	Implementation Completion and Results Report	TA	Technical Assistance
IDA	International Development Association	TL	Team Leader
IMR	Infant Mortality Rate	TOR	Terms of Reference
MCH	Maternal and Child Health	UNICEF	United Nations Children's Fund
MDG	Millennium Development Goals	USAID	United States Agency for International Development
M&E	Monitoring and Evaluation	WHO	World Health Organization

Vice President:	Laura Tuck
Country Director:	Henry G. Kerali
Sector Manager:	Daniel Dulitzky
Project/ICR Team Leader:	Claudia Rokx
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AZERBAIJAN
Health Sector Reform Project

CONTENTS

MAP IBRD 33365

A. Basic Information			
Country:	Azerbaijan	Project Name:	Health Sector Reform Project
Project ID:	P094220	L/C/TF Number(s):	IDA - 4210-AZ
ICR Date:	06/03/2014	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	GOVERNMENT OF AZERBAIJAN
Original Total Commitment:	XDR 34.3 MILLION	Disbursed Amount:	XDR 33.23 MILLION
Revised Amount:	XDR 34.3 MILLION		
Environmental Category: B			
Implementing Agencies: Ministry of Health			
Cofinanciers and Other External Partners: USAID, UNICEF, WHO			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	07/07/2005	Effectiveness:	12/20/2006	12/20/2006
Appraisal:	04/19/2006	Restructuring(s):		10/23/2012 06/29/2013
Approval:	06/29/2006	Mid-term Review:	10/19/2009	04/12/2010
		Closing:	12/31/2012	12/31/2013

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	**Moderately Unsatisfactory**
Risk to Development Outcome:	**Moderate**
Bank Performance:	**Moderately Satisfactory**
Borrower Performance:	**Moderately Satisfactory**

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	02/17/2016
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	**Moderately Unsatisfactory**		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Health	100	100
Theme Code (as % of total Bank financing)		
Health System Performance	100	100
Other Human Development		

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Laura Tuck	Shigeo Katsu
Country Director:	Henry G. Kerali	Donna Dowsett-Coirolo
Sector Manager:	Daniel Dulitzky	Armin H. Fidler
Project Team Leader:	Claudia Rokx	Enis Baris
ICR Team Leader:	Claudia Rokx	
ICR Primary Author:	Betty Hanan	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)

The objective of the Project was to improve overall health system stewardship and financing, and enhance equitable access to, and technical and perceived quality of essential healthcare services, in the selected districts in a fiscally responsible and sustainable manner with a view to improving health outcomes.

Revised Project Development Objectives (as approved by original approving authority)

The PDOs were not revised.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1:	**Public expenditures on health gradually increased to a sustainable level that would ensure full coverage of the population with the basic package of services (BBP)**			
Value quantitative or Qualitative)	In 2005, public health expenditures amounted to 162 million mantas or 1.9% of non-oil GDP.	Public health expenditures increased.		Public health expenditures increased from 162 million manats in 2005 to 609.4 million manats in 2012 or 2.3% of non-oil GDP.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The rising health budget has taken place in a context of a rapidly growing economy. According to the health chapter of Azerbaijan 2020, health public expenditures are expected to reach 2.89% of GDP and 9.5% of the State consolidated budget by 2015.			
Indicator 2:	**A White Paper on health is adopted**			
Value quantitative or Qualitative)	Non existent	White Paper adopted.		White Paper was adopted in 2008.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED**. White Paper was prepared with support from the World Health Organization (WHO).			
Indicator 3:	**A long-term health sector investment plan is prepared as a result of a nation-wide mapping of facilities and the subsequent rationalization plan**			
Value quantitative or Qualitative)	Non existent	A long-term health sector investment plan prepared as a result of a nation-wide mapping of facilities under the master plan.		Long-term sector investment plan was prepared and approved.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**OVER ACHIEVED.** The implementation of the master plan started in the five Project districts (Absheron, Agdash, Gakh, Ismayili and Sheki). Its methodology was adopted for the rest of the country. As a result of the optimization process, the number of PHC facilities increased by 31% and the number of hospital beds decreased by 48%. By 2010, optimization had been realized in 65 districts with a reduction of secondary			

	facilities from 444 to 214 and an increase of PHC facilities from 543 to 782.			
Indicator 4:	**Household out-of-pocket (OOP) expenditures for health as a proportion of total health expenditures decreased as a result of free access to essential package of health care services**			
Value quantitative or Qualitative)	N/A	OOP expenditures as a proportion of total health expenditures decreased, but probably not enough to make a significant impact in household expenditures.		Total health spending (~6% of GDP) is close to regional average, but the public share is far lower than comparators. As a result, there is a high reliance on private out-of-pocket payments.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**NOT ACHIEVED**. Health financing reform has stalled.			
Indicator 5:	**Proportion of sick people seeking healthcare increased**			
Value quantitative or Qualitative)	% of people with acute conditions seeking health care: 28.9% and 23.8% in pilot and control districts, respectively (36.2% and 28.4% regular care for chronic conditions)	Proportion of sick people seeking healthcare increased.		According to the M&E of the national master plan implementation results, there has been an increase in out-patient care seeking behavior from 4 in 2006 to 4.3 patient visits to PHC per capita in 2010.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED**. Although no survey has been undertaken, information/data collected and analyzed for the M&E of the national master plan confirms an increase.			
Indicator 6:	**Satisfaction of the community with overall access to care increased**			
Value quantitative or Qualitative)	Mean value 3.6 on a scale from one to five, five being the highest (3.7 in the control districts)	Satisfaction increased.		20% increase in mean value
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED**. Based on infrastructure, equipment, and training provided to physicians and nurses in the pilot regions and data gathered for the LSMS, satisfaction of the community with access to care has increased.			
Indicator 7:	**Perceived quality of care of the services covered by the BBP by the community increased**			
Value quantitative or Qualitative)	N/A	BBP developed and introduced.		BBP was developed but not introduced.

Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**NOT ACHIEVED.** The BBP was developed, but not adopted as health financing reforms have stalled.			
Indicator 8:	**Budget allocations to districts is made on the basis of demographic and morbidity criteria**			
Value quantitative or Qualitative)	N/A	Budget allocation to districts is made on the basis of demographic criteria as per the master plan.		Rules of health providers funding in mandatory health insurance (budget allocations) was prepared in 2010 on the basis of the master plan.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**PARTIALLY ACHIEVED.** The master plan included demographic indicators for the design of PHC services. The technical basis for piloting new financing mechanisms, including budget allocations has been determined, but not implemented as the financial reform has stalled.			
Indicator 9:	**Infant mortality rate. Under-five mortality rate. Maternal Mortality ratio. Underweight prevalence rate in children (<5y). Adult age and cause-specific mortality rates. Self-reported health status**			
Value quantitative or Qualitative)	IMR = 11.9 <5M = 16.2 MMR = 34.2 Life Expectancy 72.4	Indicators have improved.		Indicators have improved from 2006 to 2012: IMR = 11.0 <5M = 13.5 MMR = 15.3 Life Expectancy = 73.6
Date achieved	12/31/2006	12/31/2012	12/31/2013	12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Official and international data show that IMR, MMR, and <5 have decreased over the life span of the Project. Data in this indicator is from Government's statistics.			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1:	**Organization model for MOH adopted**			
Value (quantitative or Qualitative)	N/A	MOH organization model adopted.		Functional review resulted in some structural changes, which were adopted.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. %	**ACHIEVED.** MOH's functional and administrative structure was reviewed and changes made.			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement)				
Indicator 2:	**Health Policy and Planning Unit (HPPU) established**			
Value (quantitative or Qualitative)	N/A	HPPU established.		HPPU was established in 2009.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The HPPU was established with five staff. The Unit has played an important role in the certification of the health professionals' process.			
Indicator 3:	**Pharmaceutical policy adopted**			
Value (quantitative or Qualitative)	N/A	Pharmaceutical policy developed.		Several strategic reform policies for pharmaceuticals were prepared.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**PARTIALLY ACHIEVED.** The draft National Drug Policy, Essential Drug List and Drug Formulary were developed under the Project and are under review by MOH and expected to be adopted by mid-2014.			
Indicator 4:	**Set of criteria and standards for health facilities developed and adopted**			
Value (quantitative or Qualitative)	N/A	Criteria and standards for facilities were developed and adopted.		This was done as part of the Master Plan and approved in 2009.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Criteria and standards for health facilities were developed. In addition, standards were developed for equipment required in different types of health facilities.			
Indicator 5:	**Health Management Information System (HMIS) improved**			
Value (quantitative or Qualitative)	N/A	HMIS improved.		HMIS was developed and piloted at the hospital level.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED**. The IT staff have completed a number of system developments and have introduced successfully Form 66 (hospital patient discharge form), which allows government to monitor trends, compare efficiency and quality among facilities and districts. These modules are being rolled out nation-wide.			
Indicator 6:	**Mapping of health facilities completed nation-wide**			
Value (quantitative or Qualitative)	N/A	Mapping of facilities completed nation-wide.		Rationalization was implemented in 65 districts.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. %	**OVER ACHIEVED.** As a result of the optimization process, number of PHC facilities increased by 31% and the number of hospital beds decreased by 48%.			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement)				
Indicator 7:	**Proportion of PHC facilities with full staffing and equipment increased**			
Value (quantitative or Qualitative)	Proportion with full staffing is 68.8%, full equipment 0%	Proportion of PHC facilities with full staffing and equipment increased.		Each settlement is served by a number of PHC teams determined by population size. A PHC "kit" was procured and distributed among all PHCs in the Project.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** All PHC facilities in Project districts are staffed as per standards in the master plan. Essential medical equipment has been procured under the project and distributed to all PHC facilities in the pilot districts, not only the ones constructed under the Project.			
Indicator 8:	**Standard treatment protocols in the essential BBP developed**			
Value (quantitative or Qualitative)	N/A	Clinical guidelines/ protocols developed.		Around 50 clinical guidelines/ protocols were developed and are at different stages of approval.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Extensive training has been supported under the Project in the use of the protocols for over 260 health care professionals. The areas include: (i) neonatal care and resuscitation, (ii) antenatal care, and (iii) managing bleeding in labor.			
Indicator 9:	**Annual number of visits made to PHC increased**			
Value (quantitative or Qualitative)	Not base line available	Annual number of visits to PHC have increased.		Utilization of PHC in the Project districts has improved.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Utilization improved substantially in two pilot districts where the number of outpatient visits to PHC more than doubled (Agdash and Gakh). Since not all targeted regions show equal improvements further evaluation is needed to get better understanding of these results (data is from 2012 M&E of the master plan). See also PDO indicator 5.			
Indicator 10:	**Proportion of referrals from primary to secondary level of care decreased**			
Value (quantitative or Qualitative)	N/A	Proportion of referrals from primary to secondary level of care decreased.		Data not available.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments	**NOT ACHIEVED.** This data is not collected/analyzed as construction of a number of			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(incl. % achievement)	PHC facilities was completed only recently.			
Indicator 11:	**Scope, type and mix of services at primary and secondary level of care delineated**			
Value (quantitative or Qualitative)	N/A	Scope, type and mix of services at PHC and secondary level delineated.		Scope, type and mix of services at primary and secondary level of care were delineated.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** This was done as part of the draft BBP.			
Indicator 12:	**MOH capacity for disease surveillance and responsiveness improved**			
Value (quantitative or Qualitative)	N/A	Yes		National strategies for NCDs and CDs have been developed and approved.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** A National Strategy for Communicable Diseases (CD), including implementation of the international health regulations was developed as well as standard operating procures (SOP) to complement the laboratory manual on the 14 priority CDs. In addition, 15 SOPs were finalized before Project closing. Strengthened data collection and assessment of NCDs risk factors served as the basis for the preparation of a national strategy for the prevention and control of NCDs.			
Indicator 13:	**Health facilities rehabilitated and equipped according to master plan**			
Value (quantitative or Qualitative)	N/A	Health facilities constructed/ rehabilitated according to the master plan.		New hospitals and PHC facilities have been constructed and equipped in pilot districts in line with modern standards and according to the standards in the master plan.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The optimization of secondary level health care includes: (i) consolidation of beds and services for acute short-term medical care, (ii) flexible use of beds, (iii) strengthening of supporting diagnostic and treatment services, including labs, imaging departments, and operating rooms, (iv) emergency departments that are fully equipped, and (v) significant shift of treatment and care from inpatient care to outpatient departments.			
Indicator 14:	**Essential package is defined and costed**			
Value (quantitative or Qualitative)	N/A	Essential package (BBP) defined and costed.		BBP was defined, but not costed as delays with financing

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
				reforms have had repercussions.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**PARTIALLY ACHIEVED**. Delays in political decision regarding the health insurance reform led to delays in approving preliminary option on BBP, which was developed.			
Indicator 15:	**A White Paper on Mandatory Health Insurance (MHI) with various financing and coverage options developed**			
Value (quantitative or Qualitative)	N/A	A White Paper on the MHI with various financing and coverage options developed.		A concept policy on health financing reform and introduction of MHI was developed. It included a strategy of health financing, an action/operational plan, and a policy document regulating health purchasing.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The policy included the main goals for health financing reforms. The Concept and Action Plan were endorsed by the Cabinet of Ministers and the President in 2008. While the Action Plan was approved and the MHI was established by Presidential Decree, the MHI has not become operational.			
Indicator 16:	**Output-based budgeting for health facilities designed and piloted**			
Value (quantitative or Qualitative)	N/A	Out-put based budgeting for health facilities designed and piloted.		The operational plan for the MHI included a detailed roadmap of required institutional and legislative changes, piloting activities necessary for the introduction of MHI. Options were delineated in the documents regarding out-put budgeting for PHC. In addition, a new case-based hospital payment mechanism was developed (DRG), which is ready for piloting.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**PARTIALLY ACHIEVED.** In addition to documents mentioned above, the regulatory framework was also developed including: (i) sample contracts for providers, (ii) draft amendments to existing legislation with regard to the implementation of performance-based financing, and (iii) rules for the participation of private providers in MHI. Despite all this preparation work, the MHI was never established. Alternatives on its subordination were considered -- under the Cabinet of Ministers or the MOH, but this was never resolved.			
Indicator 17:	**Resource allocation formula developed and adopted for pilot districts**			
Value (quantitative or Qualitative)	N/A	Resource allocation formula developed and adopted.		Resource allocation formula was developed, but not adopted.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**PARTIALLY ACHIEVED.** This indicator was redundant as it was covered under indicators 14 and 16 (See comments under indicators 14 and 16).			
Indicator 18:	**A White Paper on long-term human resources development is produced and adopted**			
Value (quantitative or Qualitative)	N/A	A White Paper on long-term human resources development produced and adopted.		Health workers planning and human resource strategy was developed in 2008 and ratified by Ministerial Order No. 119 dated September 2008.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** MOH used recommendations of report for improving the distribution of human resources across the country.			
Indicator 19:	**PHC and hospital based physicians in project districts retrained**			
Value (quantitative or Qualitative)	N/A	PHC and hospital based physicians have received training.		PHC and hospital based physicians in Project districts have been retrained.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Training curriculum for family medicine was developed with technical assistance from Hacetepe University in Turkey and adopted at the AZ Advance Medical Training Institute. The curriculum covers internal medicine and surgical procedures, traumatology, obstetrics and gynecology, child diseases, infection disease, TB, ophthalmology, otolaryngology, and neurology. Ten physicians and 10 nurses received the training as trainees in Turkey. These trainers are providing training for family physicians and nurses in pilot and neighboring districts thereby ensuring compliance with the new skills requirements. In addition, the Project provided in-service trainings			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
	for physicians and nurses from pilot districts hospitals in and outside the country. The Medical University has also established a Residency Program.			
Indicator 20:	**Curricula for under graduate and post-graduate education of physicians, entrance and graduation criteria for medical degree and specialization are revised**			
Value (quantitative or Qualitative)	N/A	Curricula for under-graduate and post-graduate education, entrance and graduation criteria for medical degree and specialization revised.		Curricula for under-graduate and post-graduate education, entrance and graduation criteria for medical degree and specialization have been revised.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** A strategy for under-graduate medical education was developed and approved as well as a strategy for post-graduate training programs. The strategies are being implemented by the Medical University with MOH support.			
Indicator 21:	**Legal and regulatory framework for licensing, registration and certification of health professionals adopted**			
Value (quantitative or Qualitative)	N/A	Legal and regulatory frame work developed and adopted.		Legal and regulatory framework was adopted for the implementation of a certification (licensing) process.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**OVER-ACHIEVED.** All trained doctors must pass through the testing and certification process developed with support from the Project. The MOH has developed a human resource (HR) registration software to conduct registration, follow up and planning of certification process.			
Indicator 22:	**Standards for continuous medical education and re-certification developed and adopted**			
Value (quantitative or Qualitative)	N/A	Standards for continuous medical education and re-certification developed and adopted.		Standards include refreshing courses and re-certification of physicians every five years.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** 5,587 physicians and 2,321 nurses so far have participated in the certification process of which about 95% have been certified. See also comments under indicator 21.			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 23:	**Project implementation proceeds smoothly and in accordance with PIP**			
Value (quantitative or Qualitative)	N/A	Yes		Overall implementation proceeded smoothly.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Project implementation has been uneven, but overall it has proceeded smoothly. This relates to implementation of activities that do not require major policy reforms, such as health financing reforms, which have been jeopardized by the lack of decision-making, including the operationalization of the MHI.			
Indicator 24:	**M&E mechanism is set up and operational**			
Value (quantitative or Qualitative)	N/A	M&E mechanism set up.		An M&E framework was developed.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** Based on the M&E framework, two Health Sector Performance Assessment (HSPA) reports have been produced (2009 and 2011). The first report covers around 44 indicators while the second include also 13 dashboard indicators. With support from the Project, a Patient Discharge Form (Form 66) has been introduced successfully, which allows the government to monitor trends, compare efficiency and quality between facilities and districts.			
Indicator 25:	**Relevant staff trained in various aspects of project management**			
Value (quantitative or Qualitative)	N/A	Staff trained in various aspects of project management.		Several training courses have been undertaken.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The Project has financed a number of training seminars and workshops on project management, procurement, financial management and disbursements. In addition, all Project staff have participated in flagship courses in and outside the country.			
Indicator 26:	**Stakeholder communication and consultation system is in place**			
Value (quantitative or Qualitative)	N/A	Yes		See comments below.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The Project supported the establishment of a Public Relations Unit with five staff in MOH. The Project has supported a number of information activities and in the course of the development/review of the master plan conducted a number of workshops in pilot districts to improve understanding and gain the support of health authorities and other providers. In addition, the PIU has collaborated with various international organizations active in the sector in a number of workshops and training activities in various areas.			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Core Indicator:	**Health facilities constructed, renovated, and/or equipped (number)**			
Value (quantitative or Qualitative)	N/A	Partially completed		See comments.
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** 2 district hospitals, 4 village hospitals, 8 PHC facilities, and 1 maternity hospital were constructed and equipped. In addition, 2 training centers were refurbished.			
Core Indicator:	**Health personnel receiving training (number)**			
Value (quantitative or Qualitative)	N/A	Yes		7,276 health personnel
Date achieved	12/31/2006	12/31/2012		12/31/2013
Comments (incl. % achievement)	**ACHIEVED.** The Project supported training in a number of areas, including: (i) FM, (ii) health management, (iii) HIS, (iv) pharmaceutical policy and management, (v) improving MOH response capacity for emerging diseases, (vi) (vii) strengthening PHC, (viii) strengthening inpatient services, (ix) effective resource allocation in health, (x) project management, (xi) procurement, (xii) financial management. 7,276 health staff received training under the Project. This number excludes the number of staff who received training on project management, procurement and financial management.			

