

# Self-reliance review of tuberculosis prevention and care activities in Azerbaijan

03-05 April 2018  
Mission Report

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## **Abstract**

The WHO Regional Office for Europe is assessing readiness for transition from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)-financed tuberculosis (TB) activities in six selected countries (Armenia, Azerbaijan, Belarus, Georgia, the Republic of Moldova and Ukraine) in the landscape of overall dwindling external donor funding. The aim of this work is to assist (i) countries in documenting their preparedness to move from donor-funded to domestically funded anti-TB activities and (ii) country-level stakeholders to highlight and prioritize transition-focused efforts. As part of this work, two WHO experts visited Azerbaijan during 03-05 April 2018 for WHO's forth in-country meeting for discussion and assessment of the project. This report presents an overview of the transition process in Azerbaijan, some sustainability aspects and challenges stemming from donor withdrawal from TB-related activities, along with recommendations on how to overcome transition-related difficulties and ensure sustainability.

### **Keywords**

AZERBAIJAN

TUBERCULOSIS

TRANSITION

GLOBAL FUND

FINANCIAL SUSTAINABILITY

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## Abbreviations

AEC	Analytical Expertise Centre
DOT	directly observed treatment
DR-TB	drug-resistant tuberculosis
FLD	first-line antituberculosis drug
GDF	Global Drug Facility
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICRC	International Committee of the Red Cross
KAP	knowledge, attitude and practice (study)
MDR-TB	multidrug-resistant tuberculosis
MoF	Ministry of Finance
MoH	Ministry of Health
M/XDR-TB	multidrug- and extensively drug-resistant tuberculosis
NRL	national reference laboratory
NSP	National Strategic Plan
NGO	nongovernmental organization
NTP	National Tuberculosis Programme
PHC	primary health care
PIU	programme implementation unit
RR-TB	rifampicin-resistant
SLD	second-line antituberculosis drug
SRILD	Scientific Research Institute of Lung Disease
TB	tuberculosis
TB-REP	Tuberculosis Regional Eastern European and Central Asian Project
UHC	Universal health coverage
XDR-TB	extensively drug-resistant tuberculosis

## **Overview of the technical assistance mission**

On 3–5 April 2018, two WHO consultants, Ms Allira Attwill (Health Economist) and Dr Nikoloz Nasidze visited Baku, Azerbaijan to assess the self-reliance regarding financial and programmatic sustainability of TB activities in the country and its readiness to transition from a donor-financed to a government-financed programme. This document provides an overview of the mission and its findings. Annex 1 shows the list of stakeholders met and Annex 2 shows the meeting agenda.

## **Scope and purpose of the technical assistance mission**

Under the framework of a United States Agency for International Development (USAID) Regional Platform project, the WHO Regional Office for Europe is supporting the six Member States within the Eastern Partnership<sup>1</sup> (except Ukraine which is supported by different donor) to document their self-reliance, preparedness to transition to government-financed programmes and the financial sustainability of their TB activities, considering the reduction in support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donors. The project reviews the sustainability of donor-financed TB activities, analyse the challenges and potential consequences of the transition, and suggest actions to mitigate challenges and maximize opportunities in the six Eastern Partnership countries. Azerbaijan was the fourth Eastern Partnership country reviewed during this project.

The mission objectives were to:

- discuss sustainability successes and challenges to date with relevant stakeholders;
- explore the triggers and enablers for transition;
- identify the gaps in key transition-related financial, human resources and programmatic data; and
- support the review and subsequent development of tailored strategic plans in countries where these are currently lacking, and to review and provide expert opinion on existing ones.

The consultants are grateful to the Regional Office's Joint TB, HIV and Viral Hepatitis Programme for driving the preparations for the technical mission. Special thanks to Dr Javahir Suleimanova, WHO National Programme Officer and the WHO Country Office in Azerbaijan for providing overall support during the mission. This project was made possible by funding from the USAID Regional Platform project.

