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FAMILY PLANNING SITUATION ANALYSIS 2007

The Europe and Eurasia Regional Family Planning Activity

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ACRONYMS

ACQUIRE	Access, Quality, and Use in Reproductive Health Project (USAID)
BCC	Behavior change communication
CME	Continuing medical education
COPE	Client-oriented provider-efficient
DFID	Department for International Development (UK)
DHS	Demographic and Health Hurvey
EDL	Essential drug list
E&E	Europe and Eurasia
FAP	*Feldsher akusher* (midwife) point
FP	Family planning
GDP	Gross domestic product
IDP	Internally displaced person
IMC	International Medical Corps
IUD	Intrauterine device (contraceptive)
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
LMIS	Logistics management information system
MOH	Ministry of Health
NIAMT	National Institute for Advanced Medical Training
NRHO	National Reproductive Health Office
ob/gyn	Obstetrician/gynecologist
OC	Oral contraceptive
PHC	Primary health care
RH/FP	Reproductive health/family planning
RHS	Reproductive health survey
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WRA	Women of reproductive age (15–49 years)

SUMMARY

Despite a strong recovery after an initial dramatic economic decline following the breakup of the Soviet Union, Azerbaijan still remains among the lowest income countries in the Europe and Eurasia (E&E) region. The Ministry of Health (MOH) has limited current capacity to oversee the health system and implement necessary reforms. Use of modern contraception is very low (15.6 percent), while the rate of abortion (2.3 per woman) and its complications are among the highest in the E&E region.

TEN BEST FAMILY PLANNING PRACTICES IN THE EE/EA REGION

To better understand the situation in Azerbaijan, the Activity reviewed progress against ten regional best family planning policy and program practices. This list is based on the 2005 Senlet and Kantner report, "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region," a recent literature review on global best family planning practices and programs, and field interviews in selected countries participating in USAID's Europe and Eurasia Regional Family Planning Activity program. These best practices include:

1. **Liberalized provision of FP services.** National health regulations require that family planning counseling and services are readily available through a range of health professionals, including not only obstetricians and gynecologists, but also family doctors, general practitioners, pediatricians and nurse/midwives.
2. **Family planning counseling, services, and contraceptives are part of the Basic Health Benefit Package**. At the primary health care level contraceptives are provided to all women, regardless of ability-to-pay. The country's Essential Drug List includes a mix of different types of contraceptives.
3. **Up-to-date and evidence-based policies, regulations, guidelines, standards and supportive supervision systems are in place to ensure the quality of family planning services at all levels of health care:**
    a) **Service providers –** A **c**ompetency-based national qualification system is in place that allows health professionals to provide quality family planning counseling and services;
    b) **Up-to-date national regulations set minimum standards** for health facilities, equipment, commodities and infection prevention;
    c) **National guidelines and protocols for family planning counseling and service delivery** are evidence-based, widely available and updated regularly;
    d) **Effective quality assurance and supportive supervision systems** are in place to ensure the quality of family planning services and strengthen provider performance and support, especially at the primary health care level;
    e) **National health protocols** require that postpartum and post-abortion women are offered family planning counseling, methods and services**;**
    f) **Breastfeeding and the lactational amenorrhea method (LAM)** are promoted as family planning methods.

4. **A broad range of family planning methods are available, accessible, affordable, and acceptable** in both rural and urban areas.
5. **Special programs are in place that are designed to meet the needs of vulnerable target groups**, such as adolescents, internally displaced persons (IDPs), new urban migrants, prostitutes, and the very poor.
6. **Family Planning is part of pre- and in-service training programs for health care providers.** This includes the pre-service training programs in medical universities and technical schools for nurses, as well as in-service training for continuing medical education for doctors and in-service training for re-licensing health professionals, including midwives and nurses.
7. **Contraceptive security is ensured through adequate planning within the government,** guided by a well-functioning Logistics Management Information System (LMIS) that enables targeting of subsidized contraceptives and efficient supply chain management of all contraceptive commodities throughout the country.
8. **Adoption of a "culture" that promotes family planning counseling,** where providers and clients engage in frank and regular conversation about sensitive reproductive health issues and family planning and appropriate services are offered.
9. **Family planning is actively promoted through social marketing and behavior change/social mobilization efforts**, including wide distribution of quality informational materials for clients and "job aids" for providers.
10. **A well-functioning national health management information system** collects, analyses and uses FP data to monitor progress and evaluate and improve program effectiveness.

Azerbaijan has made substantial progress in strengthening family planning programs in several key areas. At the same time, there is room for further improvement. The following table describes Azerbaijan's progress against the ten family planning best practices described above.