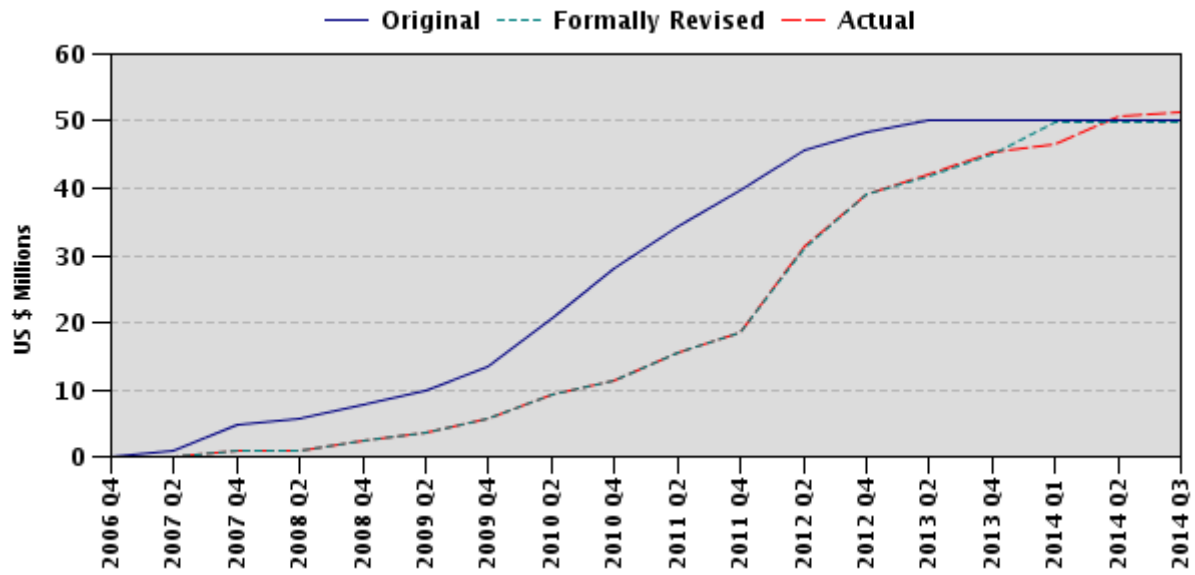
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	04/25/2007	Satisfactory	Satisfactory	1.00
2	10/15/2007	Satisfactory	Satisfactory	1.00
3	05/09/2008	Moderately Satisfactory	Moderately Satisfactory	1.89
4	10/13/2008	Moderately Satisfactory	Moderately Satisfactory	3.06
5	05/19/2009	Moderately Satisfactory	Moderately Satisfactory	5.32
6	07/31/2009	Moderately Satisfactory	Moderately Satisfactory	5.82
7	11/30/2009	Moderately Satisfactory	Moderately Satisfactory	6.65
8	05/10/2010	Satisfactory	Satisfactory	9.65
9	11/09/2010	Satisfactory	Satisfactory	13.76
10	07/05/2011	Satisfactory	Satisfactory	18.98
11	03/11/2012	Satisfactory	Satisfactory	32.06
12	11/06/2012	Moderately Satisfactory	Satisfactory	40.41
13	12/03/2012	Moderately Satisfactory	Satisfactory	42.00
14	06/18/2013	Moderately Unsatisfactory	Moderately Satisfactory	45.23
15	12/28/2013	Moderately Unsatisfactory	Moderately Satisfactory	50.70

H. Restructuring

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
10/23/2012	N	S	S	40.00	This Level II restructuring extended the closing date by 6 months from December 31, 2012 to June 30, 2013 to allow the completion of renovation of sanitary epidemiology centers, introduce information technologies, develop medical education, and train medical staff.
06/29/2013	N	MU	MS	45.23	This Level II restructuring extended the closing date by 6 months from June 30, 2013 to December 31, 2013 to correct civil works at village hospitals, finalize installation of waste water management facilities, and finalize completion of two PHC facilities.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1. ***The Health Sector Reform Project was approved on June 29, 2006. The Financing Agreement was signed on October 9, 2006 and it became effective on December 20, 2006.*** The Project was the second health-supported project by the International Development Association (IDA) for the country. The first project was the Health Reform Learning and Innovation Loan (HR LIL, 2001). In addition: (i) the Second Institution Building Technical Assistance Project (IBTA-2, 2002) financed a survey on household health expenditures, and (ii) the Poverty Reduction Support Credit Program (2005) complemented and supported the health sector reform agenda through its policy agenda, which included program budgeting, medium-term expenditure framework, and expenditure tracking in the health sector.

1.1 Context at Appraisal

2. ***The healthcare system in Azerbaijan remained largely unreformed and continued to function according to the old Soviet centralized norms both in terms of financing and allocation of human and physical resources.*** Some limited attempts were made to enhance the primary health care (PHC) level, but this had not gone beyond a few pilot initiatives spearheaded by the Bank and other development partners. The main issues with the system related to: (i) excessive but collapsing infrastructure; (ii) outdated or missing equipment; and (iii) inadequate mix and distribution of skilled and competent staff, particularly with regard to providing comprehensive and continuous care with an array of services. In theory, the country had a very high bed-to-population ratio (7.7 per 1,000 population), second only to the Russian Federation (9.5 beds) in the Former Soviet Union (FSU), and almost twice as the EU average of 4.1 beds. In practice, however, the real complement was much smaller. Yet, the average admission and occupancy rates were low, 4.7 and 25.6 percent, respectively. Meanwhile the average length of stay (ALOS) was high (15.3 days) by EU standards (EU average admission rate: 18.1 percent; occupancy rate: 77.9 percent and ALOS: 7.1 days).

3. ***Health status was poor and deteriorating,*** as evidenced by a dramatic six year decline in Life-Expectancy at birth, between 1990 and 2002, from an average of 70.9 to 65.1 years, one of the lowest in the region and 13 years lower than the EU average. This decline represented the highest downtrend in the world, excluding countries of Sub-Saharan Africa, which lost up to three times as many years due to HIV/AIDS. If this trend was to continue it was foreseen that Azerbaijan was unlikely to meet the health-related Millennium Development Goals (MDGs). Despite concerns with the reliability, validity and the limited comparability of pre- and post-independence administrative data, there was evidence that the main reasons behind this decline was high infant and under-five mortality rates (IMR: 81 and U5MRE:92 per 1,000 live births, both 16 times the EU average) and high maternal mortality ratio (MMR: 94/100,000 live births, ten times the EU average). The main causes of mortality and morbidity in infants and children were respiratory diseases and diarrhea while causes of maternal deaths were acute post-partum hemorrhage and post-abortion complications.

4. ***Azerbaijan had and still has the double burden of communicable and non-communicable diseases (NCDs).*** The decline in life expectancy related to the persisting high premature adult mortality, which accounted for 68 percent of all deaths compared with the

EU average of 51 percent. The main causes of morbidity and mortality included non communicable diseases (NCDs), accidents, injuries and poisoning as well as the re-emerging communicable diseases (CDs), including sexually transmitted infections (STIs), tuberculosis and HIV/AIDS which also posed a considerable threat to the health of the population.

5. ***Most determinants of health were and continue to be related to behavior, lifestyle and environment.*** Patterns of, and trends in, mortality and morbidity are entrenched in several determinants of health, which are responsible for the deteriorating health outcomes. Prevalent unhealthy lifestyle choices include tobacco use, alcohol abuse, a high-fat diet, lack of physical activity, a relatively low intake of fruits and vegetables, and drug addiction. The consequences include high blood pressure, high cholesterol, and diabetes, all of which contribute to high circulatory diseases morbidity accounting for 57 percent of adult mortality. Lifestyle determinants were compounded by socio-economic factors, including urban/rural and poor/rich disparities, as well as by environmental factors (inadequate water quality and sanitation). Survey data suggested that IMR and U5MR were three times higher in poor households and 50 percent higher in rural areas. The same was true for diarrhea incidence among children from poor households, with 60 percent more children suffering from diarrhea in rural than urban areas. This correlated with the fact that only 55 percent of the population in poor and rural areas had access to safe drinking water.

6. ***However, the lack of equitable access to appropriate and quality care was and still is an equally important determinant of poor health outcomes.*** The health care system has been persistently ineffective in delivering affordable, quality services equally accessible to all segments of the population. In fact, Azerbaijan was behind most post- transition countries not only in health status, but also in terms of the inadequacy of the health care system to meet needs and respond to epidemiologic and demographic challenges. For example, only half of the population utilized health services when experiencing illness, indicating that people either could not, or will not pay for what is often perceived as poor-quality healthcare. According to the 2002 Household Budget Survey (HBS), one in three households responded that they could not use health services because of their inability to pay.

7. ***The health system was and remains severely under-funded, and its resources were poorly pooled and inequitably allocated.*** Despite attempts to increase the health budget, public resources invested in health represented about 20 percent of total health expenditures, with the remaining 80 percent being out-of-pocket (OOP). With governmental health spending being roughly 1 percent of GDP for 2005 – as compared with an average of 4 percent for the countries of Europe and Central Asia (ECA) – and a mandate to provide practically all health care services for free, there was a general agreement that the health care system was in need of additional public funds, as well as a revision of the package of health care services funded by general tax revenues. In per capita terms, public expenditures on health were about US$20, or about six times less than the average for ECA (about US$130). This led to OOP expenditures of about US$96 per capita, quite a high figure in a country where about 30 percent of the population lived below the poverty line.

8. ***The governance structure of the sector was at odds with the macroeconomic and sectoral realities in the country.*** The Ministry of Health (MOH) was responsible for the

sector albeit with little clout over major policy decisions, which were the competence of the President, the Cabinet of Ministers and its advisory units. MOH's role and capacity to govern the system, make policies, set standards, regulate and control overall quality and gather the intelligence needed to monitor public health was limited. MOH did not have a unit tasked with policy-making, nor did it have departments for monitoring and evaluation (M&E), human resources or long-term planning. The system was plagued by the absence of an active purchaser of services, weak representation of providers and consumers, and fragmentation of health investment and budget decisions. MOH controlled only about 25 percent of public health expenditures, covering its central administration and the republic hospitals. The remaining of the public funds were the responsibility of the Ministry of Finance (MOF), responsible for allocating funds to district health facilities, and of the Ministry of Economic Development (MOED) in charge of budgeting for capital investment in the sector. As a result, the system suffered from the following shortcomings: (i) a legal, organization and regulatory platform that was not conducive to effective system stewardship; (ii) fragmented accountability for technical, administrative and financial matters leading to inefficient allocation of human and financial resources; (iii) excessive hospital and specialized care facilities, albeit mostly in a dire need for renovation, refurbishment and upgrading because of lack of capital investment and maintenance; (iv) poorly funded and managed, and highly fragmented, PHC services, obsolete diagnostic and laboratory equipment and shortage of supplies; (v) a de-motivated health workforce that relied on informal payments to cope with low wages and a practice environment devoid of incentives to provide appropriate care; and (vi) major inequalities in health and healthcare outcomes as a result of low public outlays, coupled with increasingly high levels of OOP payment.

1.2 Original Project Development Objectives (PDO) and Key Indicators

9. The objective of the Project was to improve overall health system stewardship and financing, and enhance equitable access to, and technical and perceived quality of essential health care services, in the selected districts in a fiscally responsible and sustainable manner with a view to improving health outcomes.

10. The wording of the PDO was the same in the main text of the Project Appraisal Document (PAD), Annex 3 of the PAD, the Financing Agreement, and the Minutes of Negotiations. The achievement of the PDO was to be measured by the following performance indicators corresponding to seven main areas supported by the Project.

- *Financial sustainability:*
    - Public expenditures on health gradually increased to a sustainable level that would ensure full coverage of the population with the basic package of services.
- *System governance*:
    - A white Paper for Health is adopted
    - A long-term health sector investment plan is prepared as a result of a nation-wide mapping of facilities and the subsequent rationalization plan.

- *Equity (*applicable to pilot districts only*):*
    - Household OOP expenditures for health as a proportion of total expenditures decreased as a result of free access to essential package of health care services.
- *Access (applicable to pilot districts only:*
    - Proportion of sick people seeking health care increased.
    - Satisfaction of the community with overall access to care increased.
- *Quality (applicable to pilot districts only:*
    - Perceived quality of care of the services covered by the Basic Benefit Package (BBP) by the community increased.
- *Efficiency (applicable to pilot districts only):*
    - Budget allocations to districts is made on the basis of demographic and morbidity criteria.
- *Health outcomes*[1] *(applicable to pilot districts only):*
    - Infant mortality rate
    - Under-five mortality rate
    - Maternal mortality rate (MMR)
    - Under-weight prevalence rate in children less than 5 years of age
    - Adult age and cause-specific mortality rates
    - Self-reported health status

1.3 Revised PDO

11. The PDO was not revised.

1.4 Main Beneficiaries

12. ***Direct beneficiaries of the project investments were to be the communities benefiting from the construction/refurbishments of hospitals/PHC facilities.*** Poor people were to benefit more from PHC interventions, including construction of PHC facilities, training of health staff, and equipment. Physicians, nurses, laboratory technicians, hospital managers, and the faculty of the Medical University are professional groups who were to benefit from the Project through training and retraining. Longer-term benefits were expected to the whole society from the implementation of the master plan. In addition, district and village hospitals, PHC facilities, and training centers to be constructed/refurbished by the Project were to benefit from investments. These facilities were to benefit from improved infrastructure, strengthened clinical capacity, improved regulatory environment, and institutional capacity for better governance and optimization. Also, MOH, local governments, the Drug Analytical and Expertise Center, the Innovation and Supply Center were to benefit from improved institutional and clinical capacities.

[1] It was recognized that it was unlikely to expect any significant reduction in MMR during the course of the Project, but these were to be monitored to establish trends and for future comparison with other districts.

1.5 Original Components

13. The Project supported the following five components:

14. **Component A – Building MOH Capacity for Stewardship** (US$8.13 million or 9 percent of total project costs) supported: (i) capacity building of MOH in policy making, planning and regulation; (ii) training of MOH staff; and (iii) upgrading MOH's technological and physical infrastructure. The component financed five sub-components to: (i) develop a health policy framework, and review and reorganize MOH functional and administrative structures, including establishing a Health Policy and Planning Unit (HPPU); (ii) develop a national drug policy and strengthen the capacity of MOH Pharmaceuticals and Medical Devices Unit to develop and monitor the effective management of this policy, develop the necessary legislative and regulatory framework, as well as procedures and tools for rational drug use; (iii) support the development of an accreditation and licensing scheme for public and private health facilities and set-up a mechanism for quality control and assurance of health care services; (iv) strengthen the health information system; and (v) improve MOH technical/information dissemination capacity for dealing effectively with emerging diseases.

15. **Component B – Improving Delivery of Health Care Services** (US$73.55 million or 85 percent of total project costs). The component supported four sub-components aiming to improve the appropriateness, quality and technical and allocative efficiency of health care services in five pilot districts -- Apsheron, Agdash, Ismaili, Sheki and Gakh by: (i) upgrading/renovating/constructing PHC facilities at the sub-district level and construction of three district hospitals in Agdash, Ismaili and Sheki; (ii) strengthening managerial and clinical skills of health care workers; (iii) introducing new planning and management methods and tools; and (iv) improving coordination and strengthening system hierarchy between the primary and secondary levels of health care. This involved an improved referral system within each district to reduce the number of referrals to Baku. The component was also to take stock of the pilot experience under the HR LIL Project and finance baseline, mid-term and final evaluations to assess the impact of investments under the component.