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<sup>1</sup> Eastern Partnership countries comprise Armenia, Azerbaijan, Belarus, Georgia, the Republic of Moldova and Ukraine

## **Executive summary**

The WHO Regional Office for Europe is supporting selected relevant countries in documenting their preparedness to move from donor to domestic funding of antituberculosis (anti-TB) activities and in helping country-level stakeholders to highlight and prioritize the transition-focused efforts that will have the greatest impact on the success of this process. This work will also contribute to the development or improvement of national transition plans and guide country-level stakeholders towards a complete move to domestic funding for anti-TB activities.

As part of this work, two WHO experts visited Azerbaijan on 3–5 April 2018 for WHO's fourth in-country discussions and assessment of preparedness to move from donor to domestic funding. The discussions focused on successes and challenges related to sustainability; triggers and enablers for transition; gaps in transition-related financial, human resource and programmatic data; and the country's development of a transition and sustainability plan. The findings are outlined below.

The Government of Azerbaijan has demonstrated its commitment to achieving universal health coverage. Significant developments in TB prevention and care activities have meant that patients are receiving care according to improved models. This development is continuing.

The government's ability to finance the full range of TB activities is currently being challenged by negative economic growth and the recent currency devaluation; moreover, it risks being undermined by inefficiencies in the health system stemming largely from overreliance on inpatient care. Even so, the government has been effectively increasing its level of co-financing of TB activities, as well as its commitment to and funding for TB. However, no assessment has been made of the size, nature or consequences of financial or programmatic gaps that may emerge after withdrawal of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), nor is there a clear action plan to guide domestic takeover of these activities.

From a policy and legislative perspective, a legal framework for TB-related activities exists, together with the 2000 the Law “On Combating Tuberculosis” in the Republic of Azerbaijan. Both require updating and endorsement.

One of Azerbaijan's major challenges relates to the fact that the National Strategic Plan for Tuberculosis Prevention and Care in the Republic of Azerbaijan 2016–2020 (NSP) was defined in 2014 and submitted to the GFATM in 2015. At that point, the full extent of the drop in the price of oil (a major source of revenue for the government) and its subsequent impact on government budgets was not yet known.

There is significant room for improved efficiency within the National TB Programme (NTP), which relies heavily on inpatient and specialist care. The government has made efforts to address this, as seen in the Strategic plan for health care development in Azerbaijan 2014–2020, which aims to increase efficiency and quality within primary health care (PHC) services and decrease the number of unnecessary beds and inpatient facilities.

A mandatory health insurance project is being piloted in two sites. The plan is to scale up this system to national-level coverage by the end of 2019. Mandatory health insurance brings great hope for achieving sustainable universal health coverage, although it remains unclear how this new system will address TB patients and PHC in general.

Supervision from the central to peripheral levels is conducted by a dedicated monitoring and supervision team. Responsibility for TB prevention, treatment and care within the penitentiary system lies entirely with the Ministry of Justice, which has produced excellent results and can be considered an example of best practice. The Country Coordinating Mechanism is working well with the inclusion of nongovernmental organizations (NGOs) as active members.

Overall, the TB programme in Azerbaijan would benefit from improved efficiency and clearer budgetary allocations to assist decision-makers identify priorities and potential funding and programmatic gaps before, during and after the transition to domestic funding.

### **Overview of key recommendations and suggested steps**

The following table gives an overview of the experts' key recommendations and suggested steps.

- NTP: Revise activities and targets planned under the NSP and reprioritize activities in the light of the declining gross national income
- NTP: Update the NSP to align with WHO's Tuberculosis action plan for the WHO European Region 2016–2020<sup>2</sup>
- NTP: Update the NSP to include detailed activities and financial figures and develop a clear transition and sustainability plan to guide the country towards full ownership of its TB activities
- NTP: Calculate the size of the potential financial gaps for NSP implementation (currently there are none)
- MOH: Revise the national budget for TB prevention and care in light of the post-devaluation currency landscape and the new GFATM grant for 2018–2020, particularly in terms of drug procurement and affordability
- MOH, GFATM: Formally agree to work towards ensuring that the government does not lose access to the GFATM procurement platform after the transition to domestic procurement
- MOJ: Review the number of TB beds in prisons based on needs and the possibility of reducing or reprofiling them
- GFATM, NTP: Ensure that supervisory visits continue after GFATM withdrawal. Build this into the NSP
- MOH, MOJ: Consider the gradual takeover of financial responsibilities for procurement of drugs for XDR-TB patients by the end of 2020 - reflect in the renewed transition plan
- Analytical Expertise Centre (AEC), GFATM PIU, MOH: Ensure that all necessary drugs have been preregistered and are ready for importation following GFATM withdrawal
- For consideration of TB-REP working group: Provide technical assistance to the Ministry of Health Working Group on Sustainability and Transition on optimization of services with adequate financing mechanism  
MOH, MOJ: Identify alternative forms of funding to support NGOs working with former prisoners with TB to prevent the spread of M/XDR-TB from this risk group