Summary Table of the Azerbaijan Situation Analysis

Best Practices	Existing Situation	Needs Improvement
#1: Liberalized provision of FP services	• Unknown	• Most clinical methods restricted to ob/gyn only. Midwives allowed to counsel only. • Providers not compensated for FP services
#2: Family planning counseling, services and contraceptives are part of the Basic Health Benefit Package	• Official policy is that FP services are free • Free contraceptives are available at UNFPA pilot districts and facilities	• Contraceptives unavailable at most health centers, so clients must buy at private outlets. • FP commodities not included on EDL.
#3: Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive	• National FP guidelines under development	• Currently there is no strategy or plan for nationwide implementation, promotion, or enforcement of new guidelines

supervision system are in place to ensure quality of FP services at all levels of health care		and protocols once developed. • No QA or supervision system except at ACQUIRE-funded sites • Poor compliance with postpartum/postabortion FP counseling
#4: A broad range of FP methods are available, accessible, affordable, and acceptable in both rural and urban areas	• Most contraceptives are available in urban private pharmacies for paying clients	• Medical barriers for most methods • Cost of lab tests deters low-income clients • Lack of awareness of LAM as a FP method
#5: Special programs designed to meet the needs of vulnerable target groups are in place	• "Family Life" course designed and implemented for grades 8-10 • UNFPA program for youth on IEC	• No programs for other vulnerable populations, including the poorest of the poor
#6: FP is part of the pre- and in-service training program for health care providers	• 2 curriculum hours in pre-service medical education program for FP	• Pre-service and in-service training not evidence- or competency-based • Continuous medical education in FP does not exist
#7: Contraceptive security is ensured through adequate planning within the government	• Unknown	• Lack of government planning or financing for FP commodities • LMIS not adequate to forecast contraceptive use, conduct trend analyses or determine future needs
#8: Adoption of a "culture" that promotes family planning counseling	• Unknown	• FP information and counseling provided "on request" only. • Cost of providing FP services not reimbursed to providers
#9: FP is actively promoted through social marketing and behavior change/social mobilization efforts	• FP promoted in ACQUIRE project districts through a variety of means	• No plan to expand FP BCC activities outside of pilot districts, and no funding for current activities beyond end of project
#10: A well functioning National Health Management Information System is in place	• USAID supports 3 districts to improve hospital-based MIS, which the MOH wants to expand.	• Available data not used to improve or expand FP services

I. PURPOSE AND METHODOLOGY

PURPOSE

This review of the FP situation in Azerbaijan was conducted under USAID's Europe and Eurasia (E&E) Regional Family Planning Activity. The Activity is a regional effort with the goal to leverage best practices in family planning to accelerate program implementation across the region and, ultimately, to increase modern contraceptive use and decrease abortion rates.

This desk review is designed to:

- Assess factors that affect family planning service delivery in Azerbaijan;
- Identify and document supportive policies and best practices in FP program implementation; and
- Propose recommendations for scaling up best FP practices and new interventions to improve program effectiveness and increase utilization of modern contraception.

This Azerbaijan review is one of a series of situation analyses of the family planning environment in several countries in the E&E region. Each review provides a country background, with a special focus on describing the health care system and the status of reproductive health (RH). It also describes each of ten best practices as they relate to the particular country context; and provides recommendations for focusing further interventions and resources.

METHODOLOGY

In order to systematically assess the family planning situation in each of the priority countries, the Europe and Eurasia Regional Family Planning Activity team began by reviewing Senlet and Kantner (2005), "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region." Reviewers then developed a questionnaire for in-depth interviews with key informants. Persons interviewed in Azerbaijan are included in Annex III.

The team identified a list of ten family planning policy and program best practices (listed above) based on the Senlet and Kantner assessment report, a literature review on global best family planning practices and programs, and field interviews in-country. The team conducted a review of available documents and an Internet search to obtain additional information on country background, policies, and programs in family planning. These ten best practices are briefly described in Annex IV.

This review of the family planning programs in Azerbaijan is a summary of the generally available literature with qualitative input from key stakeholders in country. The review's intention is to serve as a basis for discussion of country and regional priorities for family planning program improvement based on the best available information. It is not intended as a comprehensive analysis of the country situation, but rather as a brief "snapshot" of this particular point of program development to guide future programming. Data included in this report cover the first quarter of 2007. Due to rapidly changing circumstances in the country, some information may have already changed.