16. **Component C – Ensuring Sustainable Health Financing and Resource Allocation** (US$1.83 million or 2 percent of total project costs). It supported health financing reform to gradually introduce universal risk protection against OOP expenditures and move towards insurance principles through improved revenue mobilization, pooling and allocation of sector resources, and purchasing of services. It supported two sub-components: (i) strengthening planning, implementation and monitoring mechanisms for effective formulation of a health care financing policy; and (ii) establishment of a health fund to act as a single pool for health sector funds and a single payer/purchaser of health care services.

17. **Component D – Human Resources (HR) Development** (US$1.32 million or 2 percent of total project costs). It had two sub-components: (i) developing a labor adjustment policy, including provisions for a more dynamic retirement and compensation policy and a detailed strategy/plan for the sector; and (ii) reviewing reform initiatives for under-graduate medical education, specialty training and post-graduate training programs to improve the quality of education. Support was also provided to develop clinical guidelines/protocols,

improvements in the education programs, strengthening the medical faculty to develop new curriculum for under-graduate education and post-graduate training of physicians, nurses and other PHC staff. The component also supported the development of a certification program for medical personnel and the strengthening of Physicians' Associations in the country.

18. **Component E – Project Management, Monitoring and Evaluation** (US$1.93 million or 2 percent of total project costs). The component was to ensure effective administration and implementation of the Project by supporting the operations of a Project Implementation Unit (PIU) in the MOH responsible for day-to-day implementation, coordinating with relevant stakeholders and donors, procurement, financial management, disbursements, coordination of training activities, and monitoring and evaluation (M&E).

1.6 Revised Components

19. The components were not revised.

1.7 Other significant changes

20. ***There were two amendments to the Financing Agreement*** both related to the extension of the Closing date for a cumulative extension of 12 months.

- **The first amendment**, letter of October 23, 2012 extended the Closing Date by six months from December 31, 2012 to June 30, 2013. It allowed for: (i) completion of construction of two PHC facilities in Sheki and Gakh regions; (ii) completion of renovation of the premises of sanitary epidemiology centers; (iii) wider-scale introduction and application of information technologies; (iv) further development of medical education; and (v) additional training for medical staff.
- **The second amendment**, letter of June 29, 2013 extended the Closing Date by six months from June 30, 2013 to December 31, 2013. The extension was necessary to: (i) implement necessary corrections to village hospitals in the Sheki and Gakh districts, including ensuring proper ventilation, adding rails to stairways, and installing adequate heating systems, (ii) finalize the installation of waste water management facilities for the Sheki and Agdash hospitals; and (iii) finalize the completion of the two PHC facilities in Sheki and Gakh districts. The second extension required a Waiver to Bank Operational Procedures (OP) 10.00 from the Bank's Managing Director given that financing agreements are typically not extended when projects' development objectives are not deemed to be achievable.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

21. ***This evaluation rates Design and Quality at Entry as Moderately Satisfactory.*** This rating reflects the formulation of an overly ambitious and difficult to measure PDO, and of a complex Results Framework, which often lacked baseline figures, limiting the ability to

properly assess and attribute project outcomes. All other elements for preparation were Satisfactory, as discussed in the following paragraphs.

22. ***Soundness of background analysis.*** The background analysis conducted during preparation was Satisfactory. Preparation was supported by a Policy and Human Resource Development (PHRD) Grant of US$580,000 of which US$186,893 were cancelled. The Grant assisted GoA to develop design, including architectural blue prints for the hospitals, a GPS study to measure distances between facilities, and the Environmental Management Plan (EMP). Project design benefited from the findings of a Health Sector Review (HSR) conducted by the Bank (Report No. 31468-AZ of June 20, 2005). The HSR addressed the burden of ill-health, its distribution and trends, adequacy of the healthcare system in meeting the unmet needs and in responding to the epidemiologic and demographic challenges, and provided a set of options for reforming the system. It examined the issues affecting the sector and presented a set of options for reforming the system, ranging from changes in the margin to a full-blown systemic reform, albeit phased in sequentially. The HSR provided recommendations on the ways the sector should be organized, i.e. main functions, including: (i) stewardship; (ii) financing arrangements; (iii) organization and delivery structure; (iv) human resources; and (v) pharmaceuticals. The design also benefited from extensive analytical work on health financing and expenditures under the Bank-financed Institutional Building Technical Assistance Project and health financing papers produced by USAID.

23. ***Project design addressed several key lessons from the design and implementation of health project in the ECA region, as well as those derived from the HR LIL.*** Key lessons of the LIL were: (i) political commitment and ownership, a sine qua non for buy-in, collaboration and accountability for results, which excluded MOH from the direct implementation of PHC activities in the field; (ii) accurate sector diagnosis made possible through the commissioning of high quality studies on health financing, expenditures and pharmaceuticals; (iii) involvement of both providers and communities in the process of rationalization of facilities and staffing, which helped build consensus at the district level, although not implemented because of lack of MOH commitment and ownership; (iv) flexibility in view of the rapid political and economic transition during implementation such as foregoing the introduction of revolving drug funds which were no longer needed due to wide-spread availability of pharmaceuticals in the market; (v) value added of investment in PHC; and (vi) a built-in rigorous M&E scheme to measure Project accomplishments.

24. ***Quality Enhancement Review (QER).*** The QER of February 17, 2006 concluded that: (i) recent events (appointment of a new Minister of Health) provided a new window of opportunity for the Bank to become seriously engaged in the sector in a way that was not feasible in the past; (ii) poor health outcomes, especial IMR and MMR and the absence of reforms since independence made the health sector a priority for new investments; (iii) the Bank's experience in systemic reform in neighboring countries increased its potential value-added; (iv) the impressive progress in project preparation over the past two months suggested a level of high commitment and ownership; (v) the task team's clear sense of priorities and the analytical work underway suggested that it should be possible to deliver a project of acceptable technical quality before the end of the fiscal year (to enable the country to benefit from its final IDA allocation); and (vi) acknowledgement that a number of critical analyses

will not be completed by the proposed approval date – June 2006 – and that both MOH and the new established PIU lacked experience and capacity to manage an operation ten times the size of its predecessor. The QER recommendations were for the most part introduced in the design of the Project and addressed in the PAD.

25. ***Assessment of project design.*** The Project design was based on a highly consultative preparation process. The Bank team visited Azerbaijan frequently to engage a wide range of counterparts at the central and district level to ensure that the scope and content of the Project was well understood and accepted. The team engaged actively in discussions, including through policy seminars, with highest level of government, including the Prime Minister, Minister of Finance and Governor of the Central Bank. The consultative process included visits to selected districts and consultations during national and district level seminars with the participation of other development partners. In fact, WHO and USAID participated in Bank's missions and USAID financed the costs of workshops and seminars. Notwithstanding the strong elements of project design, the content of the Results Framework had some problems, discussed in more detail in Section 2.3.

26. ***A number of options were considered during preparation*****,** including: (i) more limited involvement (only capital investments and no policy reforms); (ii) a policy based operation or sector-wide approach; (iii) Adaptable Program Lending; and (iv) a more comprehensive investment with nation-wide coverage.

27. ***The objective of the Project was relevant and consistent with development priorities of both the Government and the Bank, but its formulation was overly complex and ambitious relative to the scale and scope of the project.*** Dealing with the key issues affecting the performance of the sector was central to the goals of the GoA and the Bank. The State Program on Poverty Reduction and Sustainable Development (SPPRED) developed prior to Project processing focused on the need to improve the quality of, and equity in access to health, central goal of the Project. Similarly, the FY03-05[2] Country Assistance Strategy (CAS, Report No. 25790-AZ) approved on April 29, 2003 underlined the importance of improving the quality, efficiency and coverage of health services. Reforming healthcare also featured prominently in the Country Partnership Strategy (CPS) approved in September 2006. The Project was approved earlier in the CPS preparation cycle than originally planned to take advantage of the new commitment given to healthcare reform by the GoA. At the same time, PDO achievement partly depended on the formulation and approval of specific policy reforms, such as the one on Health financing, which are normally beyond the scope and scale of an investment lending operation.

28. ***Risk Assessment.*** The PAD identified five risks, whose rating ranked from Modest to High. The fifth risk – potential lack of inter-ministerial coordination was rated Substantial and proved to be a strong constraint to moving forward with the reform agenda for health

[2] The Project was prepared during the time frame of the FY03-05 CAS, thereby its relevance in this paragraph.

financing, including lack of operationalization of the Health Insurance Agency. The mitigation measured identified for this risk proved to be unworkable.

2.2 Implementation

29. ***The ICR team rates implementation as Moderately Satisfactory.*** The Project was successful in delivering most of the outputs and achieving for the most part its expected outcomes (see details in Section 3.2, Annex 2, and the data sheet). Project implementation performance was mixed. Two components were implemented well such as Component A – Building MOH Capacity for Stewardship and Component D – Human Resources Development. Part of Component B, i.e. B.1 – Strengthening District and National Level Health System, and B.2 – Strengthening PHC Services were also implemented fairly successfully, with the exception of the number of PHC facilities constructed (8 instead of 30 planned) because of low cost estimates at project appraisal together with substantial cost inflation. While B.3 – Upgrading Impatient Care Services was well executed, it was not fully realized for the same reasons as for the PHC facilities (4 instead of 14 village hospitals and 2 instead of 3 district hospitals). Although, several important activities were completed under Component C -- Ensuring Sustainable Health Financing, the health financing reforms stalled pending political decisions regarding the placement of the Health Insurance Agency.

30. ***Project Management was rated Satisfactory (S) for most of its life span***, but was downgraded to Moderately Satisfactory (MS) when constraints were identified. The ratings fluctuated between S and MS for *Implementation Progress and Progress towards achieving of PDO* for most of the implementation period. The rating for PDO was downgraded to Moderately Unsatisfactory (MU) during the last six months of implementation as it was judged that the PDO could not be achieved. The rating was also linked to a decision by the Government not to proceed with the Additional Financing (AF) as had been agreed with the Bank, which would have provided an opportunity to restructure the Project's Results Framework among others. Similarly, Financial Management and Procurement were rated S for most of its implementation period while there were some periods when one or the other was rated MS.

Positive factors and events that influenced project achievements

31. ***The Project has helped to strengthen MOH's stewardship by***: (i) developing capacities to formulate and implement health policies; (ii) developing the Health Management Information System (HMIS); (iii) improving M&E capacity; (iv) strengthening pharmaceutical policy and management; (v) strengthening quality assurance and accreditation of health facilities; and (vi) improving response capacity for emerging diseases.

32. ***The Project has assisted in improving delivery and efficiency of health care services*** through the: (i) construction of health facilities in the participating regions following development of the master plan; (ii) development of investment plans for rehabilitation/construction and equipping of PHC and other health facilities; (iii) training and retraining of health staff; (iv) strengthening of the medical education system; and (v) strengthening of district management capacity through in-country training and study tours.

33. ***Hospital rationalization has been effective.*** The importance of the implementation of the master plan, especially the decision of GoA to implement rationalization plans nation-wide, cannot be under-estimated. In the international context of how difficult such reforms are, its successful implementation nation-wide becomes even more notable. By 2010 the plans had been implemented in 65 districts resulting in reduction from 444 to 214 secondary care facilities and increase from 543 to 782 PHC facilities.

Less effective factors and events which influenced Project's achievement

34. ***The Project has been less successful in supporting financial sustainability and equity.*** Despite a substantial increase in health public spending (from 168.9 million mantas in 2006 to 609.4 million mantas in 2012), by international comparisons it remains low. Total spending on health is about 6 percent of GDP, which is close to the regional average, but the public share is far lower than the comparators. As a result, there is a high reliance on OOPs[3].

35. ***Although the Project supported preparation of various policy documents covering the legislative framework in the context of the health financing reforms, the Health Financing Component has not been fully implemented.*** The policy documents included a paper on the status of health financing and recommendation for reforms. Legislation was drafted for new provider payment mechanisms in the hospital sector. Based on the Hospital Patient Discharge Form AZ#66, the Project collected and analyzed data in 31 hospitals to calculate diagnosis-related groups (DRGs) for Azerbaijan. Alongside the data collection, the Project supported the preparation of cost estimates for different DRGs. While the technical basis for piloting new financing mechanisms, including budget allocations, has been established, the system has not been piloted, due to stalling of the health financing reforms.

36. ***GoA formally requested the Bank on May 12, 2011 to provide AF to scale-up the activities initiated by the Project and to finance remaining activities that could not be finished under the Project due to cost-overruns***. The AF also meant to improve availability and quality of health services in other districts. The AF was to support: (i) upgrading of health infrastructure by reconstructing 17 new PHC and 4 village hospitals in ten additional districts; (ii) health system stewardship; (iii) health care management; (iv) the HMIS; (v) training for PHC physicians and nurses across the country beyond the selected pilot districts, including training abroad and in-country for narrow specialists and managers in selected hospitals; (vi) technical assistance to expand reforms in the under- and post-graduate medical education and certification of health professionals; and (vii) the ongoing health finance reforms. The AF also intended to simplify the PDO and streamline the Results Framework.

37. ***There were delays in reaching agreement with the Government on how to proceed with the AF***. A Project Paper for the AF was prepared in June 2012 and appraised in August 2012, with negotiations planned for October 2012. However, GoA chose not to go ahead

[3] A survey (EBRD Life in transition Survey, 2010) showed that the prevalence of informal payments for health in Azerbaijan is the highest among 30 ECA countries, and, after Georgia, is the highest in the ECA region.

with the AF and instead requested an extension of the Credit closing date initially for six months until June 2013 and later for an additional six months, i.e. to December 31, 2013.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

38. ***Design, implementation, and utilization of M&E are rated Moderately Unsatisfactory*** for reasons elaborated below**.**

39. ***Design.*** The Results Framework in the PAD included 9 PDO indicators and 26 Intermediate Outcome Indicators. This evaluation finds that PDO 4 indicator (see datasheet) was too ambitious and difficult to achieve over the life span of the Project. In addition, the number of intermediate indicators was excessive (26) and some were repetitive (indicators 17 and 22), with different wording for monitoring the same type of information. Also, no baseline data were defined at Project approval for the majority of indicators. As per the PAD, USAID was to finance the design and field-testing in one district of the health utilization and health facilities survey. This survey was to provide baseline data for the indicators. It is not clear if this happened, but the baseline data were not recorded in ISRs.

40. ***Implementation.*** *The PIU was responsible for collecting and reporting on the monitoring indicators.* To assess the health system performance, the Project developed a comprehensive M&E framework. With support from the PIU, MOH prepared two Health System Performance Assessment Reports covering the results of 2009 and 2011. The Project supported a nation-wide survey (2011) to identify the risk factors of NCDs. On the basis of the data collected and analyzed, a national strategy for NCDs was prepared. That said, while information on some indicators was issued by the PIU and reported in Aide Memoires, perhaps because of the attempt to make changes to the results framework during the MTR and AF preparation, several indicators were not measured or not reported in ISRs nor was the baseline data recorded. The qualitative studies and the ex-post evaluation surveys that were to be conducted prior to the completion of the Project did not materialize. The datasheet in this ICR comprises all PDO and intermediate indicators as agreed at negotiations. Since several indicators were not measured/reported in ISRs, this evaluation reviewed a number of reports and held discussions with MOH and other relevant agencies/research/education centers to obtain/validate information presented in this report.

41. ***Utilization***. M&E has become an important learning tool. It has been strengthened significantly with the development and piloting of the HMIS at the hospital level and it is being rolled out nation-wide. Staff has completed a number of system developments, including introduction of the Hospital Patient Discharge Form AZ#66.

2.4 Safeguard and Fiduciary Compliance

42. ***This was a Category B project, which triggered Safeguard Policy OP/BP 4.01 – Environmental Assessment.*** Safeguards implementation is ***rated Moderately Satisfactory.*** An environmental analysis conducted during preparation identified potential adverse impacts. They were found to be restricted in scope and severity. They were associated with construction and rehabilitation of health facilities and included excessive dust and noise,

generation of construction and domestic wastes, and collection and disposal of medical wastes. As a result of the EMP, measures were introduced to mitigate the risks in the design, planning, and supervision of the construction as well as during the operation of the facilities. During implementation, facility-specific EMPs were prepared as part of the design of each hospital. Mitigation measures identified in the EMPs were incorporated in the terms of reference (TOR) for detailed design and construction supervision. However, at the time of the preparation of the AF, it was found that due to insufficient in-house environmental expertise within the PIU, the environmental compliance of the original Project activities had not been properly monitored. To address the shortcoming, the PIU prepared and implemented a time- bound action plan with installation of on-site waste water treatment facilities for the hospitals, measures for proper collection and disposal of waste from health facilities, and training on medical waste management for staff of the facilities. These measures were implemented thanks to the second credit extension. This was the first project to focus on issues of waste water management. It led to the development of a Waste Water and Sanitation Plan, which was implemented in all facilities under the Project. All health facilities to be constructed in future, regardless of source of finance, will include such plans.

43. ***The Project did not have significant or irreversible negative environmental impacts during the construction phase of the facilities***. Environmental impacts during the construction phase were typical for all small to medium scale rehabilitation/construction activities and were limited to the Project sites. Project sites were state-owned land plots with user rights already granted to the medical institutions operating on those plots.