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<sup>2</sup> Tuberculosis action plan for the WHO European Region 2016–2020. Copenhagen: WHO Regional Office for Europe; 2015 (EUR/RC65/17 Rev.1).



## Socioeconomic and geopolitical context

Azerbaijan ranks 78th in the United Nations Development Programme's Human Development Index. The population is approximately 9.65 million, with 54.6% living in urban areas.<sup>3</sup>

The collapse of the former Soviet Union had a major impact on economic and social indicators in Azerbaijan. Intense political, military and financial turmoil in the early years of independence combined with the remains of the former state systems prevented the implementation of reforms in most areas and made the prospect of swift economic prosperity almost impossible. At the turn of the 21st century, however, the substantial increases in the global price of oil led to a boom in the country's growth rate.

Azerbaijan is one of the oldest oil-producing countries in the world, with an economy inextricably linked to the oil industry. The increases (beginning in 1996) and decreases (beginning in 2014) in gross domestic product (GDP) per capita largely reflect the fluctuating contribution of oil to the economy.<sup>4</sup> Considerable investment from multinational companies in Azerbaijan's oil and gas industries has not been matched by direct foreign investment in other branches of the economy, such as agriculture or manufacturing. These sectors are still predominantly state owned: initial privatization efforts stalled in the early 1990s owing to the prevailing socioeconomic conditions.

Azerbaijan reached upper-middle-income status in 2011 when the GDP per capita grew to US\$5560. Following this shift in income status, many donors left the country and many NGOs subsequently lost support even though increasing financial capacity does not necessarily indicate political will, domestic prioritization, or the capacity or efficiency of technical and health systems.

The government has demonstrated its commitment to achieving universal health coverage and the health and well-being of the population; the right to health care is also protected in the constitution. Nevertheless, its ability to finance the full range of TB activities might be undermined by inefficiencies in the health system (largely stemming from overreliance on inpatient care), negative economic growth and a currency devaluation in recent years. This is especially true given that the current NSP was defined in 2014 and submitted to the GFATM in 2015, at a time when the full extent of the drop in oil price was not yet known. The changed financial landscape now means that the activities and targets planned under the NSP need to be revised and the activities reprioritized.

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<sup>3</sup> Azerbaijan: Human development indicators. In: Human development reports [website]. New York: United Nations Development Programme; 2018 (<http://hdr.undp.org/en/countries/profiles/AZE>, accessed 11 July 2018).

<sup>4</sup> Azerbaijan: GNI per capita, Atlas method (current US\$). Washington (DC): World Bank; 2016. (<https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=AZ>), accessed 9 April 2018).

## **Recommendations**

In the light of the country's declining gross national income, the following actions are recommended.

*Ministry of Health, Ministry of Finance, NTP*

- The dialogue between the Working Group on Sustainability and Transition (which includes the Ministry of Finance, Ministry of Health and insurance agency) and the NTP should be continued to increase efforts to establish realistic budget allocations and priorities.

*NTP*

- Based on the above revised, realistic budget allocations and priorities from the Ministry of Finance and Ministry of Health, the NTP should revise the activities and targets planned under the NSP and reprioritize the activities.

## **Health care system and TB programme overview**

The health system is financed through general tax revenues and private (out-of-pocket) payments.