II. BACKGROUND

COUNTRY CONTEXT

Following the breakup of the Soviet Union, Azerbaijan's economy suffered a dramatic decline as a result of several factors: The war with Armenia over the Nagorno-Karabakh region; internal dislocation of the population; emigration; and a disruption of traditional trade routes. Despite the economic recovery that began after 1996 and which has accelerated since 2005, Azerbaijan still remains among the lowest-income countries in the E&E region, with a registered 34.5 percent annual real growth in the gross domestic product (GDP) in 2006. Azerbaijan's GDP per capita had a purchasing power parity of US$ 7,500 in 2006[1]. Nearly half the Azerbaijan population is living below the poverty line, with the highest rate of poverty (63 percent) reported in the Nakhichevan Autonomous Republic. A household budget survey conducted in 2002 found that poverty levels were slightly higher in urban versus rural areas. In Baku, a city that comprises one-fifth of the country's population, 40 percent of households reported incomes below the absolute poverty line. Azerbaijanies constitute more than 90 percent of the country's population.

HEALTH CARE SYSTEM

Reforms to Soviet-style centralized financing and normative allocation of human, financial, and physical resources have not yet penetrated the health care system in Azerbaijan. The MOH has very limited current capacity to oversee the system, introduce reforms, regulate and control overall quality, and gather information needed to monitor public health. The Ministry has neither a policy development unit nor departments for monitoring and evaluation, human resources, or long-term planning. Health care services are delivered through facilities that are organized in a three-tiered network:

- **Tier I:** Rural hospitals, ambulatory clinics, and village health posts or *feldsher akusher* points (FAP)
- **Tier II:** District and city hospitals and polyclinics [2]
- **Tier III:** National-level tertiary hospitals and policlinics in Baku

In addition, there are a large number of specialized hospitals and outpatient clinics that address the specific medical conditions or needs of special population groups (e.g., railway workers, marine workers, and Ministry of Interior staff). The medical training curriculum does not yet include up-to-date, internationally-recognized approaches based on proven evidence, and most physicians, including obstetrician/gynecologists (ob/gyns), continue to rely on training materials and methodological tools from the Soviet period.

[1] The World Factbook: https://www.cia.gov/library/publications/the-world-factbook/print/aj.html, accessed 17 09 07.

[2] PHC level facilities are staffed by specialty providers i.e. internist, surgeon, radiologist, ophthalmologist, ob/gyn, neurologist and other

An expensive and low standard of care negatively influences household health-seeking behavior. A 2002 study[3] found that one in three households did not use formal health services when they needed them. For example, 36 percent of all births in rural areas took place at home because of high out-of-pocket payments demanded at health care facilities. Only 57 percent of women had ever been examined by a gynecologist in their lifetime. In urban areas, access to pharmaceuticals, including oral contraceptives (OC), condoms, intrauterine devices (IUDs), and injectables has recently become less of a problem due to a significant increase in the number of private pharmacies. However, there are still many rural areas without a pharmacy or access to drugs and contraceptive commodities, and clients must travel to bigger cities to obtain them.

REPRODUCTIVE HEALTH

Azerbaijan is experiencing a reduction in population growth as a result of a steady decline in total fertility and emigration. Use of modern contraception is very low, while the rate of abortion and its complications are among the highest in the E&E region[4]. In rural areas, access to modern contraceptive services is severely limited for most women. Women face three significant barriers when attempting to access modern contraceptive services:

- Ob/gyns are the only providers who can offer family planning counseling and initial prescriptions of clinical methods. Most Ob/gyns are concentrated in central district hospitals and women's consultation centers in district capitals and bigger towns. Hence, to receive FP services, rural first-time users must travel to a major city, which creates additional financial and time burdens.
- Medical tests are over-used by providers when prescribing methods, which in turn increases the cost of services and makes them unaffordable for at least half of Azerbaijan's population.
- Free or subsidized contraceptives for vulnerable populations are not available in the country.

As demonstrated by the 2001 Reproductive Health Survey (RHS 2001), women have a relatively high level of awareness of some modern contraception methods (mostly condoms, IUDs, and pills). However, prevalence of modern contraceptive methods among married women of reproductive age (WRA: 15–49 years) is only 14.3 percent, one of the lowest in the region (Demographic and Health Survey 2006). Azeri women marry in their early 20s, reportedly have first sexual intercourse at marriage, a first child at the median age of 23.7 years, and desire a family size of two children. More than 70 percent of married WRA have two children before the age of 30 and more than 80 percent of women who have two living children do not want more. The total fertility rate in Azerbaijan is below the replacement rate with a tendency to decline: 2.1 and 2.0 in 2000 and 2006, respectively. It is higher, however, than elsewhere in the Caucasus and Eastern Europe. Key reproductive health indicators are summarized in Annex II.