44. ***Financial Management (FM) is rated Satisfactory***. The FM arrangements at the PIU, including accounting, reporting, budgeting and planning, internal controls, funds flow and staffing, were considered to be strong and were rated Satisfactory throughout implementation with one exception when the rating was downgraded to MS (November 2009). External audits were prepared and issued on a timely manner and have consistently been unqualified. The 2013 external audit was finalized and sent to the Bank in mid-March 2014. Disbursements under the Project proceeded generally as planned. As of May 2, 2014[4], US$51.56 million equivalent have been disbursed from the Credit. Withdrawal applications were prepared regularly and supporting documentation was complete.

45. ***Procurement is rated Moderately Satisfactory.*** Procurement was rated Satisfactory for most of the Project's implementation period. Some procurement issues arose during the last year when the rating was downgraded to MS, rating which was maintained up to the closing date. The Procurement Plan was updated as required. Procurement under the Project included: (i) civil works; (ii) medical and office equipment; (iii) furniture; (v) medical supplies; and (vi) consulting services.

2.5 Post-completion Operation/Next Phase

[4] The original SDR amount of SDR 34.3 million was equivalent to US$50 million at the time of Credit approval. The availability of more US dollars reflects the appreciation of SDR currencies against the US dollar. Total Credit proceeds at the time of this ICR (May 2014) were equivalent to US$53.22 million.

46. Although discussions are ongoing, no agreement has been reached yet with the Government for a new Bank-supported operation in the health sector.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

47. ***While the relevance of objectives, design and implementation are rated as Substantial, the relevance of implementation arrangements for the health financing reforms is rated as Modest.*** This evaluation finds that the Project was relevant and consistent with development priorities of both the Government and the Bank (see paragraph 27). However, given the slow advancement of health financing reforms, the project should have been restructured to maintain its relevance several attempts to restructure were undertaken but failed to come to closure.

3.2 Achievement of Project Development Objectives

48. ***This evaluation rates achievement of the PDO as Modest.*** This evaluation is based on the achievement of the PDO indicators and on the analysis of the accomplishment of intermediate indicators (Table 1). Despite the high number of achievements and outputs as listed below, some of the core achievements were not reached, such as the number of health centers rehabilitates and the health financing reforms. In addition, the missed restructuring of the PDO and realignment of the results framework during the life of the project contributed to an overall difficulty in attributing some of the outcomes to the project, and to adequately measure improvements in some of the indicators, given the lack of several baselines.

Table 1 – Status of Progress Against Project Indicators

Status	**9 PDO Indicators**	**% of total PDO**	**26 Intermediate Outcome Indicators**	**% of total PDO**
Over-achieved	1	11%	1	4%
Achieved	5	56%	19	73%
Partially Achieved	1	11%	5	19%
Not Achieved	2	22%	1	4%
Total	**9**	**100%**	**26**	**100%**

49. The evaluation was also based on analysis of how Project activities were linked to achievement of the PDO. Table 2 illustrates these linkages for each of the two PDOs. Achievement of the PDO is further addressed in the subsequent paragraphs.

Table 2 – Achievement of PDO Indicators

1. Public expenditures on health gradually increased to a sustainable level that would ensure full coverage of the population with the basic package of services	**ACHIEVED.** Public health spending increased from 168.9 million mantas in 2006 to 604.9 million mantas in 2012 or 2.3% of non-oil GDP. However it remains low in international comparisons.	PDO 2
2. A White Paper on health is adopted	**ACHIEVED.** White Paper was adopted in 2008.	PDO 1
3. A long-term health sector investment plan is prepared as a result of a nation-wide mapping of facilities and the subsequent rationalization plan	**OVER ACHIEVED.** Long-term sector investment plan was prepared and approved	PDO 1
4. Household out-of-pocket expenditures for health as a proportion of total health expenditures	**NOT ACHIEVED.** Health financing reform has stalled.	PDO 1

decreased as a result of free access to essential package of health care services.		
5. Proportion of sick people seeking healthcare increased	**ACHIEVED.** Although no survey was undertaken, information/data gathered and analyzed for the M&E of the national master plan confirms an increase.	PDO 2
6. Satisfaction of the community with overall access to care increased	**ACHIEVED.** 20% increase in mean value.	PDO 2
7. Perceived quality of care of the services covered by the BBP by the community increased	**NOT ACHIEVED.** The BBP was developed, but not adopted as health financing reforms have stalled.	PDO 2
8. Budget allocations to districts is made on the basis of demographic and morbidity criteria	**PARTIALLY ACHIEVED.** The master plan included demographic indicators for the design of PHC services. The technical basis for piloting new financing mechanisms, including budget allocations has been determined, but not implemented as the financial reform has stalled.	PDO 1
9. IMR, under-five MR, MMR, underweight prevalence rate in children (<5y). Adult age and cause-specific mortality rates. Self-reported health status	**ACHIEVED.** Official and international data show that IM, MM, and under 5 have decreased over the life span of the Project, however it is not possible to attribute this to the project. As stated earlier, this objective was too ambitious.	PDO 2

50. ***PDO 1 – Improve overall health system stewardship and financing.*** The Project was successful in helping to strengthen MOH's stewardship by developing capacities to formulate and implement health policies and by developing the HMIS, thus improving M&E capacity, including the successful introduction of the Hospital Patient Discharge form (Form 66). A White Paper on health was developed and adopted; a policy unit was established at MOH; a restructuring Master Plan was developed and implemented (paragraphs 33 and 56); and background studies to support future drug policy reform were conducted and policies prepared (paragraph 51). A number of HR policies in the area of medical education and certification were adopted and implemented (paragraph 55). Information technology activities, including system development and training, were implemented. As a result, MOH has a tool and data with which to assess the performance of the country's health system on a regular basis. Form 66 also allows the government to monitor trends and compare efficiency and quality among facilities and districts. Form 66 has been used to develop a hospital payment system which is ready for implementation and can contribute to improved efficiency of the hospital system. The HMIS was strengthened with the introduction of Form 66. Using this form, a data-base with 100,000 discharged cases was established and has been used to determine costs of services and to allocate departmental budgets. It served as the basis for the development of a DRG-based hospital payments mechanism, which is ready to be piloted. Together, these developments have resulted in a much improved information system, including policy development and monitoring capacity at the higher management levels, and quality of medical education. All these are drivers of improved quality of services and health outcomes in the long-term.

51. ***The Project has been successful in supporting MOH in its health system stewardship capacity.*** It supported, inter alia: (i) development of the Health Strategy for the period 2007-12 and later updated to cover up to 2015; (ii) development of a health system performance framework and, based on the M&E framework, two Health System Performance Assessments; (iii) upgrading the legal and regulatory framework of MOH; (iv) upgrading pharmaceutical policy and management through the development of a number of

strategic reforms – essential drug list, national drug policy and drug formulary; (v) MOH's improved response capacity for emerging diseases, including development of national strategies for NCDs and CDs; (vi) development of a licensing system for health facilities; and (vii) setting up mechanisms for quality control and assurance of services.

52. ***The Project has been less successful in supporting health financing reforms.*** Although important steps have been made during the past six years to prepare for financing reforms, initiatives in this area have not proceeded as far as expected. Based on a comprehensive review of the current legislation, regulatory documents necessary for implementing future health financing reforms were drafted. A Policy Concept on Health Financing Reform and Introduction of Compulsory Medical Insurance, which stated the main goals for the health financing reforms, was developed. The Concept and an Action Plan for its implementation were endorsed by the Cabinet of Ministers and the President in 2008. This document was to serve as a roadmap for the reforms. However, as discussed earlier, the Health Insurance Agency has not become operational and, as a result, few actions have materialized as they depend on the agency being in place. Finally, training for medical and administrative staff on different aspects of health care financing was conducted. Much of these preparatory efforts, however, will be outdated and some of them lost, such as the institutional capacity that was established.

53. ***PDO 2 – enhance equitable access to, and technical and perceived quality of essential healthcare services, in the selected districts in a fiscally responsible and sustainable manner with a view to improving health outcomes.*** The Project was successful in improving access and delivery of health care services through, *inter alia*, the construction of health facilities in the participating districts, the training and retraining of health staff, the development and implementation of clinical protocols and guidelines, and the strengthening of the medical education system. As discussed in Annex 3, in terms of fiscally responsible and sustainable manner, the operation and maintenance costs of the facilities constructed/refurbished under the Project are not significantly high when compared with the public expenditures of the health sector in the country. Therefore, the recurrent cost impacts of the Project are not significant.

54. ***Following the Master Plan, rationalization resulted in a reduction of the number of beds by about 56 percent.*** The importance of the master plan, especially the decision of the government to implement rationalization plans nation-wide, cannot be under-estimated (see also paragraph 33). The Project supported improvements in quality of care through, *inter alia*: (i) development of 40 guidelines and clinical protocols in the areas of neonatal care and resuscitation, antenatal care, and preventing bleeding in labor and the training of health workers in the use of the protocols; (ii) development of standard operating procedures to complement the laboratory manual on the 14 priority CDs; (iii) strengthening data collection and assessments of NCDs risk factors as the basis for the preparation of a national strategy for the prevention and control of NCDs; (iv) strengthening of PHC services through the training and retraining of physicians and nurses in the FM approach, followed by training of trainers for physicians and nurses in participating and neighboring districts; (v) provision of health management training for hospitals managers and mid-level staff; (vi) improving the quality of medical education; (vii) alignment of the medical education curricula to

international standards; (viii) establishment of close linkages between theoretical training and practical applications; and (ix) improvements of teaching methods in medical education.

55. ***A policy document was prepared to support the improvement of undergraduate medical education in the country,*** including a revision of the curricula. Recommendations were provided on strengthening the curricula and implementation of an integrated curriculum system at the Medical University under a long-term implementation plan. In parallel, the Project provided technical support for the introduction of a residency program to develop and improve post-graduate medical education. To that effect, state education standards for the residency program were developed and a process to align the residency curricula to international standards started. Curricula of 40 subjects in the residency program were reviewed by Hacetepe University of Turkey to be aligned to international standards and were approved and introduced at the Medical University. A new curriculum on health care management was developed and introduced at the Medical University for the 2013 study year. Based on this course, a Health Care Management Faculty is planned to open at the Medical University. Moreover, the Project: (i) developed implementation mechanisms for the certification process; (ii) developed the legislative documents regulating these processes; (iii) identified exam questions for the certification of health professions; (iv) developed an electronic portal for the Certification Commission; (v) designed training materials to improve awareness among health professionals on certification; and (vi) provided technical assistance to facilitate the operations of the Certification Committee.

56. ***Implementation of the above-mentioned Master Plan has contributed to rationalization of health infrastructure.*** Monitoring data show positive trends in utilization of health care services at the facilities in general, and from skilled birth attendance in particular. There are also signs of efficiency gains with a much higher bed occupancy rate and an increased number of out-patient visits.

57. ***Nonetheless, the Project has not entirely succeeded in achieving financial sustainability and equity.*** Despite a substantial increase in public spending for health, by international comparisons it remains low and there are no signs yet that the increase in public expenditures has impacted the reduction of OOPs spending. Throughout the country, there remains a high level of inequality in health care utilization. Richer households use health facilities more often than the poor. Nonetheless, proportion of sick people throughout the country seeking health care has increased slightly from 4 in 2006 to 4.3 patient visits to PHC per capita in 2010 (PDO Indicator 5). Annual number of visits made to PHC facilities has increased substantially in some Project-districts (see intermediate indicator 9). In general, households spend a considerable proportion of their budgets, 10 percent on average, for health care services. They face uncertainty of OOP payments and potentially high costs as the majority of services have to be out of pocket. Publicly financed health worker salaries are low and informal payments are often requested for services. The World Bank-EBRD Life in Transition Survey of 2010 indicated that the prevalence of informal payments for health in Azerbaijan is the highest among 30 other ECA countries and Western Europe and, after Georgia, Azerbaijan has the highest level of OOPs in the region. The survey also showed that the other large part of the high OOPs costs is due to high cost of drugs.

3.3 Efficiency

58. ***Efficiency is rated Modest.*** Three types of economic/financial analysis were carried out in the PAD. The first was a cost-benefit analysis for the Service Delivery Component (Component B). The second was a qualitative analysis that took into account all project components and established the economic rationale behind the Project on the basis of: (i) establishing a firm justification for public involvement; (ii) determining the counterfactual, i.e. with and without the Project; and (iii) identifying the fiscal impact of the Project on public funds. Although the PAD assigned the major share of estimated project benefits to the Service Delivery Component, other components/subcomponents of the Project also yielded large efficiency gains, leading to a reasonably balanced economic outcome across the activities. Thanks to the Project, there was a strong performance with respect to: (i) reduction in ALOS (from 15.1 in 2005 to 12.2 in 2011), thereby reducing productivity losses associated with medical care; (ii) reduction of hospital beds (from 444 secondary facilities to 214 and concomitant reduction of beds by 56 percent); and (iii) increase in bed occupancy at hospitals (from 25.6 in 2005 to 51.2 in 2011). In addition, thanks to the master plan, the Project has contributed to the rationalization of the health infrastructure not only with the decrease of hospitals, but a substantial increase in the number of PHC facilities from 543 to 782, yielding concomitant increases in utilization of primary care. The Project focus on primary care addresses the growing burden of NCDs, which account for over 80 percent of the overall burden of disease and cause of death in the country. There are also indications of efficiency gains with an increased number of out-patient visits.

59. ***The Project has had significant impact on health reforms in the country***. In particular, the Project records significant achievements in: (i) implementing PHC reforms with emphasis on the family medicine model; (ii) rationalizing health infrastructure; (iii) strengthening stewardship capacity of MOH to formulate and implement health policies; (iv) improving MOH's monitoring and evaluation capacity through the design and implementation of the HMIS; (v) improving human resources policies in the areas of medical education and certification of health professionals; (vi) upgrading the legal and regulatory framework of MOH; (vii) upgrading pharmaceutical policy and management; (viii) upgrading MOH's response capacity for emerging diseases; and (ix) setting up mechanisms for quality control and assurance of services. All these features are drivers of improved quality of services and health outcomes, both during implementation and for the long-term. This said, the Project was not as successful in implementing the health financing reforms as the Health Insurance Agency did not become operational.

3.4 Justification of Overall Outcome Rating

60. Notwithstanding the achievements under the Project discussed under Section 3.3, the Project's overall outcome is considered ***Moderately Unsatisfactory.*** This rating is consistent with the rating in the last ISR of November 2013. While relevance is rated Substantial (Section 3.1), both Efficacy and Efficiency are rated Modest. As far as Efficiency is concerned, available data are not sufficient for the original economic analysis to be reproduced (see also Section 3.2). Although it is clear that the Project achieved most of its indicators and targets (Table 1), the failure to restructure the PDO and Results Framework as well as the issues with the implementation of the health financing reforms (paragraphs 35 and

52) led to Modest achievement for Efficacy. The formulation of the PDO, which was considered ambitious, was to be addressed through a restructuring at the time of the AF, when the PDO was to be simplified and the Results Framework streamlined. As discussed in paragraph 37, the AF never materialized.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

61. While the Project was not explicitly classified as a poverty-targeted operation, it has had some positive impact on the poor of participating districts. The physical and system improvements in the two district hospitals, the four village hospitals and the PHC facilities constructed under the Project have improved access and the quality of care for of all socio-economic groups, including the poor and women, especially in rural areas. During ICR discussions, patients noted that with the new and improved health facilities, they did not have to travel to Baku to access hospital services.

(b) Institutional Change/Strengthening

62. ***The Project had a significant impact on institutional development and building long-term capacity in various areas.*** During ICR discussions, central and district authorities recognized the important impacts that project investments in capacity building and technology had on institutional development. The Project strengthened several institutions (MOH, training centers, hospitals and PHC facilities, Medical University, Advance Medical Training Institute) and supported development of the family medicine approach to improve PHC. It also strengthened the legal framework for health care waste management, which is highly praised by GoA. Staff highlighted the direct benefits of the Project in training and retraining of doctors and nurses, enabling them to work as teams in the FM setting. Physicians and nurses in participating hospitals and other health facilities acknowledged the positive role the Project has played, not only in improving the physical infrastructure and availability of medical equipment, but in promoting staff efficiency and productivity gains.

63. ***Each of the components supported institutional strengthening in its respective area.*** **Component A - Building MOH Capacity for Stewardship** supported TA and training for: (i) development of a health system performance capacity; (ii) a nation-wide survey of risk factors for NCDs; (iii) improving the reliability and frequency of data on health through the electronic collection and analyses of data from inpatient facilities; (iv) developing a roadmap for a Unified HIS for Azerbaijan, including standardization, collection and analysis of health information; (vi) developing software for certification of health care professionals; (v) strengthening the health information system (620 staff trained); (vii) strengthening pharmaceuticals policy, including development of procedures and tools for rational drug use (80 staff trained); (viii) improving quality assurance and accreditation of health facilities; (ix) improving MOH response capacity for CDs and NCDs (35 staff trained).

64. **Component B – Improving Delivery of Health Care Services** financed TA and training for: (i) developing a master plan to rationalize health infrastructure and human resources; (ii) strengthening the SanEpid system through surveillance and development of

guidelines and clinical protocols; (iii) strengthening PHC services through the training of physicians and nurses in the family medicine approach (240 physicians and 570 nurses trained); (iv) upgrading impatient care services in the pilot districts through health management training for hospital managers and middle-level health staff (244 hospital staff trained); and (v) upgrading of skills of clinical specialists through local training and study tours (250 medical staff trained, including 20 trained as trainers).