At the central level, the Ministry of Health has responsibility for, and funds, TB prevention and care in the relevant national institutions and tertiary level hospitals. From here, funding is directed to local governments and, in turn, to district hospitals, polyclinics and dispensaries operating under the district health authorities.

In parallel with the health care services led by the Ministry of Health, current and former employees of the Ministries of National Security, Defence, Internal Affairs and Justice and the State Customs Committee, State Caspian Shipping Company and State Railway Company also receive health care from these ministries and enterprises. In relation to TB, by far the most important of these parallel health service providers is the Ministry of Justice. In 2014, the Ministry of Justice's prison-based TB programme was officially recognized as a WHO collaborating centre on the prevention and control of TB.

The SRILD is dedicated to coordinating the national reference laboratories (NRLs), liaising with drug stores, providing clinical advice, and training and research. The NRLs are part of the SRILD. The National TB Laboratory Network consists of the NRLs, five regional laboratories, 68 microscopy laboratories in the civilian services and a reference laboratory in the penitentiary system.

TB diagnostic and curative services are provided to the population through a network of 75 specialized TB institutions (the SRILD, three specialized MDR-TB hospitals in the civilian sector, one TB hospital in prisons, 10 TB dispensaries, 11 TB departments in general district hospitals, 14 TB hospitals and 36 TB clinics in outpatient polyclinics), often in collaboration with PHC providers. The specialized TB service has about 1100 staff, including 256 TB doctors, 752 nurses, 40 laboratory doctors (bacteriologists), 60 laboratory technicians plus about 400 ancillary staff.

The NTP is responsible for the continuing education of TB service staff. The training programme has been supported by international partners (mainly the GFATM) and covers PHC providers, with specific topics such as management of drug-resistant TB (DR-TB) cases and TB/HIV coinfection. There is a total of 4139 PHC doctors and 11 381 PHC nurses.

The vertical structure of the TB prevention and care programme means that it is not fully integrated into PHC services. The provision of ambulatory directly observed treatment (DOT) to M/XDR-TB patients from day one is a first step towards the integration of TB and PHC services. The TB services are financed

per number of beds, which remains one of the biggest constraints to efficient TB treatment. The number of DOT points is limited, and they are usually affiliated with existing health care facilities.

The TB programme consists of the NTP, the central unit of which is situated in the Ministry of Health. The NTP assumes a managerial role and is tasked with initiating policy changes and coordinating all TB-related activities in the civilian sector. The Ministry of Justice is fully autonomous and provides excellent TB care within the penitentiary system.

In 2014, the Ministry of Health launched the development of the current NSP. This was built on previous national plans and was designed to align Azerbaijan's national TB response with the Consolidated action plan to prevent and combat M/XDR-TB in the WHO European Region 2011–2015<sup>5</sup> and World Health Assembly resolution WHA67.1 on the Global strategy and targets for tuberculosis prevention, care and control after 2015.<sup>6</sup> The NSP now requires to be updated to align it with WHO's Tuberculosis action plan for the WHO European Region 2016–2020.<sup>7</sup>

The NSP includes programmatic interventions but not detailed activities or financial figures. Further, it is not supported by a clear transition and sustainability plan to guide the country towards full ownership of its TB activities.

The NTP is implemented by the SRILD, which sits within the Ministry of Health. The main tasks of the NTP include acting as the key agency on TB and lung diseases and overseeing five regional TB laboratories and three in Baku, one of which is a reference laboratory that performs first- and second-line anti-TB drug (FLD and SLD, respectively) sensitivity tests.

GFATM support has enabled the SRILD to bring TB equipment (consumables, screening, diagnostics and treatment-related equipment) up to international standards and provide transport for GeneXpert units and sputum from the regional centres to Baku. There are 16 GeneXpert units, for which the costs of cartridge replacement and calibration are covered by the GFATM: the cost of consumables is split 50:50 between the GFATM and the government.