Women in Azerbaijan still rely heavily on abortion as a method of fertility control. Access to low-cost abortion services is relatively easy and services are available without restriction during the first 12 weeks of gestation. Beyond 12 weeks, abortion services are available only on medical

[3] Household Budget Survey 2002
[4] RHS Azerbaijan 2001 and RHS Georgia 2005.

and selected socioeconomic grounds. The total induced abortion rate has decreased in recent years from 3.2 in 2001 to 2.3 in 2006. Most abortions are performed in clinics. Anecdotally, some are performed outside clinical settings and are unsafe and unreported. The high rate (21 percent) of post abortion complications is indicative of the low quality of abortion service in clinics (RHS 2001).

The National Reproductive Health Office (NRHO) has established a task force comprised of representatives of the MOH (National Institute of Obstetrics and Gynecology), UNFPA, USAID, WHO, and UNICEF to develop a National Reproductive Health Strategy. With leadership from WHO, this document should be finished by the fall of 2007. Preliminary results from the USAID-sponsored DHS are now available.

III. TEN BEST FAMILY PLANNING PRACTICES: AZERBAIJAN

The following describes the situation in Azerbaijan regarding each of the 10 best practices.

BEST PRACTICE #1 – LIBERALIZED PROVISION OF FAMILY PLANNING SERVICES

As mentioned above, the MOH currently mandates that only ob/gyns can prescribe hormonal methods, insert IUDs, or perform medical sterilizations. After training, midwives at FAPs are only allowed to provide family planning counseling and cannot provide contraceptives themselves. This significantly restricts access to and use of modern contraceptive services, especially in rural areas where the number of ob/gyns is limited. There are no regulations, however, restricting internists (therapists) and pediatricians from providing family planning counseling and services. For example, with the aim of expanding availability of quality family planning services in their 14 pilot districts, the USAID-funded ACQUIRE project has conducted training in FP counseling and services (except skills training in IUD insertion) for internists and pediatricians, who are now expected to provide FP services to clients.

POTENTIAL FOCUS AREAS

- **In order to make family planning services more widely available, family planning advocates should lobby the MOH and key policy stakeholders to change current regulations and practices to allow general practitioners, family doctors, pediatricians, and primary health care (PHC) nurses to conduct initial family planning counseling and prescribe FP methods. In the short term, a ministerial waiver should be issued for initial family planning counseling and service delivery at ACQUIRE project sites.**
- **In order to promote family planning service provision, advocates should work with the MOH and other stakeholders involved in the design of health financing models to introduce reasonable compensation packages for RH/FP service providers under the Basic Health Benefit Package.**

BEST PRACTICE #2 – FAMILY PLANNING COUNSELING, SERVICES, AND CONTRACEPTIVES ARE PART OF BASIC HEALTH BENEFIT PACKAGE

Family planning counseling and services are officially free in publicly funded health facilities, but most of the key informants interviewed (see Annex III) indicated that there is only a very limited supply of free contraceptives available at family planning service facilities, therefore, clients pay out of pocket for family planning services by purchasing commodities from commercial pharmacies. Because clients need to purchase contraceptives at pharmacies, financial barriers mean that a significant proportion of the population cannot afford FP services or modern contraceptives, particularly in rural areas. Anecdotal data suggest that more than 40 percent of the population cannot afford to purchase any contraceptives at pharmacies. Free contraceptives are only available in a few UNFPA pilot districts where Reproductive Health Centers have remaining stocks of Copper-T IUDs, and in the ACQUIRE Project pilot districts where male condoms financed by the Global Fund are distributed for free. The government does not allocate funds to procure contraceptives and has not established an effective commodities distribution system.

Even though Azerbaijan's essential drug list (EDL) is overseen by a "Technical Expert Committee" at the MOH is purportedly based on WHO recommendations, it does not include contraceptives.

POTENTIAL FOCUS AREAS

- **In order to ensure that family planning services and products are reliably available, FP proponents should advocate with senior policy stakeholders at the Azerbaijan MOH to include FP services in the basic health benefit package, add contraceptives to the EDL, and begin to allocate a budget for contraceptive procurement.**
- **Purchase enough contraceptives to allow for free distribution to low income clients.**

BEST PRACTICE #3 – UP-TO-DATE AND EVIDENCE-BASED POLICIES, REGULATIONS, STANDARDS, GUIDELINES AND SUPPORTIVE SUPERVISION SYSTEM ARE IN PLACE TO ENSURE QUALITY OF FAMILY PLANNING SERVICES AT ALL LEVELS OF HEALTH CARE

Service providers

At present, family planning services at the provider level are limited by the fact that only ob/gyns are able to provide initial family planning counseling and method prescription. An old Soviet regulation mandates that doctors take advanced medical training in their specialty once every five years, though no regulation or procedures exist for re-licensing medical personnel. The National Institute for Advanced Medical Training (NIAMT) offers a traditional three-month post-diploma course in obstetrics and gynecology, which reportedly covers family planning topics.