65. **Component C – Ensuring Sustainable Health Financing and Resource Allocation** supported TA and training for: (i) designing options for sustainable financing, including the development of policy papers and legislation for implementation of new provider mechanisms in the hospital sector (1,793 staff trained); (ii) developing a publicly-financed basic benefit package (BBP); (iii) developing a concept policy on health financing reform and introduction of compulsory medical insurance; and (iv) reviewing legislation and developing regulatory documents for implementation of future health care financing reforms.

66. **Component D – Human Resources Development** financed TA and training for: (i) developing a strategy for reforms of under-graduate medical education and a strategy for post-graduate training programs; (ii) developing a national strategy for Human Resources; (iii) designing mechanisms for the implementation of a certification process of physicians and nurses; (iv) developing software for the certification program; (v) developing guidelines and clinical protocols; (vi) implementing the under-graduate strategy through extensive training of the Medical University faculty (3,713 staff); (vii) introduction of the residency program; and (viii) developing a strategy to strengthen health professional associations.

67. **Component E – Project Management and M&E** has improved overall project management and coordination through staff participation in training courses, on-the job training provided by consultants and PIU participation in training courses in procurement and financial management in and outside the country. Key PIU staff has been absorbed in strategic departments of the MOH further contributing to health sector reforms led by MOH.

(c) Other Unintended Outcomes and Impacts (positive or negative)

68. ***Close coordination and synergies with activities financed by WHO, UNICEF and USAID has resulted in stronger outcomes for the sector.*** USAID has supported health financing reforms' efforts and has worked with MOH to help review and revise hospital payment mechanisms. WHO has provided technical assistance for improving health policy formulation, including development of the health strategy. WHO and UNICEF supported the preparation of clinical guidelines and protocols.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

69. Not applicable.

4. Assessment of Risk to Development Outcome

70. The risk at the time of the ICR that development outcomes (or expected outcomes) will not be maintained is rated ***Moderate.*** Reforms in medical education, family medicine, and certification of health professionals have been important and are likely to be expanded. Equally, improvements in the health information system are likely to be expanded as there is commitment beyond MOH to create an integrated information system in the country. However, caution should be exercised about the capacity of MOH to remain committed to the reforms, especially considering the high level of staff turnover.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

71. ***This evaluation rates the Quality at Entry as Moderately Satisfactory.*** The Project design was relevant to the objectives of the CAS and the Government's strategy as described in Section 1.1. The design benefitted from the analysis and recommendations of the Health Sector Review. The Bank team applied the lessons drawn from implementation of the Bank-supported HR LIL as well as other health projects in the region. The background analysis was sound. The team considered a number of options during preparation, which were well justified in the PAD. The Bank team ensured a participatory approach during Project preparation and engaged both central and local counterparts, as well as other development partners, in discussions to ensure that there was overall agreement in project design and scope. This said, the M&E system for monitoring project implementation and assessing its achievements was not adequate, including a lack of baseline data for most indicators. In addition, as stated earlier, the PDO formulation and Results Framework were overly complex and in part difficult to link to the project's activities.

(b) Quality of Supervision

72. ***The ICR team rates the quality of supervision as Moderately Satisfactory.*** The Team Leader (TL) responsible for processing the Project for approval continued as TL for one and a half years after Credit effectiveness. The second TL guided implementation for over three years, and the third TL saw the Project to the closing date (two years). Generally there were two missions annually. At the beginning of Project implementation, the team addressed in Aide Memoires progress with implementation of overall health sector reform, in addition to reporting on progress with implementation of the Project. This is a good practice, which helped ensure that the Project was closely linked to, and contributed to, the overall sector performance. Unfortunately, this practice was not continued by other Project teams.

73. The Project team developed strong relations with MOH and prepared a health sector note and the health chapter of the Public Expenditure Review to help identify continuing bottlenecks in sector's performance and ways on how the Bank could expand collaboration with the Government. The team's focus on waste water management, led to the development of a Waste Water and Sanitation Plan. MOH decided to apply it to all the facilities

constructed under the Project and future construction of health facilities in the country. Project implementation was monitored regularly by Bank staff during and between missions. The skills mix was appropriate, with the exception of the lack of a health facility architect during the planning and construction of the physical facilities. Such expertise was only added to the Project team during the last six months of implementation and proved to be most useful. One less optimal part of supervision was that Aide Memoires and ISRs did not focus and/or reported on the complete set of indicators as per the Financing Agreement. They reported on a limited number of indicators.

74. Procurement and financial management was well managed throughout the life of the Project. Management of safeguards policies was a particular focus of the Project team during the last year and a half of project implementation, which helped identify and ensure that measures were taken to rectify issues that were identified.

75. From discussions during the ICR mission and a review of Aide Memoires and other documents, it is evident that teams for the most part coordinated well with other development partners, including WHO, UNICEF and USAID, to ensure optimal use of resources.

(c) Justification of Rating for Overall Bank Performance

76. ***Overall Bank performance is rated Moderately Satisfactory.*** Although implementation support frequency, quality, regularity and skills mix was good, it can be argued that more should have been done to restructure the project. Two main attempts were made with frequent follow up, however they did not materialize. The team could have explored alternative, and more simple, restructuring possibilities.

5.2 Borrower Performance

(a) Government Performance

77. ***Government's performance during project preparation and implementation is rated Moderately Satisfactory.*** Prior to Project approval, GoA had developed key strategic documents such as the Health Sector Policy Note. Also, the SPPRED focused on the need to improve the quality and equity in access to health. In addition: (i) a draft Project Implementation Plan was prepared by an inter-governmental working group; (ii) a draft contribution for the ICR of the HR LIL was developed; (iii) background studies for a report on pharmaceuticals were prepared; and (iv) the PIU within MOH was re-established[5]. GoA engaged actively in discussions during project design at the highest possible levels. The Prime Minister, Minister of Finance and Governor of the Central Bank engaged in these discussions and helped reach agreement on its overall scope and content. Notwithstanding, GoA's political and institutional commitment to the health financing reform during implementation as well as delays in processing the AF and ultimately GoA's decision not to negotiate its Financing Agreement were less than Satisfactory.

[5] The PIU for the HR LIL had been abolished by the previous Minister of Health.

(b) Implementing Agency or Agencies Performance

78. ***MOH's performance is rated Moderately Satisfactory***. In general, MOH's commitment to health reform has been strong since November 2005. MOH management was effective in helping resolve complex issues arising during development and approval of the master plan and coordinated well with other agencies participating in the Project, such as hospital and other health facilities' management, the Medical University, and district authorities. The appointment of a former PIU staff as Head of Apparatus of MOH helped a great deal to resolve difficult issues during implementation requiring the Ministry's intervention. MOH's commitment to the Project extended throughout Project implementation. Its management and staff participated actively in the ICR discussions and the Ministry prepared a solid contribution to the ICR (Annex 7).

79. Overall coordination, as well as procurement, financial management, and M&E, worked well. The PIU was successful in building and maintaining productive relationships at all levels of the health system. It worked effectively to monitor and evaluate project performance and facilitated the full participation of a number of institutions charged with implementing various parts of the Project. As indicated earlier, project management and coordination was assessed as fluctuating between S and MS during the life of the Project.

(c) Justification of Rating for Overall Borrower Performance

80. The reasons for the MS rating include: (i) overall commitment to the objectives of the Project; (ii) adequate allocation of counterpart funds for civil works; (iii) compliance with fiduciary and safeguards requirements; and (iv) effective administration and coordination of project activities. However, as noted in paragraph 77, GoA's political and institutional commitment to the health financing reform during implementation was less than ***Satisfactory***.

6. Lessons Learned

81. Lessons learned can be categorized under the following headings:

Government ownership and capacity development

- ***Reforms to a sector such as health are costly and time consuming.*** The Project devoted resources to building the capacity of MOH to be a better steward of the sector. It also focused on building the capacity for health information and for the formulation and implementation of reforms and associated policies. The direct tangible benefits of the policies and of the training for improved efficiency and health outcomes will only become visible several years after Credit closing.
- ***Strong Government ownership is critical, particularly with reform-oriented projects***. Reforms in the health sector not only concern technical health-related changes, but depend heavily on institutional capacity and the political process. Limited government ownership and commitment affected negatively the

passing/adoption of policies and strategies such as the Essential Drug List, National Drug Policy, drug Formulary, Basic Benefit Package.

- ***Lack of strong leadership to ensure effective implementation of health financing reforms critically impacted the performance of the health financing component.*** Despite several policy papers, legislation and related documents to support these financing reforms, the Health Insurance Agency has not become operational.
- ***Consensus building among stakeholders is critical***, not only during preparation but during implementation as it can affect the success and sustainability of any reform. The consensus needed to overcome the government impasse for the Health Insurance Agency to start functioning did not happen.
- ***Long-term engagement.*** Health sector reforms are complex and often take 6-10 years. The Bank should adopt a longer-term approach in supporting such reforms. Unfortunately this was not the case in the country as the first HR LIL did not focus much on reforms and now, with the closing of this Credit, the momentum gained is likely to be lost.

Coordination

- ***Close coordination with development partners was critical.*** Close coordination and collaboration with USAID and WHO during preparation was exemplary. Both institutions provided technical expertise and USAID financed and participated in seminars and workshops. Close collaboration during implementation helped keep key activities on track and ensure complementarity of the interventions.

Implementation guidance by the Bank

- ***A focus on identifying problems and seeking solutions*** by the Bank-client team is important for achieving results.
- ***Both the Bank and the Government need to maintain appropriate expertise in all areas of the Project.*** While strong expertise was provided in most areas, Bank supervision was wanting until the last year of the Project, specifically in the provision of expertise in health facilities construction. The PIU, with no civil engineer or health facility architect to review required technical specifications and bid evaluations, and later to help supervise the construction, was unable to secure the quality of the designs. The fact that the Bank's team did not include the expertise of a health facility architect during the design and construction phases exacerbated the situation.
- ***More flexibility and pro-activeness from the Bank to address implementation weaknesses should be considered.*** Bank procedures provide for exceptions to extend projects whose objectives may not be achievable. These exceptions can be lengthy and burdensome. However, when reputational risks call for remedial actions to be taken, as was the case in this project, more flexibility and positive incentives should be provided.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

82. Authorities contacted by the ICR mission commented positively on the role the Project has played in helping to further develop the sector. During the ICR mission, the Minister of Health commented positively about the achievements of the Project and the role the Bank has played in assisting GoA in the development of the sector and expressed his wish for future Bank cooperation in the sector. The MOH provided its contribution to this ICR, including Annex 1. The Bank provided GoA the Azeri and English versions of the draft ICR for comments on April 28, 2014. However, by the time of completion of this ICR, comments had not been received despite several follow ups by the ICR team.

83. The ICR team visited the 100-bed central district hospital in Aghdash District, the Golgati Village Hospital, two PHC facilities in Aghdash and the Peri-natal Center. In discussions with medical staff, they expressed their enthusiasm for the quality of the facilities, including the equipment. Likewise, discussions with patients and family members attested to their satisfaction with the improved services.

(b) Cofinanciers

84. Not applicable.

(c) Other partners and stakeholders

85. The ICR team held discussions with WHO and UNICEF, but could not meet with USAID staff as USAID is no longer active in the sector. WHO's and UNICEF's comments are reflected in this document to the extent possible.

Annex 1. Project Costs and Financing

(a) **Project Cost by Component**

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
A. Building MOH Capacity for Stewardship	6.26	6.95	111%
B. Improving Delivery of Health Care Services	61.45	65.35	106%
C. Ensuring Sustainable Health Financing and Resource Allocation	1.36	0.68	50%[6]
D. Human Resource Development	1.10	1.89	172%[7]
E. Project Management, Monitoring and Evaluation	1.72	3.84	223%[8]
Total Baseline Cost	**71.89**	**78.71**	**109%**
Physical Contingencies	2.10	0.00	
Price Contingencies	4.25	0.00	
Total Project Costs	**78.24**[9]	**78.71**	**100%**

(b) **Financing**

Source of Funds	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower	28.24	27.15	96%
International Development Association	50.00	51.56[10]	103%
TOTAL	**78.24**	**78.71**	**100%**

[6] Actual expenditures represent only 50% of projected at appraisal as several activities were not undertaken because the health financing reform stalled. Activities not undertaken include: (i) public expenditure reviews; (ii) development and institutionalization of the National Health Accounts; (iii) pilot testing of provider payment mechanisms and population-based allocation formula for district budgets (See also Annex 2). Some of the unused funds were diverted towards activities under the Human Resource Development Component (see below).

[7] This Component was successful and in view of its progress, additional funding was provided for technical assistance and training towards design of mechanisms for the implementation of a certification process of physicians and nurses covering 95% of physicians and nurses. Also, additional funds than initially allocated were used to finance additional training for the Medical University for the implementation of the undergraduate strategy.

[8] The Credit closing date was extended by 12 months, therefore increasing project management costs. The costs also include additional consultancies and training financed under the Component.

[9] Total Project costs do not include parallel financing from USAID (US$8.0 million, WHO (US$0.04) million and UNICEF (US$0.47 million). USAID is no longer involved in the sector and data on UNICEF and WHO's parallel financing was not available during the ICR mission.

[10] Increases in IDA's contribution reflect exchange rate fluctuation in the SDR to dollar exchange rate over the Project life

(c) **Project Cost by Category**

Categories	Appraisal Estimate (USD millions)	Actual Disbursement (USD millions)	Percentage of Appraisal
(1) Civil Works	39.70	46.27	117%
(2) Goods	25.38	22.78	90%
(3) Consulting Services	7.10	7.20	101%
(4) Training	2.39	2.46	103%
(5) Incremental Operating Costs	1.40	0.00	
(6) Unallocated	2.27	0.00	
Total	**78.24**	**78.71**	**100%**

Annex 2. Outputs by Component

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
Component A – Building MOH capacity for stewardship (US$ 8.13 million)	**A.1 Building capacity for health policy** (a) Develop a health policy framework. (b) Develop a health system performance framework. (c) Review and redefine MOH's current mission, its functional and administrative structure. (d) Establish a Health Policy and Planning Unit (HPPU). (e) Upgrade the legal and regulatory framework. (f) Provide support to MOH public awareness campaign.	The Project has been successful in supporting MOH in its health system stewardship capacity. It supported: (a) Development of a Health Strategy for the period 2007-2012 with assistance from WHO. The strategy was updated to cover up to 2015. In addition, the health chapter of the Development Concept – Azerbaijan 2020 was approved in December 2012. (b) Development of a health system performance framework and based on the M&E framework, two Health System Performance Assessments (HSPA) have been prepared (2009 and 2011) to guide policy making, planning and regulation (US$161,342). (c) MOH's functional and administrative structure has been reviewed and changes were made. (d) Establishment of an HPPU in 2009 with five staff. The Unit has played an important role in the certification of health professionals - (US$175,000). (e) Upgrading of the legal and regulatory framework of MOH with the support of technical assistance (US$67,277). (f) The Project has supported MOH's public information in general. In the context of the master plan, the Project supported a number of workshops in the pilot and neighboring districts to discuss methodology and proposals before the master plan was finalized. The Project conducted surveys to design MoH's PR campaigns (US$95,143). (g) Surveys were conducted to identify the risk factors of NCDs and CDs, which enabled MoH to develop national strategies for NCDs and CDs management (US$167,125).
	A.2 Strengthening pharmaceuticals policy and management (a) Develop a national drug policy. (b) Strengthen the capacity of MOH Pharmaceuticals and Medical Devices	Pharmaceutical policy and management have been strengthened with support from the Project: (a) and (d): A number of strategic reform policies have been prepared

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	Unit. (c) Develop and monitor effective management of the national drug policy, including institutionalization of an essential drug list, standard treatment protocols. (d) Development of legislative and regulatory framework. (e) Develop procedures and tools for rational drug use, including training of staff and the establishment of a Drug Information and Monitoring Department in MOH.	and are awaiting approval from MOH. – (i) essential drug list, (ii) National Drug Policy, and (iii) Drug Formulary. (US$116,134). (b) The Drug Analytical and Expertise Center (DAEC) and the Innovation & Supply Center (ISC) have been strengthened through training of staff and provision of equipment (including 2 pieces of bio-equivalence lab equipment, drug quality control lab equipment and IT equipment) - (US$404,719). A total of 33 staff have been trained in both institutions (US$ 34,274). (c) and (e): International and local practices were analyzed and a methodology recommended for drug quantification. The methodology has been piloted in a hospital in Baku in cooperation with USAID's Health Sector Development Project. It is expected to be implemented nation-wide once the facilities are provided with necessary IT equipment. (e) Forty five staff from pilot regions were trained on pharmaco-vigilence and rational drug use by the PIU staff. (f) Standard operating procedures (SOPs) were developed for the Innovation and Supply Center to improve the centralized procurement of drugs and equipment for the health care organizations under MOH's direct supervision (US$145,139).
	A.3 Quality Assurance and Accreditation of Health Facilities (a) Development of an accreditation and licensing system for public and private health facilities. (b) Set up mechanisms for quality control and assurance of services. (c) Establishment of an Accreditation Unit and a Licensing Unit at MOH.	Quality assurance and accreditation has been strengthened through: (a) and (b): A consultant developed a licensing system for private medical facilities - (US$48,500). A number of legislative documents were prepared to improve the quality of health care services in the country (US$67,277). (c) MOH is working on establishing an Accreditation Unit. The Project has supported the Commission in Accreditation through review of international experience and legislative documents.
	A.4 Strengthening the Health Information System	The HIS was strengthened significantly with support from the Project by:

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	(a) Build capacity to monitor the health of the population and the performance of the sector by reviewing the HMIS and developing recommendation to improve it. (b) Adequate functioning of the Health Policy and Planning Unit.	(a) The development and piloting of a HMIS at the hospital level, which is being rolled out nation-wide. IT staff have completed a number of system developments and have introduced successfully the Hospital Patient Discharge Form AZ#66 (Form 66), which allows the government to monitor trends, compare efficiency and quality between facilities and regions. All hardware and software for the "Prototype Information System for Medical Facility Management" – Agkun System has been installed in Gakh Central Hospital and staff trained, entry of data has started - (US$201,503). (b) A Unified Health Information System Road Map was developed to promote the future integration of health information systems and strategic development of HIS in the country (US$86,670). (c) Several modules were prepared to support the operation of various priority areas of MOH including Form 66, HR, certification, etc. (US$185,867) As noted earlier, the HPPU was established and has operated effectively with support of the Project (US$175,000).
	A.5 Improving MOH response capacity for emerging diseases (a) Development of a surveillance system by improving laboratory capacity (equipment and training of staff). (b) Establishment of a Public Relations Unit in MOH	MOH's response capacity for emerging diseases has been improved by: (a) A national strategy on CDs, including implementation of the international Health Regulations was developed as well as standard operating procedures (SOPs) to complement the laboratory manual on the 14 priority CDs. In Addition, 15 SOPs are being prepared - (US$141,990). An electronic version of case investigation forms supported by GIS for CDs was introduced - (US$524,264). Strengthened data collection and assessment of NCDs risk factors have served as the basis for the preparation of a national strategy for the prevention and control of NCDs - (US$77,125).

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		(b) A Public Relations Unit (5 staff) was established in MOH with support from the Project (US$55,000).
Component B – Improving Delivery of Health care Services (US$73.55 million)	**B.1 Strengthening District & National Level Health System** (a) Mapping exercise and household survey in the pilot districts. (b) National mapping study. (c) Development of the district health care network and national rationalization plan and new district level service provision model. (d) Development of investment plans for rehabilitation/construction and equipping of PHC units, hospital and SanEpic laboratory facilities. (e) Assessment of the training needs of each district. (f) Strengthening SanEpid system through surveillance guidelines/protocol development and staff training. (g) Strengthening district management capacity through study tours and training. (h) Development and carrying out effective Information and Education Campaign. (i) Review and enhance the National Health Care Waste Management Plan.	District and National level have been strengthen: (a), (b) and (c): A master plan to rationalize health infrastructure and human resources was developed and approved in 2009. Its implementation started in four of the 5 project districts (Agdash, Gakh, Ismayili, and Sheki). Methodology used for rationalizing the facilities and the master plan was adopted for the rest of the country - (US$621,904) (d) Investment plans were prepared as part of the master plan for PHC facilities and other health facilities. (e) Assessment of training needs was conducted for selected districts. (f) The CD strategy was prepared and is awaiting review and approval by MOH. In addition, SOPs for lab operations were prepared for 15 diseases. Also, (i) Training of Trainers (TOT) for 23 persons was conducted on epidemiology and guidelines for the control over the selected CDs was developed, and (ii) a workshop was conducted with 12 staff to review the CD strategy - (US$141,990). (g) Various management training activities have been conducted for managers and other health personnel - (US$80,000). (h) Equipment was procured to support health promotion efforts to increase population's awareness on prevention of CDs - (US$153,032). (i) The National Health Care Waste Management Plan has been reviewed and enhanced - (US$21,250).
	B.2 Strengthening PHC Services (a) Appraisal of selected facilities to identify goods, civil works, training, etc. (b) Detailed specifications and architectural designs of all selected facilities. (c) Civil works for selected sites. (d) Development of a business plan for each facility, including details on how	The sub-component provided support to strengthen PHC services: (a) and (b): An assessment of needs was conducted of the selected facilities, including civil works, equipment and training of staff as part of the master plan and architectural design of the facilities (US$1.8 million).

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
	each site will maintain equipment and other operating costs. (e) Provision of retraining for doctors and nurses. (f) Civil works/training materials/equipment for training facilities. (g) Provision of training for GP trainers, including study tours with further training of all district level staff. (h) Training of all district level staff.	(c) 8 PHCs (US$3.3 million) were constructed under the Project. In addition, the Perinatal Hospital in Sheki was refurbished (US$2.2 million). (d) Business plans for each of the two hospitals were developed. (e), (g) and (h): Ten physicians and 10 nurses received retraining in Turkey as part of TOT. The physicians trained for 5 months and the nurses for 3 months - (US$364,670). They have conducted training through 2 months training modules and other short courses for physicians as well as 1 month training and short modules for nurses in the selected and neighboring districts. A total of 229 physicians and nurses have been retrained through this TOT - (US$191,706). (f) Refurbishments of two training centers/equipment and materials have been provided – Training Center in Baku and Sheki Training Center (US$558,743).
	B.3 Upgrading Impatient Care Services in the pilot districts (3 district hospitals – Aghdash, Sheki and Ismaili) (a) Upgrading of physical hospital infrastructure. (b) Training of clinicians and hospital managers both through local workshops and study tours. (c) Detailed architectural design and equipment plans on the basis of the mapping exercise for the selected hospitals. (d) Development of standards and norms for the hospital upgrades. (e) Development of training program for hospital managers and mid-level staff. (f) Upgrading of skills of clinical specialists through study tours.	The sub-component financed: (a) The construction of two 100-bed hospitals in Aghdash and Sheki (US$32.74 million), four village hospitals (US$4.8 million) and the renovation of the Prenatal Center in Sekhi. (b) Three-week training events for hospital managers -(US$80 000). (c) Detailed architectural designs and equipment plans for the selected hospitals (US$1.8 million). (d) Standards and norms for the construction of hospitals as part of the master plan and the architectural designs. Around 100 normative and regulatory documents were reviewed and updated with support of the Project - (US$22,166). (e) A three-week health management training course for hospital managers and mid-level - (US$80,000). Training materials for 5 key areas of health management (health economics, general management, financial management, organization behavior

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		and change management were developed. (f) Training for a total of 249 medical staff, including 20 medical staff that were trained as TOT. The training has included several study tours to Turkey, Israel, Poland, England and Lithuania – (US$348,553).
Component C – Ensuring Sustainable Health Financing and Resource Allocation (US$1.83 million)	**C.1 Designing Options for Sustainable Financing** (a) Medium and long-term projections of health sector revenues and expenditures. (b) Assessment of the efficiency of health sector allocations through the use of public expenditure surveys. (c) Develop and institutionalize National Health Accounts (NHA). (d) Develop a national medium and long-term health care financing policy, including implementation strategy for improved revenue mobilization.	The sub-component supported: (a) Three year projections of health sector revenues and expenditures are prepared with support of the Project annually. In addition, the 2008-2013 State Program for Vertical Programs has been prepared. Also, five year investment plan covering 30% of expenditures is prepared annually. (b) and (c): Public expenditure surveys have not been conducted, nor has NHA been developed. (d) Three legislations have been drafted in support of the implementation of new provider mechanisms in the hospital sector. (US$76,014). In addition, all selected hospitals were provided with relevant software to implement AZS-66 (US$73,876).
	C.2 Improving Allocative Efficiency in Health Care (a) Definition of a publicly-financed package of essential health services. (b) Design and establishment of a Health Fund to act as a single purchaser of heath care services. (c) Elaboration of a population-based allocation formula for district budgets. (d) Elaboration of new provider payment mechanisms. (e) Pilot testing of above activities in project districts.	Activities under this sub-component have been problematic. (a) A publicly-financed package of essential health services was not developed. (b) Although all relevant documentation was prepared and the establishment of the Health Insurance Fund was approved by the President, the HIF has not become operational. (c) In view of (b), a population-based allocation formula for PHC has not been developed. (d) and (e): Extensive work was conducted with assistance from USAID to review and revise hospital payment mechanisms. 21 DRGs were established based on cost accounting analysis and data on discharged patients collected in 10 city hospitals. However, the system has not been piloted. A total of 448 staff were trained on Form AZ 66, DRGs,

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		national accounting standards, and ICD – (US$42,702).
Component D – Human Resources Development (US$1.32 million)	**D.1 – Health Workforce Policy and Planning** Technical assistance and training to: (a) Review of under-graduate and post-graduate human resource programs and capacity and asses methods for assuring quality of education and training programs. (b) Development of human resources planning models/guidelines taking into account the projected supply of physicians and demand for health care. (c) Design of a scheme for rural areas through financial and professional rewards. (d) Support the establishment of a National Commission for Health Sector Manpower Development to work with MOH. (e) Development of a labor adjustment policy and detailed plan with provisions for a more dynamic early retirement and compensation policy.	The sub-component was successful and provided technical assistance and training as follows: (a) Development and approval of a strategy for under-graduate medical education reform - (US$183,847) and a strategy for post-graduate training programs - (US$342,961). (b) A Human Resources national strategy was developed with support from consultants - (US$143,358). (c) A scheme for rural areas through professional and financial rewards has not been prepared. (d) Effective mechanisms were developed and approved by MOH for the implementation of a certification process - (US$233,528). Around 12 000 health care professionals were involved in the certification process (95% were successful). IT hardware and software equipment was provided for the certification program - (US$135,638). (e) A labor adjustment policy was not prepared as it was seen as a difficult policy to implement.
	D2 – Health Workforce Education and Training (a) Development of clinical guidelines/protocols. (b) Improving the quality of under-graduate education and management of medical education programs and strengthening faculty for under-graduate education. (c) Curriculum development for under-graduate education and post-graduate training for physicians, feldshers, nurses and other PHC personnel. (d) Development of a certification program for medical personnel. (e) Review and propose a regulatory and legal framework for strengthening the Physicians' Association.	Considerable work has been undertaken under this sub-component, including: (a) Development of clinical guidelines and Clinical protocols - (US$15,798). (b) After the development of the under-graduate strategy, extensive support has been provided to the Medical University 30 faculty members were trained in Turkey - (US$52,627). A total of 3,711 staffs have received a variety of training various subjects – (US$172,960). (c) With support from a consultant a strategy for post-graduate training was developed to strengthen Post-graduate medical education. (d) The certification program was developed by the HPPU with support from consultants. 20 500 healthcare professionals were involved in the certification process.

Component	Planned outputs at Appraisal	Actual outputs/outcomes at ICR
		(e) To support improved policy-making on human resources, a strategy was developed to strengthen professional associations - (US$30,700).
Component E – Project Management and M&E (US$1.93 million)	Technical assistance: (a) Project Management Advisor. (b) Salaries of Component Coordinators. (c) WGs supplementary compensation. (d) Salaries of other PIU staff (7 project coordinators, two procurement officers, two disbursement officers, administrative assistant, translator and driver). (e) Project audits. (f) IT equipment for PIU staff. (g) Vehicle. (h) Training (i) Incremental operating costs	Project administration and coordination has been effective. (a) to (d): The sub-component financed the salaries of the following PIU staff: (i) Project Management Advisor, (ii) Component Coordinators for Quality Control, PHC, Inpatient Care, Human Resources, and Health Information System, (iii) supplementary compensation for members of working groups, (iv) Procurement Officers, (v) financial staff, (vi) administrative assistant, (vii) translator, and (viii) driver. (e) It also financed annual project audits, (f), (g), (h) and (i): It also financed equipment for the PIU, a vehicle, training, and incremental operating costs

Annex 3. Economic and Financial Analysis

1. The main text (Section 3.3) notes that the Project activities resulted in ***Modest*** efficiency gains, particularly as a result of reductions in redundant hospital capacity and related performance improvements. The activities undertaken as part of the major component - *Improving Delivery of Healthcare Services* (Component B) represented a major step in the progression away from the previous soviet service delivery model towards the current European and international norm, with their emphasis on a strong PHC health care model and a streamlined hospital sector. These reforms, which directly improve efficiency in the use of physical and human resources in the health sector, were intended also to contribute to the overall objective of better health outcomes.

2. The cost-benefit analysis presented in the PAD only accounted for the costs and benefits related to Component B. The total cost of the component, including contingencies, was estimated at appraisal to be US$73.55 million, to be disbursed over 7 years. It included the construction of three new hospitals, 30 PHC facilities and 14 village hospitals, together with associated equipment and training. In addition, the component included technical support for a mapping exercise and preparing a rationalization plan to cover existing health facilities throughout the country. The benefit stream expected to derive from these investments was based on several efficiency considerations tied to increased service delivery.

3. The main benefits expected were decreases in unnecessary hospital stays due to improved primary care in the selected districts, decreases in ALOS due to better equipped hospital facilities, savings in travel costs to Baku through decreased referrals of rural patients, , and a reduction in mortality rates due to improved service delivery. The PAD noted that the cost-benefit analysis served more as an attempt to estimate the dimension of the improvements in service delivery necessary to generate a positive NPV than as one of the criteria for Project approval.

4. The cost-benefit analysis for Component B estimated an IRR of 44 percent over a horizon of 20 years as the base case scenario. It was estimated that the IRR would decrease to 25 percent in the event the assumed benefits were reduced by 40 percent. When taking into account the entire costs of the Project (US$78.24 million), instead of the costs of Component B (US$63.35 million), the base case IRR was estimated to be 34 percent over a horizon of 20 years and 21 percent over a horizon of 10 years. Assuming the benefits of the supported interventions to be 40 percent lower, the IRR was expected to decrease to 20 percent over a horizon of 20 years and to 2 percent over a horizon of 10 years.

5. The NPV of the Project was also estimated applying a 10 percent discount rate and considering benefits and costs over 20 years as well as applying a 5 percent discount rate and considering benefits and costs over 10 years. These NPV estimates respectively were US$104.4 million and US$43.4 million. When assuming a reduction in benefits of 40 percent, the NPV over a horizon of 20 years was estimated at US$36.6 million and at minus US$5.3 million over a horizon of 10 years.

6. The Efficiency Section in this ICR (Section 3.3) takes into account several areas where the Project has had a positive impact on the efficiency of health services delivery. The available data, however, are not sufficient for the original economic analysis to be reproduced. New assumptions on benefits would have to be made for the analysis.

7. It is difficult moreover to delineate the impact on the Category B benefits of expenditures on Components A, C, D, and E, which comprise primarily technical assistance and training activities. They were designed to benefit the country's health sector as a whole (65 districts) rather than focused on the five districts included in the Project.

8. At this point we should refer to three major changes during implementation of the Project, which have impacted on its economic viability. First, under Component B only two of the three planned district hospitals were built, only eight of the planned 30 PHC facilities were constructed, and only four of the planned 14 village hospitals were built. Besides these facilities, the Project refurbished a Pre-natal center (as planned) and two training centers, which had not been planned. The actual total cost of Component B turned out to be US$65.35 million compared to US$61.45 million (net of contingencies) in the PAD. It follows that the unit costs of constructing these Component B facilities were higher than expected at appraisal. For example, each district hospital was projected to cost US$9.75 million but actually cost US$16.37 million (68 percent increase); each PHC was projected to cost US$77,000 but actually cost US$412,000 (435 percent increase; and each village hospital was projected to cost US$335,000 and actually cost US$1.2 million (258 percent increase).

9. If the economic benefits deriving from each facility were consistent with those assumed in the PAD, the IRR of Component B would be clearly less than the base case 44 percent (over 20 years) estimated in the PAD. On the other hand, the Component generated substantial efficiency gains that were not captured by the Project monitoring indicators, but nonetheless were important drivers of improved quality of services and health outcomes. For example: (i) ALOS were reduced from 15.1 in 2005 to 12.2 in 2011; (ii) and the number of secondary hospitals were reduced from 444 to 214 resulting in a 56 percent reduction of hospital beds; and (iii) bed occupancy increased from 25.6 percent in 2005 to 51.2 percent in 2011. These data suggest that Component B generated a satisfactory economic outcome, but again, the actual data are not sufficiently consistent to enable reproduction of the original economic analysis.

10. Second, an important reason for the increase in the unit costs of facilities in Component B were movements in the AZN/US$ exchange rate and domestic inflation, caused by an oil boom and a huge expansion in budgetary spending amid a situation that has been referred to as a modern case of the "Dutch disease". According to the IMF Article IV consultations for Azerbaijan, the exchange rate in 2005 when the project was appraised was AZN0.945 = US$1. The AZN appreciated by 18 percent to 0.802 by when most of the Project costs had been incurred. In terms of domestic inflation, the CPIs for the years 2005 to 2011 were 9.7, 8.4, 16.6, 20.8, 1.6, 5.7, and 7.9 percent, yielding an overall price increase of 94 percent from 2004 to 2011. The impacts of these price movements on Project costs were considerably greater than the 6 percent price contingency assumed at appraisal.

11. The third major change during implementation was the Government's decision to develop and implement rationalization plans (closing secondary health facilities and increasing the number of PHC units) in the entire country rather than just in the five pilot districts of the Project. This scaling-up became possible due to the mapping exercise and preparation of the national rationalization plan financed by the Project. Just as important, the breadth of technical and institutional support and training built into the Project enabled the Government to accelerate district rationalization plans to effect the efficiencies described in paragraph 9 above and Section 3.3. No funds from Component B for civil works or equipment were expended in non-Project districts.

12. Project outcomes suggest that due to the application of Components A, C, D, and E (and some technical support included in Component B) to the health system of the entire country, the economic impact of these interventions has been considerable.