Health care facilities where family planning services are provided

Ob/gyns provide FP services at the primarily urban public Reproductive Health Centers at the Central District Hospitals and in women's consultation clinics and private outpatient clinics. Rural clients are typically referred to Reproductive Health Centers and women's consultation clinics, thus creating a financial barrier to access for added travel costs and time. In UNFPA and ACQUIRE pilot districts, women can reportedly receive information on family planning methods from nurse/midwives at FAPs in rural areas.

At present, there are no national regulations setting norms for staffing, office, equipment, or medical commodities for health facilities licensed to provide family planning services.

Guidelines and protocols for family planning service provision

Currently, there are no MOH-approved modern and consistent national standards, guidelines, or protocols for the provision of family planning services. Trainees typically receive a wide range of reference materials and instruction for providing FP counseling and services at family planning trainings conducted by different international organizations. The absence of national standards and guidelines can increase medical barriers such as overuse of diagnostic checks for IUD insertion and hormone screening for prescription of OCs.

The ACQUIRE project has successfully advocated for and collaborated with national and local health authorities to achieve: a) leadership and active support from the MOH for the development of a national RH strategy and b) strong awareness among the MOH/NRHO staff of the need to develop standard guidelines and protocols for family planning service delivery. The NRHO recently requested that the ACQUIRE project assist in the development of standards, guidelines, and protocols for FP services. Yet, currently there is no strategy or plan for nationwide implementation, promotion, or enforcement of new guidelines and protocols once developed.

Quality assurance and supportive supervision systems

Nationally, there are no routine quality assurance or performance improvement support mechanisms in place to strengthen the knowledge, skills, and practices of service providers. Supportive supervision and reporting systems appear to be weak, including in the ACQUIRE family planning training pilot districts.

Postpartum and postabortion family planning counseling and service provision

Since regulations do not require the provision of family planning services and providers are not reimbursed for service delivery, postabortion and postpartum family planning counseling and services depend on the good will of the provider. In addition, the high dependence that ob/gyns and assistant nurses have on revenues obtained from abortion services is a significant obstacle to post-abortion FP counseling and service delivery.

POTENTIAL FOCUS AREAS

- **Work with the MOH and Health Reform Team to develop evidence-based national family planning service guidelines, protocols and standards.**

- **Develop a national plan for a) disseminating family planning standards, guidelines and protocols; b) training providers—including PHC providers—in the new FP service guidelines.**
- **Strengthen supportive supervision and reporting mechanisms in ACQUIRE pilot districts and collaborate with the Health Reform Team on the inclusion of a supportive supervision component for family planning services in the PHC reform strategy.**
- **Institutionalize COPE[5], a service quality improvement methodology, in all ACQUIRE pilot health facilities.**
- **Introduce community-based COPE to reveal client preferences for obtaining modern family planning services.**
- **Advocate for the integration of family planning counseling and services into maternity care—routine antepartum, intrapartum, and postpartum care—under the safe motherhood section of the newly developed Reproductive Health Strategy.**

BEST PRACTICE #4 – A BROAD RANGE OF FAMILY PLANNING METHODS ARE AVAILABLE, ACCESSIBLE, AFFORDABLE, AND ACCEPTABLE IN BOTH RURAL AND URBAN AREAS

According to the NRHO, free contraceptives are not available for clients, except for Global Fund-sponsored condoms distributed by ACQUIRE in its pilot sites. Reportedly, in Baku and other regional cities, different contraceptives—including combined and progestin-only pills, emergency contraceptive pills, and condoms—are available in pharmacies. Pharmacists mentioned that, in contrast to short-term methods, longer-term methods (IUD and Depo Provera) have low and unpredictable demand. Hence, although the latter could be obtained through most major pharmacies, there could be delay in product delivery.

Rural clients have to travel to district town centers to obtain contraceptives. Another major barrier to access in rural areas is the total cost of family planning services (e.g., costs of medical tests, informal payment for counseling, contraceptives at pharmacies, and roundtrip transportation). All respondents mentioned that most rural clients cannot afford modern contraceptives and the unofficial payments required for repeat visits to ob/gyns.

The ACQUIRE Project has strengthened the links between health authorities, pharmacies, health providers, peer educators, municipalities, and communities ("Bridge to RH/FP"). Bridge meetings have provided a chance for stakeholders to discuss and jointly solve service-related problems, resulting in:

a) Increased awareness of family planning among stakeholders;
b) Local authorities paying more attention to family planning issues in their districts; and
c) Renovation of health facilities.