13. The Project is expected to yield reasonable returns over the next few years. The operation and maintenance costs are not significantly high when compared with the public expenditures of the health sector in the country. Therefore, the recurrent cost impacts of the Project are not significant.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Andrina Ambrose-Gardiner	Senior Finance Officer	LOAG1	Disbursements
Enis Baris	Senior Public Health Specialist	ECSHD	Team Leader
Jennifer Manghinang	Program Assistant	ECSHD	Project processing
Ida Njeri Muhoho	Senior Finance Management Specialist	ECSHD	Financial Management
Hans Jurgen Gruss	Chief Counsel	ECSHD	Counsel
Antonio Lim	Operations Officer	ECSHD	Operations
Panagiota Panopoulou	Economist	ECSHD	Economics
Maria Gracheva	Operations Officer	ECSHD	Operations
Elvira Anadoluok	Operations Officer	ECSHD	Operations
Kaarl Shansing	Procurement Specialist (Consultant)	HDHNE	Procurement
Brian Yates	Environmental Specialist	ECSHD	Environment
Supervision/ICR			
Elvira Anadolu	Operations Officer	ECSHD	Operations
Johanne Angers	Senior Operations Officer	ECSH1	Operations
Carmen F. Laurente	Senior Program Assistant	ECSHD	Administration
Sujani Eli	Program Assistant	ECSHD	Administration
Enis Baris	Senior Public Health Spec.	MNSHH	Public Health
Yagut I. Ertenlice	Procurement Officer	ECSS2	Procurement
Deepal Fernando	Senior Procurement Specialist	ECSS2	Procurement
Alberto Gonima	Health Management Consultant	ECSDH	Health Management
Tamar Gotsadze	Health Specialist	ECSHD	Public Health
Sabina Guliyeva	Program Assistant	ECSHD	Operations
Gulana Hajiyeva	Environmental Specialist	ECSHD	Env. Management
Sabina Jafarova	Program Assistant	ECSHD	Operations
Tural Jamalov	Financial Management Specialist	ECSS2	Fin. Management
John Malmborg	Health Facilities Architect (Consultant)	ECSHD	Architect
Patricio Marquez	Lead Health Specialist	ECSHD	Public Health
Nino Moroshkina	Health Specialist	ECSHD	Public Health
Claudia Rokx	Lead Health Specialist	ECSHD	Public Health
Kaarl Shansing	Procurement Specialist (Consultant)	HDHNE	Procurement
Owen K. Smith	Economist	ECSH1	Economics
Rob Verhage	Pharmaceutical Procurement (Cons.)	ECSHD	Pharm. Procurement
Norpulat Yaniyarov	Financial Management Specialist	ECSS2	Fin. Management
Betty Hanan	Implementation Specialist (Consultant)	ECSHD	ICR author

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY05	10.58	50.19
FY06	41.70	256.80
Total:	**52.28**	**306.99**
Supervision/ICR		
FY06	0.00	28.89
FY07	32.97	129.99
FY08	26.28	106.74
FY09	25.87	133.45
FY10	31.84	169.62
FY11	35.48	219.50
FY12	32.11	114.62
FY13	30.00	94.12
FY14	20.21	117.21
Total:	**234.76**	**1,114.14**

Annex 5. Beneficiary Survey Results

Not applicable.

Annex 6. Stakeholder Workshop Report and Results

Not applicable.

Annex 7. Summary of Borrower's ICR and/or comments on Draft ICR

A. Summary of Borrower's ICR (Ministry of Health)

I. PROJECT START UP and CONTEXT AT APPRAISAL

1. The national health strategy paper of January 2006 created outstanding opportunities for the national level project and the Bank's involvement in the sector. The improved cooperation among the government organizations and the Bank also contributed to the launch of the Project.

2. Health status in Azerbaijan had been poor and deteriorating, as evidenced by a dramatic six year decline in Life Expectancy at birth, between 1990 and 2002, from an average of 70.9 to 65.1 years, one of the lowest in the region and 13 years lower than the EU average. This decline represented the highest downtrend in the world, excluding countries of Sub-Saharan Africa which lost up to three times as many years during the same period due to HIV/AIDS.

3. In this context, Azerbaijan was unlikely to meet the health-related MDGs. Despite concerns with the reliability, validity and the limited comparability of pre- and post-independence administrative data, there was evidence, backed up by survey data, that the main reasons behind this decline were high infant and under-five mortality rates (IMR: 81 and U5MR: 92 per 1,000 live births, both 16 times the EU average) and high maternal mortality ratio (MMR: 94/100,000 live births, ten times the EU average). The causes led to these problems were all easily avertable by effective interventions and could be largely prevented or effectively dealt with by a well-performing healthcare system.

4. Azerbaijan had the double burden of communicable and non-communicable diseases. The decline in life expectancy was also due to the persisting high premature adult mortality, which accounted for 68 percent of all deaths compared with the EU average of 51 percent. The main causes of morbidity and mortality included NCDs, accidents, injuries and poisoning as well as the recently (re)emerging communicable diseases, including STIs, tuberculosis, and HIV/AIDS, which also posed a considerable threat to the health of the population. As a result, the probability of dying between the ages 15 and 60 was 23.1 percent for Azeri males and 12.2 percent for females, twice as high, for both sexes, as the EU average.

5. Most determinants of health were related to behavior, lifestyle and environment. Patterns of, and trends in, mortality and morbidity in Azerbaijan are, in fact, entrenched in several determinants of health which were responsible for the deteriorating health outcomes.

6. However, the lack of equitable access to appropriate and quality care was an equally important determinant of poor health outcomes. The healthcare system in Azerbaijan had been persistently ineffective in delivering affordable, quality services equally accessible to all segments of the population. In fact, Azerbaijan lagged behind most post-transition countries not only in terms of health status, but also in terms of the inadequacy of the existing healthcare system to meet healthcare needs and respond to epidemiologic and demographic challenges. For example, only half of the population utilized health services when experiencing an illness, indicating that people either could not, or would not pay for what was often perceived as poor-quality healthcare. According to the 2002 Household Budget Survey, one in three households declared that they could not use health services because of their inability to pay.

7. There was a general consensus that the healthcare system in Azerbaijan remains largely unreformed, and continued to function according to the old Soviet centralized norms both in terms of financing and allocation of human and physical resources. Some limited attempts had been made to enhance the primary health care level in Azerbaijan, but that had not gone beyond a few pilot initiatives spearheaded by the Bank and the donor community. The main reasons were: (i) excessive but collapsing infrastructure; (ii) outdated or missing equipment; and (iii) inadequate mix and distribution of skilled and competent staff, particularly with regard to providing comprehensive and continuous care with an array of services, mainly preventive in nature, thereby limiting the high rate of referrals to district and republican hospitals. Indeed, while in theory, Azerbaijan had a very high bed-to-population ratio (7.7 per 1,000 population), almost twice as high as the EU average of 4.1 beds. Yet, the average admission and occupancy rates were low, 4.7 and 25.6 percent, respectively. Meanwhile the ALOS was high (15.3 days) by EU standards (EU averages being 18.1 percent, 77.9 percent and 7.1 days, respectively).

8. The health system also remained severely under-funded, and its resources were poorly pooled and inequitably allocated. Despite several attempts to increase the health budget, public resources invested in health represented approximately 20 percent of total health expenditures, with the remaining 80 percent being OOP, mostly informal. With government health spending being roughly 1 percent of GDP for 2005 - as compared with an average of 4 percent of GDP for the countries of the ECA region - and a mandate to provide practically all health care services for free, there was a general agreement that the health care system was in need of additional public funds, as well as a revision of the package of health care services funded by general tax revenues. In per capita terms, public expenditures on health were about US$20. Inevitably, this led to OOP expenditures of about US$96 per capita, quite a high figure in a country where about 30 percent of the population lived below the poverty line.

9. The governance structure of the health sector was at odds with the macroeconomic and sectoral realities in the country. MOH's actual role and capacity to govern the system, to make policies, set standards, regulate and control overall quality and gather the intelligence needed to monitor public heath was limited. The ministry did not, for example, have a unit tasked with policymaking, nor did it have departments for monitoring and evaluation (M&E), human resources or long-term planning. Indeed, MOH controlled only about 25 percent of public expenditures on health which covered its central administration and the republican hospitals.

10. As a result, the system suffered from the following shortcomings:

- a legal, organizational and regulatory platform that was not conducive to effective system stewardship;
- fragmented accountability for technical, administrative and financial matters, leading to inefficient allocation of human and financial resources;
- excessive hospital and specialized care facilities, albeit mostly in a dire need for renovation, refurbishment and upgrading as a result of lack of capital investment and maintenance;
- poorly funded and managed, and highly fragmented, primary healthcare services obsolete diagnostic and laboratory equipment and shortage of supplies;
- a de-motivated health workforce that relies on informal payments to cope with low wages and a practice environment devoid of incentives to provide appropriate care; and,

- major inequalities in health and healthcare as a result of very low public outlays, coupled with increasingly high levels of out-of-pocket payments.

1.2 Long term project Objectives

11. Dealing effectively with some of the key issues plaguing the health sector in Azerbaijan was central to the goals of the government and the Bank. The State Program on Poverty Reduction and Sustainable Development (SPPRED) focused on the need to improve the quality of, and equity in access to, health and education, a goal central to the Project. The SPPRED was candid about the large burden of disease in Azerbaijan, the deterioration in quality of care and the need to strengthen services to the population. Similarly, the Bank's FY03-05 CAS (Report No. 25790-AZ approved by the Board on April 29, 2003) also underlined the importance of improving the quality, efficiency and coverage of health services for better health outcomes.

12. The project aimed to help the Government to initiate and pilot a gradual but a comprehensive reform of the healthcare system.

1.3. Short Term Project Objectives

13. The development objective of the proposed project was to improve overall health system stewardship and financing, and enhance equitable access to, and technical and perceived quality of essential healthcare services, in the selected districts in a fiscally responsible and sustainable manner with a view to improving health outcomes. The Project aimed at: (i) reforming the overall system governance by increasing MOH's policy, planning, management and M&E capacity; (ii) improving allocative and technical efficiency by developing new models of resource allocation, pooling, and provider payment; and (iii) enhancing equity by designing a fiscally sustainable package of essential healthcare services for free delivery to the poor.

1.4. Project Components and Sub-components

14. **Component A: Building MOH Capacity for Stewardship.** This component assisted MOH to build its capacity in policy making, planning and regulation to design and introduce mechanisms, instruments and tools, training MOH staff and upgrading MOH's technological and physical infrastructure. To this end, support was provided under five sub-components to: (i) develop a health policy framework, and review and reorganize MOH functional and administrative structures, including establishing a Health Policy and Planning Unit (HPPU) to strengthen MOH capacity to lead health and healthcare policy analysis and development; (ii) develop a national drug policy and strengthen the capacity of the MOH Pharmaceuticals and Medical Devices Unit to develop and monitor the effective management of this policy, develop the necessary legislative and regulatory framework, as well as procedures and tools for rational drug use; (iii) support the development of an accreditation and licensing scheme for both public and private health facilities and set-up a mechanism for quality control and assurance of health care services; (iv) strengthen the health information system to improve MOH capacity to monitor population health and health sector performance; and (v) improve MOH technical and information dissemination capacity for dealing effectively with emerging diseases, such as Avian Influenza in humans.

15. **Component B: Improving Delivery of Healthcare Services.** This component included three sub-components which aimed to improve the appropriateness, quality, and technical and allocative efficiency of health care services in five pilot districts of Apsheron, Agdash, Ismailli, Sheki and Gakh by: (i) upgrading/renovation/construction of primary health care facilities at the sub-district level and construction of three district hospitals in Agdash, Ismailli and Sheki in lieu of the old hospitals which

were to be decommissioned; (ii) strengthening managerial and clinical skills of the healthcare workers; (iii) introducing new planning and management methods and tools; and (iv) improving coordination and strengthening system hierarchy between the primary and secondary levels of health care. This involved an improved referral system within each district and with the national level, with an aim to reduce the number of referrals to Baku.

16. **Component C: Ensuring Sustainable Health Financing and Resource Allocation.** This component supported health care financing reform aiming at gradually introducing universal risk protection against out-of-pocket health expenditures and moving towards insurance principles through improved revenue mobilization, pooling and allocation of health sector resources and purchasing of health care services. This component included two sub-components which addressed: (i) the need to strengthen planning, implementation and monitoring mechanisms for effective health care financing policy; (ii) the need to define a package of publicly financed health care services and design new output-based budgeting and funding allocation mechanisms at national, district and facility level; and (iii) the need to design and assist in the establishment of a health fund that will act as a single pool for health sector funds and a single payer/purchaser of health care services.

17. **Component D: Human Resources Development.** This component included two sub-components which aimed to address the long term human resource needs of the health sector by: (i) developing a labor adjustment policy - including provisions for a more dynamic retirement and compensation policy - and a detailed strategy/plan for the health sector, based on review of existing capacity and programs, which outlined the human resources needs, in terms of skills and competence mix and equitable distribution, and proposed solutions regarding which areas of medical specialty needed to be emphasized and/or curtailed; (ii) reviewing the current reform initiatives regarding under-graduate medical education, specialty training and post-graduate training programs, with a view to improving the quality of education. Support was provided to develop clinical guidelines/protocols, improve management of medical education programs, strengthen faculty for undergraduate education, and develop new curriculum for under-graduate education and post-graduate training of physicians, feldshers, nurses and other PHC personnel. This component also supported the development of a certification program for medical personnel and the strengthening of Physicians' Associations in Azerbaijan.

18. **Component E: Project management, monitoring and evaluation.** This component ensured effective administration and implementation of the Project by supporting the operations of a PIU in the MOH which was responsible for the day-to-day project implementation, including coordinating with relevant stakeholders and donors, as well as for procurement, disbursement, financial management, coordination of training events, and for ensuring effective monitoring and evaluation of the outcomes of the Project.

19. The Project was implemented by MoH. However, project activities were also supported by three international agencies, WHO, UNICEF and USAID, which were conducting projects in the sector.

II. PROJECT ACHİEVEMENTS

20. During the Project period, new health care facilities were constructed and put into operation, reform policies were developed and implemented on health care service delivery mechanisms, improving health policy, applying information technologies in health care, financing health care and developing human resource as well as organizing medical education at a level to meet the current demands. Moreover, trainings were provided in and outside the country for the purposes of

improving knowledge and skills of health care professionals. The Project conducted activities under the following components:

2.1. **Component A – Building MOH capacity for stewardship**:

2.1.1. **A1 - Building capacity for health policy**: The Project has been successful in supporting MOH in its health system stewardship capacity. It achieved: (i) development of a Health Strategy for the period 2007-2012 with assistance from WHO, which was updated to cover the period up to 2015. In addition, the health chapter of the Development Concept – Azerbaijan 2020 was approved in December 2012; (ii) development of a health system performance framework and based on the M&E framework, two Health System Performance Assessments (HSPA) have been prepared to guide policy making, planning and regulation; (iii) MOH's functional and administrative structure has been reviewed and changes were made; (iv) the establishment of the HPPU in 2009, which played an important role in the certification of health professionals' process; (v) upgrading major legal and regulatory documents facilitating the operation of MoH and health care system; (vi) public information campaigns through a number of workshops in the pilot and neighboring districts in the context of the master plan, its methodology and proposals before the master plan was finalized; and (vii) identification of the risk factors of NCDs and CDs which enabled MoH to develop national strategies for NCD and CD management.

2.1.2. **A2 - Strengthening pharmaceuticals policy and management**: Pharmaceutical policy and management have been strengthened with support from the Project through achieving: (i) development of a number of strategic reform policies, such as: (a) essential drug list, (b) National Drug Policy, and (c) Drug Formulary; (ii) trainings for the Drug Analytical and Expertise Center (DAEC) and the Innovation & Supply Center (ISC) of MoH and provision of equipment (including 2 pieces of bio-equivalence lab equipment, drug quality control lab equipment and IT equipment); (iii) analyses of international and local practices and implementation of a methodology recommended for drug quantification; (iv) trainings on pharmaco-vigilence and rational drug use; and (v) development of standard operating procedures to improve the centralized procurement of drugs and equipment for the health care organizations under MoH's direct supervision.

2.1.3. **A3 - Quality Assurance and Accreditation of Health Facilities**: Quality assurance and accreditation has been strengthened through achieving: (i) development of a licensing system for private medical facilities; and (ii) development of a number of legislative documents to improve the quality of health care services in the country.

2.1.4. **A4 - Strengthening the Health Information System**: The HIS was strengthened significantly by: (i) the development and piloting of a HMIS at the hospital level, completion of a number of system developments (e.g. Patient Discharge Form AZ#66 (Form 66)), which allow the government to monitor trends, compare efficiency and quality between facilities and regions; (ii) development of a Unified Health Information System Road Map to promote the future integration of health information systems and strategic development of HIS in the country; and (iii) preparation of several modules to support the operation of various priority areas of MoH, including Form 66, HR, Certification etc.

2.1.5. **A5 - Improving MOH response capacity for emerging diseases**: MOH's response capacity for emerging diseases has been improved by achieving: (i) development of the national strategy on CD, including implementation of the international Health Regulations as well as standard operating procedures (SOP) to complement the laboratory manual on the 29 priority CDs; (ii) introduction of an electronic version of case investigation forms supported by GIS for CD; (iii) preparation of a national

strategy for the prevention and control of NCDs through strengthened data collection and assessment of NCDs risk factors; and (iv) establishment of the Public Relations Unit (5 staff).