Breastfeeding is promoted by ob/gyns at maternity hospitals and is widely used in rural areas, but is not as common in Baku. Nevertheless, education and the promotion of LAM as a

[5] A process and tool for quality improvement in family planning and reproductive health services: http://www.engenderhealth.org/ia/sfq/qcope.html.

contraceptive method are provided sparsely. According to the recent EngenderHealth contraceptive prevalence study, only 6 percent have used LAM among those who ever used contraception.

POTENTIAL FOCUS AREAS

- **Conduct an ability-to-pay analysis to: a) estimate affordability of contraceptives, b) strategically and accurately define market segments, and c) develop effective subsidization strategies for family planning service and/or contraceptives.**
- **Family planning programs will not succeed if contraceptives cannot be procured and distributed, In the short term, because the government does not include contraceptives in the EDL, USAID is the only potential source of funding for public sector contraceptive procurement. Provision of free contraceptives to vulnerable populations in both rural and urban areas is required to ensure minimal contraceptive security. Over time, it is essential to work with the MOH to improve contraceptive procurement and distribution systems.**
- **Consider promoting long-term and permanent methods in the ACQUIRE pilot districts. Provide training to ob/gyns in voluntary surgical contraception counseling and female laparoscopic sterilization; and provide equipment to introduce, institutionalize, and create demand for sterilization services.**
- **Promote LAM in pilot districts and advocate for its nationwide implementation.**

BEST PRACTICE #5 – SPECIAL PROGRAMS ARE IN PLACE DESIGNED TO MEET THE NEEDS OF VULNERABLE TARGET GROUPS

Currently there are very few special family planning programs targeting vulnerable groups, including the poor, by the government, national or international nongovernmental organizations, or private-sector organizations. With funds coming from DFID and UNFPA, UNHCR implemented a six-month program three years ago to provide RH/FP services to the refugee and internally displaced persons (IDP) population.

Since 2001, the Ministry of Education has promoted a "family life" course for 8th to 10th grade students in high schools. UNFPA provided technical support for the development of the curriculum, which includes family planning. In 2007, UNFPA will launch a three-year program for youth that addresses RH/FP information, education, and behavior change communication.

In collaboration with the MOH, the ACQUIRE Project provided outreach counseling and IUD insertion services for poor populations in their pilot districts. This activity was effective in:

a) Demonstrating the effectiveness and advantages of family planning, and
b) Providing an opportunity for the MOH FP experts to conduct on-the-job training for rural health providers.

POTENTIAL FOCUS AREAS

- **Design and implement family planning programs targeted to vulnerable groups in the ACQUIRE pilot districts and advocate with the MOH for scaling up such tested programs to the national level.**

BEST PRACTICE #6 – FAMILY PLANNING IS PART OF PRE- AND IN-SERVICE TRAINING FOR HEALTH CARE PROVIDERS

Pre-service training for family planning is included in the curricula of the ob/gyn training course at the Medical University. Reportedly, this is a two-hour lecture that does not include counseling skills training or practical skills for provision of FP methods. Continuing medical education (CME) in the area of family planning does not exist. The NIAMT offers a three-month Soviet style "advanced" training for ob/gyns, who are required to take the training once every five years, but family planning is not included in this curriculum. Neither pre- nor in-service family planning training curricula are based on WHO's "Medical Eligibility Criteria for Contraceptive Use" or other international guidelines, nor have they been updated in accordance with current evidence-based standards. Recently, NIAMT applied to the ACQUIRE Project to help with developing a family planning training curricula for family doctors.

POTENTIAL FOCUS AREAS

- **Emphasize pre-service training and curriculum reform and work with the MOH, NRHO, and Health Reform Team/IMC to introduce updated family planning curricula in medical schools to ensure that newly graduating family doctors and other health service providers have evidence-based FP knowledge and skills.**
- **Revise the CME curricula in the context of family planning for ob/gyns with an emphasis on evidence-based FP/RH and clinical practice, in order to reduce medical barriers.**

BEST PRACTICE #7 – CONTRACEPTIVE SECURITY IS ENSURED THROUGH ADEQUATE PLANNING WITHIN THE GOVERNMENT

Assuring the reliable and uninterrupted supply of contraceptives for all who want them when they want them—the essence of contraceptive security—is a key requirement for developing and maintaining a quality family planning program and services.

From 1994 until 2005, UNFPA was the only source of contraceptive supplies for Azerbaijan. The last shipment was delivered to Baku in the summer of 2005. During that period, the number and type of FP commodities delivered depended predominantly on the availability of UNFPA funds and products rather than program need. UNFPA distributed contraceptives to 27 pilot RH centers rehabilitated in accordance with NRHO's distribution plan. Currently, no one donor or agency procures FP commodities for Azerbaijan and, according to key informants interviewed, there are no provisions enabling the government to finance the procurement of contraceptives in coming years—and little interest within the government to do so.

NRHO has a logistics management information system (LMIS) and distribution system in place, but these are not working effectively. UNFPA and UNHCR introduced a computerized LMIS data entry system in 2001 in 27 pilot districts, including equipment and training. This system was meant to collect service and commodity data from RH centers for compilation and analysis at NRHO. Due to the lack of funds for maintenance of the system, data are only collected quarterly and submitted manually to NRHO. The situation analysis team reviewed sample data and found that they include predominantly clinical and service delivery information and some data on pill, IUD, injectable, and condom use. The system does not provide basic information required for logistics such as monthly consumption, stock on hand, losses, or adjustments for each method. NRHO senior management would like to improve the LMIS and have expressed an interest in receiving technical assistance in this area.

POTENTIAL FOCUS AREAS

- **Provide technical assistance to revise and institutionalize the LMIS.**
- **Ensure adequate supply and distribute a full range of commodities.**

BEST PRACTICE #8 – ADOPTION OF A "CULTURE" THAT PROMOTES FAMILY PLANNING COUNSELING

According to all key informants interviewed, family planning counseling and services are provided on request only. Clients who come to a women's clinic for other reasons are rarely offered information on family planning methods. Service providers are not reimbursed separately for FP services, hence they have no financial incentive to offer them. Furthermore, Ob/gyns who perform abortions are able to collect higher revenues from abortion services than from FP services and, therefore have a disincentive to promote family planning.

POTENTIAL FOCUS AREAS

- **Design a strategy, methodology, and implementation plan to make sure that all clients attending PHC clinics, RH centers, women's consultations, or maternity houses nationwide are counseled about family planning and offered a method as appropriate.**

BEST PRACTICE #9 – FAMILY PLANNING IS ACTIVELY PROMOTED THROUGH SOCIAL MARKETING AND BEHAVIOR CHANGE/SOCIAL MOBILIZATION EFFORTS

The ACQUIRE project, working in ten pilot districts, conducts the only social marketing or behavior change communication (BCC) program in Azerbaijan that actively includes family planning. This effort will ultimately be expanded to all 14 ACQUIRE districts. The project disseminates community and client informational materials and conducts mass media and public campaigns, including the promotion of a special logo for the social marketing of contraceptives. Pharmaceutical companies Gedeon Richter and Schering contribute leveraged resources to market contraceptives in the pilot districts. EngenderHealth provides guidelines, quick reference materials, and flip charts to all providers participating in their FP trainings. There are no family planning social marketing or community BCC programs implemented outside the pilot districts and no current plan to expand them further.

POTENTIAL FOCUS AREAS

- **Expand social marketing and BCC efforts into other pilot districts and regions and ensure an adequate supply of contraceptives to meet demand generated by these activities.**
- **Advocate with the MOH, pharmaceutical companies, and other interested stakeholders to scale up social marketing activities to the national level.**

BEST PRACTICE #10 – A WELL FUNCTIONING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM COLLECTS, ANALYSES, AND USES FAMILY PLANNING DATA

The health information system is poorly organized and ill-equipped, especially at the district level. Production and use of good quality health information is affected by many factors, including technical difficulties (inadequate data collection tools and processes, limited information technology, and poor data analysis); organizational weakness; and limited experience and support for using data for decision-making.

Recently, USAID's Primary Health Care Strengthening Project conducted a comprehensive training course on "Improving Health Information Systems" as part of an effort to develop a hospital-based information system in the three main districts of Azerbaijan: Ismayilli, Sheki and Gakh. The Ministry of Health of Azerbaijan plans to introduce this new information system nationwide in the future.

Information on family planning service and commodity utilization is manually collected from only 27 district RH centers of 60 districts in the country (see LMIS description in Best Practice #7). In the national health system, family planning data are not used to make informed decisions for improving family planning service delivery.

POTENTIAL FOCUS AREAS

- **Identify opportunities for and constraints to effective (and strategic) data collection, production, and use of information for decision making.**
- **In collaboration with the NRHO, develop unified family planning service and commodity utilization reporting forms and institutionalize information registration and reporting in ACQUIRE pilot sites.**
- **Advocate with the MOH and PHC Strengthening project for a national-level implementation of FP service and commodity utilization information registration, collection, and transfer.**

ANNEX I

FAMILY PLANNING PROGRAMS FUNDED BY USAID AND OTHER DONORS

USAID

ACQUIRE (ACCESS, QUALITY, AND USE IN REPRODUCTIVE HEALTH 2004–2008)

The ACQUIRE Project in Azerbaijan is implemented through the partnership of EngenderHealth, ADRA, IntraHealth International, and Meridian Group International, Inc. ACQUIRE is mandated to serve as a key mechanism for scaling up FP services in the country. The project is implemented in 14 pilot districts to advance and support the use of RH/FP services through:

- **Improving access to FP services by increasing the number of health facilities and pharmacies providing FP counseling, services, and quality contraceptives;**
- **Informing the population about available FP services by employing creative multi-media approaches, community mobilization, and awareness raising;**
- **Improving the quality of FP services by training service providers and introducing quality improvement management systems;**
- **Increasing the sustainability of FP services by strengthening service delivery systems, building management capacity, and supporting FP policy development at the national level.**

PRIMARY HEALTH CARE (PHC) STRENGTHENING PROJECT (2006–2011)

Primary Health Care Strengthening Project, sponsored by the World Bank, USAID, and UNICEF aims to create a supportive policy environment that helps to increase the responsiveness and effectiveness of the primary health care system in Azerbaijan. With USAID funding International Medical Corps (IMC, 2005–2007) implements five components:

- **Increase public expenditure for health and improve allocations for PHC;**
- **Create a policy and legal framework that defines PHC and the PHC delivery system;**
- **Improve quality of PHC services;**
- **Promote personal responsibility for health among individuals and families;**
- **Strengthen the Government of Azerbaijan's surveillance and response to human avian influenza.**

Under component #3, IMC plans to review the existing family medicine curricula and elaborate recommendations for the MOH on inclusion of family planning training modules in the family doctors' retraining curricula as well as include FP services on the list of the PHC services.

UNFPA

UNFPA support to Azerbaijan started in 1994. Contraceptive supplies, RH commodities, as well as training in the use of modern methods of family planning were provided to service providers in 27 pilot RH Centers. Currently, major UNFPA program activities include:

- **Contraceptive distribution, including pills, condoms, spermicides, injectables, and IUDs to pilot RH Centers;**
- **Support to the National Reproductive Health Office (NRHO);**
- **Co-funding of RHS implementation in Azerbaijan;**
- **Co-funding the operationalization of the LMIS in pilot RH Centers and the NRHO.**

ANNEX II

AZERBAIJAN DEMOGRAPHIC AND REPRODUCTIVE HEALTH INDICATORS

Table 1: Demographic and Reproductive Health Indicators: Azerbaijan

Indicator	Parameter
Total population	8.4 million
Population annual growth rate	1%
Women of reproductive age 15–44	2.5 million
Total fertility rate among WRA (2004)*	2.0
Contraceptive prevalence rate (total)	51.1%
Traditional methods (total)	36.8%
- Withdrawal	32.5%
- Rhythm method (Periodic abstinence)	4.0%
Modern methods (total)	14.3%
- IUD	9.2%
- Condom	2.2%
- Pill	1.3%
- Female sterilization	0.4%
Factors for not using modern methods among married women (RHS 2001)	
- Fear of side effects	90%
- Lack of knowledge	71%
- Cost	61%
- Lack of access	53%
- Partner preference for traditional methods	49%
Unmet need for modern contraception	53%
Total abortion rate per women of reproductive age	2.3
Receipt of postabortion FP counseling (RHS 2001)	32%
- received a contraceptive method or prescription (RHS 2001)	7%
Maternal morbidity rate attributable to abortion (RHS 2001)	21%
Receipt of postpartum FP counseling	†
Infant mortality (per 1,000 live births)**	79
Maternal mortality (per 100,000 live births)**	79
HIV prevalence ***	0.1%–0.2%
Estimated number of people living with HIV by 2007	5,400

† Unfortunately, this information is not available at this time.
Source: DHS Azerbaijan 2006; RHS Azerbaijan 2001.
*World Bank, WDI 2006; ** UNICEF 2006; ***UNAIDS 2007
http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS_PDFs/EFS2004_AZ.pdf

ANNEX III

KEY INFORMANTS INTERVIEWED

Ministry of Health

Dr. Faiza Aliyeva	Head of the National Reproductive Health Office Director of National Institute for Obstetrics and Gynecology National coordinator of RH/FP programs
Dr. Zenfira Guseinova	Training Coordinator, NRHO
Dr. Gulnara Rzayeva	RH/FP expert, NRHO
Dr. Olga Stilidi	Finance Director, NRHO

ACQUIRE Project

Dr. Akif Hasanov	RH/FP Program Advisor, EngenderHealth

PHC Strengthening Project, International Medical Corps

Adam Sirois	Chief of Party, IMC
Dr. Akaki Zoidze	Senior Health Finance Analyst, IMC

UNFPA

Farid Babayev	National Program Officer
Ramiz Huseynov	Monitoring and Evaluation Coordinator

ANNEX IV

LIST OF DOCUMENTS CONSULTED

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