2.2. **Component B – Improving Delivery of Health care Services**

2.2.1. **B1 - Strengthening District & National Level Health System**: District and National level have been strengthened through achieving: (i) development and approval of the Master Plan to rationalize health infrastructure and human resources. Its implementation started in four out of the 5 project districts (Absheron, Agdash, Gakh, Ismayili, and Sheki) and the methodology was used for optimization of health facilities in the entire country; (ii) development of the CD strategy and SOPs for lab operations; (iii) training of trainers (TOT) (23 persons) on epidemiology and guidelines for the control over the selected CDs; (iv) preparation of the investment plans as part of the master plan for PHC facilities and other health facilities; (v) trainings for the health care professionals of the selected districts on a wide range of topics; and (vi) development of the National Health Care Waste Management Plan.

2.2.2. **B2 Strengthening PHC Services.** This sub-component provided support to strengthen PHC services through achieving: (i) a needs assessment of the selected facilities, including civil works, equipment and training of staff as part of the master plan and architectural design; (ii) construction of two hospitals, 4 village hospitals and 8 PHCs and renovation of the Perinatal Hospital in Sheki; (iii) development of the business plans for the two newly-constructed hospitals; (iv) training of 10 physicians and 10 nurses TOT on family practice; and (v) refurbishments of two training centers/equipment and materials – Training Center in Baku and Sheki Training Center.

2.2.3. **B3 Upgrading Impatient Care Services in the pilot districts.** The sub-component has achieved its goals through: (i) The construction of two 100-bed hospitals in Aghdash and Sheki), four village hospitals and 8 PHC facilities and renovation of the Prenatal Hospital in Sheki; (ii) three weeks training for hospital managers; (iii) development of the detailed architectural designs and equipment plans for the selected hospitals; (iv) preparation of the standards and norms for the construction of hospitals as part of the master plan and the architectural designs; and (v) trainings for medical staff, including TOT and study tours to Turkey, Israel, Poland, England and Lithuania.

2.3. **Component C - Ensuring Sustainable Health Financing and Resource Allocation**

2.3.1. **C1 Designing Options for Sustainable Financing.** This sub-component partially reached its goals through achieving: (i) preparation of three year projections of the health sector revenues and expenditures, the 2008-2013 State Program for Vertical Programs, and annual five-year investment plan covering 30% of expenditures; (ii) development of the legislations in support of the implementation of new provider mechanisms in the hospital sector; and (iii) provision of all the selected hospitals with corresponding software to implement Form AZS-66.

2.3.2. **C2 Improving Allocative Efficiency in Health Care.** This component did not achieve most of its objectives since a publicly-financed package of essential health services was not developed, Health Insurance Fund did not become operational. However: (i) extensive work was conducted to review and revise hospital payment mechanisms; (ii) 21 DRGs were established based on cost accounting analysis and date on discharged patients collected in 10 city hospitals. However, the system has not been piloted; and (iii) a total of 448 health professionals were trained on AZ 66, DRGs, national accounting standards and ICD.

2.4. **Component D – Human Resources Development**

2.4.1. **D1 Health Workforce Policy and Planning.** The sub-component successfully achieved: (i) development and approval of a strategy for under-graduate medical education reform and a strategy for post-graduate training programs; (ii) development of the National Strategy for Human Resources in Health; (iii) development and approval of effective mechanisms for the implementation of a certification process; and (iv) involvement of around 12,000 health care professionals in the certification process (95% were successful).

2.4.2. **D2 Health Workforce Education and Training** - Considerable work has been undertaken under this sub-component, including: (i) development of clinical guidelines/protocols; (ii) training of faculty members of Azerbaijan Medical University; (iii) development of a strategy for post-graduate education; (iv) certification program for health care professionals; and (v) strategy for strengthening professional associations.

III. PROJECT IMPACT

21. The Project had a significant impact in the health sector reform in Azerbaijan, particularly on the following directions: (i) promoting health care reforms through developing policy documents on health care reform and applying information technologies in health care; (ii) improving access and availability of health care services through infrastructure development; and (iii) building capacity through organizing trainings for health care professionals.

Promoting health care reforms in Azerbaijan

22. The Project played an outstanding role in creating necessary databases, performing analyses and developing assessments based on this information, as well
as proposing alternatives to conduct reforms in the health care sector of the country. HSRP produced tens of monitoring and assessment documents, including more than 20 pieces of reform packages. These documents mainly cover the areas of building capacity for stewardship, improving health care service delivery, ensuring sustainable health financing and resource allocation and supporting human resource development.

23. **Building capacity for stewardship and strengthening health policy**: Effective health system stewardship and health policy require creating database, analyzing and assessing the information on this area. To assess the health system performance, HSRP developed a monitoring and evaluation framework composed of 140 indicators and developed "Azerbaijan Health System Performance Assessment Reports" covering the results of 2009 and 2011 (based on 45 and 13 indicators respectively). Moreover, HSRP financed a nation-wide survey on the "Risk Factors of the Non-Communicable Diseases in Azerbaijan" and prepare an assessment report thereon, which aimed to monitor the health status of the population, specifically to identify the risk factors of NCDs.

24. Furthermore, in order to improve the reliability and frequency of data on health, HSRP provided technical support on electronic collection and analyses of the data from the inpatient facilities of the country based on patient discharge forms. Consequently, it became possible to electronically collect and analyze the data on 700.000 cases electronically. This database enabled to assess the quality of health care services, including the performance of inpatient health care facilities and develop health care policy.

25. Last but not least, the "Roadmap on a Developing Unified Health Information System in Azerbaijan" was prepared to improve health information database and effective health information

exchange. The recommendations of the Roadmap were incorporated in the State Program of MoH on Developing Health Information and Communication Technologies as well as MoH's long-term development objectives. Respective software programs were developed to enhance the information database of the health care sector, collect and transmit information electronically as well as perform electronic services, and the information and communication infrastructure and supply of the pilot and other districts as well as MoH was strengthened.

26. Strengthening the normative and legislative basis of MoH is another important area addressed by HSRP. Thus, the Project supported the improvement and development of more than 100 pieces of normative and legislative documents governing the health care sector. Moreover, the project developed "National Drug Policy", "Essential Drug List", "National Drug Formulary" for the purposes of improving drug supply and drug policy, and prepared "Health Care Quality Control and Accreditation" for the purposes of implementing quality standards in the health care sector of the country.

27. At the same time, the Project established and facilitated the operations of the Health Policy and Planning Unit, Public Relation Unit and IT Support Group, which are closely supporting MoH in developing and implementing health policy.

28. **Improving health service delivery:** To strengthen the delivery of primary and secondary health care services the "National Master Plan on Health Workforce and Health Network Rationalization" (National Master Plan) was developed and implemented not only in the pilot districts, but also across the country. The implementation of the new methodology based on the Geographical Information System (GIS) enabled to determine the number and location of the primary and secondary health care facilities in the regions based on the local demands, optimize the network of health care facilities and adjust to the international experience, strengthen primary health care services and ensure a more effective distribution of health care workforce. According to the analyses on the implementation plans of the National Master Plan, the number of primary health care facilities increased by 44% and the population access to primary health care services increased compared to the beginning of the Project.

29. Additionally, training materials and curriculum on health care management were developed to improve the knowledge and skills of health care administrators and non-medical staff. The training focused on progressive international management practices and some fundamental areas of the health care sector such as delivering health care services based on effective, quality and evidence-based medicine, quality control, effective health care financing mechanisms, health insurance etc.

30. **Health care financing**: HSRP conducted activities to develop the necessary reform strategies and normative and legislative documents to reform the health care financing in Azerbaijan. That is, a program and action plan was developed for the purposes of implementing the National Health Accounts in Azerbaijan and the “Action Plan for the National Concept on Reforming Health Care Financing System and Implementation of the Mandatory Health Insurance in Azerbaijan”. The Action Plan covers issues such as establishing a single body to reimburse health care services, developing the basic benefit package, mobilizing resources, making the budget, reimbursing health care providers for the services delivered, implementing per capita financing in health care and implementing the new financing mechanisms in pilot areas and across the country.

31. Additionally, the existing normative and legislative documents regulating the health care financing in Azerbaijan were comprehensively reviewed and the draft legislative acts required for the implementation of the new financing mechanisms in Azerbaijan in future and the amendments to the existing legislative documents were developed.

32. **Developing human resources in health care**: To improve human resource policy and planning, the Project developed a policy document namely "Health Workforce Planning and Policy" (methodology and assessment) on determining the long-term needs of the country for health workforce and its planning based on the equal distribution methodology on medical specialties. Based on this policy document, MOH introduced Order#151 on the "Thresholds for the Provision of Health Workforce in Azerbaijan" dated 31.10.2008.

33. Another important area that HSRP supported for the purposes of strengthening human resources in health, was to improve the quality of medical education, align the medical education curricula to international standards, establish close relations between the theoretical training and practical application and improve teaching methods in medical education. Thus, to improve under-graduate medical education in Azerbaijan, a policy document was prepared, the curricula used in the under-graduate medical education were reviewed, recommendations on improving the curricula and implementation of an integrated curriculum system at the Medical University were developed, and preparation of a long-term implementation plan started on this direction.

34. At the same time, HSRP provided technical support to the introduction of the residency program to develop and improve post-graduate medical education. That is, the state education standards for the residency program were developed and the process of aligning the residency curricula to international standards started. Moreover, the Project developed the implementation mechanisms of the certification process as well as the legislative documents regulating these processes, the exam questions were prepared for the certification of health professionals, the electronic portal of the Certification Commission was developed, training materials were prepared to improve the awareness among health professionals on certification, and provided expertise in facilitating the operations of the Certification Commission.

Improving access to and availability of health care services

35. HSRP financed the construction and renovation of health care facilities in the pilot districts as well as supplying them with necessary medical equipment to improve primary and secondary health care services. Constructed in accordance to the modern standards, these facilities created a new health care facility model in Azerbaijan. Two 100-bed surgery corps of Sheki and Aghdash central district hospitals were built and put into operation, and the delivery department, sanitary-epidemiology center and blood bank in Sheki region and the sanitary-epidemiology center in Gakh region were renovated.

36. To improve the population access to health care services in remote areas, 4 village hospitals and 8 primary health care facilities were built and put into operation in Aghdash, Ismayilli, Gakh and Sheki. These health care facilities were supplied with the medical and other equipment meeting the current demands. At present, these facilities are providing health care services to approximately 46,247 rural people in the respective areas.

Building capacity of health care professionals

37. HSRP provided trainings for the medical and non-medical professionals both from the pilot districts and other regions as well as MOH staff. The training was to facilitate the development and implementation of health care reforms, exploring international experience, learning the modern treatment methods, ensuring the application of progressive technologies and overall managing health care system more effectively. HSRP can be considered as one of the most successful projects in the country in terms of the number of professionals (more than 7,000 persons) involved in the trainings.

These trainings are of great importance from the view point of building local capacity in health and improving the knowledge and skills of health care professionals.

IV. ACTIONS TAKEN BY THE WORLD BANK, GOVERNMENT AND TECHNICAL ASSISTANCE

38. There was a direct supervision and strong support by the Bank team to the Project with close involvement in its design and implementation. The Bank was particularly supportive in helping to introduce reform initiatives, which were new for the country and therefore the country had little experience with reforms. The key decision made by the Bank to adapt the Project activities to the country's needs facilitated the effective identification and implementation of activities. However, considering that some activities such as health financing reforms, were not successfully launched, the Bank could have taken the role of advocacy as the biggest funding organization in the health care sector of the country and could have promoted policy dialogue of key decision makers for policy solutions to the critical pending issues.

39. The GoA, particularly MOH, MOF and the Ministry of Economy and Industry (previously, Ministry of Economic Development) demonstrated outstanding support to Project implementation. As the implementing agency, MOH maintained effective partnership with the Project throughout its life and went beyond the Project areas and introduced nation-wide reforms based on the products prepared under the Project. Compared to other initiatives, GoA demonstrated a very flexible approach towards the Project, which helped the Project team to be more flexible in design and implementation. However, some of the Project activities, particularly health financing reforms, were pending and waiting for the decision by the GoA, which was not made during the Project period.

V. LESSONS LEARNED

40. Project coordination and management was Satisfactory in terms of identifying the country's needs for health reforms, implementing reform initiatives, building and sustaining good relationships with all the stakeholders and keeping key decision makers informed about Project activities. Despite focusing on the selected districts, many activities conducted under the Project went beyond the selected areas and became national initiatives. Project activities were adapted to the changing priorities of MOH effectively and reflected the existing needs of the country. However, the Project management and coordination could have been more effective if MOH professionals were more active participants of the activities and the PIU was more integrated to MOH.

6. SUSTAINABILITY OF PROJECT INVESTMENTS

41. The activities described above are of great importance from the view point of accomplishing the goals and objectives of the Project, as well as the successful implementation of reforms. The reform strategies developed, infrastructure created and health care professionals trained have provided a significant input in the health care sector of the country and played an important role in developing the health system and the application of the international experience in the country. The strong basis created under the Project and knowledge will serve to further develop the health care sector of Azerbaijan and improve the population health.

B. Comments on Draft ICR (Ministry of Health)

42. The Bank provided Azeri and English versions of the draft ICR for GoA comments on April 28, 2014. By the time of completion of this ICR, no comments had been received.

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

1. During discussion with the ICR mission, WHO expressed its appreciation for the close collaboration the Bank team has maintained with its staff and consultants. WHO recognized the role the Project played in the development of the sector and the importance of the areas that it addressed. While the technical assistance and training provided by WHO were important in building institutional capacity for the development of the health strategy, WHO acknowledged that the integration of the various pieces of analytical work were part of a bigger picture in the sector.

2. UNICEF also expressed its appreciation for the collaboration the Bank team has maintained with its staff. UNICEF recognized the importance of working together towards achieving the same goals of supporting the sector and the comparative advantages each of the organizations had in different areas. UNICEF was particularly encouraged by the strong collaboration during the development of clinical protocols and guidelines.

3. Unfortunately, the ICR mission did not meet with USAID as they are no longer active in the health sector and the staff remaining in the USAID office in Baku had no knowledge of activities financed by USAID in the health sector.

Annex 9. List of Supporting Documents

1. World Bank, 2005, Project Concept Note (PCN)
2. World Bank, 2005, Minutes of PCN Review Meeting
3. World Bank, 2005, Peer Review Comments on PCN
4. World Bank, 2005, Project Information Document
5. World Bank, 2005, Health Sector Review
6. World Bank, 2006, Quality Enhancement Review
7. World Bank, 2006, Minutes of Negotiations
8. World Bank, 2006, Project Appraisal Document
9. World Bank, 2006, Financing Agreement
10. World Bank, 2010, Background Sector Note
11. World Bank, 2010, Health Financing Reform Status and Recommendations
12. World Bank, 2012, Draft Public Expenditure Review
13. World Bank, 2013, Draft Health Policy Note
14. World Bank, 2012, Draft Project Paper for Additional Financing
15. World Bank, 2012-2013 – Amendments to Credit Agreements
16. World Bank, 2005-2013 Aide Memoires and Back-to-Office Reports
17. World Bank, 2005 – 2013 management and other important letters and memoranda
18. World Bank, 2007 - 2013 Implementation Status and Results Reports (ISRs)
19. Ministry of Health, 2005, Environmental Management Plan
20. Project Implementation Unit, 2006 – 2013 – Summary Management Reports
21. Borrowers Contribution to ICR – February 2013 (to come)
22. Ministry of Health, Health System Performance Assessment (2009-2011)


AZERBAIJAN
GEORGIA
RUSSIAN FEDERATION
ARMENIA
ISLAMIC REPUBLIC OF IRAN
TURKEY
Caspian Sea
Lake Sevan
Mingechevir Reservoir
Greater Caucasus Mountains
Lesser Caucasus Mountains
Kura Lowland
Lenkoran Lowland
BAKU
NAKHCHIVAN
Balaken
Zagatala
Gakh
Sheki
Oghuz
Gabala
Ismailli
Shamakhy
Khachmaz
Gusar
Guba
Devechi
Siyazan
Khizi
Sumgayit
Khyrdalan
Maraza
Akhsu
Udjar
Goychay
Agdash
Yevlach
Mingechevir
Barda
Tartar
Kyurdamir
Zardab
Agdzhebedi
Agdam
Khodzhaly
Khodzhaveno
Beilagan
Imishli
Saatly
Sabirabad
Gazi-Mammad
Ali Bayramli
Salyan
Bilasuvar
Neftchala
Jalilabad
Masally
Yardymly
Lerik
Lenkoran
Astara
Shusha
Lachin
Fizuli
Gubadly
Dzebrail
Zangilan
Shakhbuz
Sharur
Sadarak
Babek
Dzhulfa
Ordubad
Kelbadzhar
Ganja
Nabiagaly
Shemkir
Gedabay
Dashkesan
Khanlar
Geranboy
Tovuz
Agstafa
Gazakh
To Tbilisi
To Vanadzor
To Yerevan
To Sevan
To Salmas
To Tabriz
To Makhachkala
To Rasht
Kura
Araz
0 10 20 30 40 50 Kilometers
0 10 20 30 40 50 Miles
45°E
46°E
47°E
48°E
49°E
50°E
51°E
41°N
40°N
39°N
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AZERBAIJAN
RAYON CAPITALS
CAPITAL OF AUTONOMOUS REPUBLIC
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
RAYON BOUNDARIES
INTERNATIONAL BOUNDARIES
SEPTEMBER 2004
IBRD 33365