Azerbaijan has reported 7129 cases of TB (all forms) notified in 2017<sup>8</sup>. The government provides 100% of the budget for non-drug-resistant-TB. For all forms of DR-TB, the burden and financing are as follows:

- MDR-TB (1580 patients as of 2016): 100% covered by the domestic budget, which is anticipated to have cleared by June/July 2018;
- pre-XDR-TB and XDR-TB (227 patients): 77% receive ambulatory treatment and 23% are treated as inpatients; drugs are 100% funded by the GFATM; and
- the cost of treatment for side-effects has been covered domestically since 2013.

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<sup>5</sup> Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015. Copenhagen: WHO Regional Office for Europe; 2011 (EUR/RC61/15 + EUR/RC61/Conf.Doc./8).

<sup>6</sup> Resolution WHA67.1. Global strategy and targets for tuberculosis prevention, care and control after 2015. In: Sixty-seventh World Health Assembly, Geneva, 21 May 2014. Geneva: World Health Organization; 2014 (Agenda item 12.1).

<sup>7</sup> Tuberculosis action plan for the WHO European Region 2016–2020. Copenhagen: WHO Regional Office for Europe; 2015 (EUR/RC65/17 Rev.1).

<sup>8</sup> WHO, Tuberculosis country profiles (<http://www.who.int/tb/country/data/profiles/en/>)

There are three inpatient facilities for treatment of MDR-TB: facility No. 6 has 80 beds for treating both MDR-TB and XDR-TB patients; facility No. 9 has 70 beds for treating XDR-TB patients; and a third facility has 30 beds for treating rifampicin-resistant TB (RR-TB) patients. These 180 beds are included in the overall total of 1855 TB beds for adults and 105 beds for children in the country. In addition, there is a separate palliative care facility. Patients presenting at clinics are diagnosed according to sensitivity testing guidelines using GeneXpert.

No clear calculations of the needs and gaps in the NTP are available. As part of TB-REP, members of the national TB-REP Working Group have been provided with tools to calculate such needs and gaps, although these calculations are yet to be completed.

The NTP estimates the following figures for 2018:

- 155 XDR and pre-XDR TB patients (180 were covered by the last GFATM grant);
- zero stockouts or drug shortages, and no waiting list for treatment;
- a 12% rate of new resistant cases; and
- 28% TB treatment retreatment (a significant decrease compared with the rate of 39% in 2016).

TB care is provided at the following levels:

1. by DOT centres in either village feldsher health care points or central rayon polyclinics, and by TB doctors at the level of central district/rayon polyclinics or dispensary clinics;
2. at the secondary level, by dispensary clinics with beds and outpatient departments (applicable for most of the regions/rayons and districts of Baku city); and
3. at the tertiary level, by SRILD and the specialized M/XDR-TB hospital.

To increase efficiency in these facilities, the Ministry of Health ratified the Strategic plan for health care development in Azerbaijan 2014–2020, which aims to increase efficiency and quality within PHC services and decrease the number of unnecessary beds and inpatient facilities by 50%. This plan provides a legal framework to reinforce the right of all citizens to a state-guaranteed basic benefit package in line with the targets set by the Global Strategy and Targets in WHA 67/11<sup>9</sup> and World Health Assembly resolution WHA62.15 on Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis<sup>10</sup> to provide universal access to diagnosis and treatment for TB and MDR-TB.

Azerbaijan is in the process of introducing a mandatory health insurance system within the health care reform framework. The system is being piloted in Mingachevir city and Yevlakh district (started in 2017), with the aim of expanding it to national level in 2019. As part of this process, additions and changes to the law on Health Insurance (1999) will be made, including the creation of a legislative basis for protecting patient rights. Scaling up a small pilot project – regardless of how successful it has been – to national level at the speed anticipated will be quite a feat: a staged or more iterative upscale process could be another option.

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<sup>9</sup> Resolution WHA67.1. Global strategy and targets for tuberculosis prevention, care and control after 2015. In: Sixty-seventh World Health Assembly, Geneva, 21 May 2014. Geneva: World Health Organization; 2014 (Agenda item 12.1).

<sup>10</sup> Resolution WHA62.15. Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis. In: Sixty-second World Health Assembly, Geneva, 22 May 2009. Geneva: World Health Organization; 2009 (Agenda item 12.9).

Many in-country stakeholders and TB colleagues are looking with hope towards this mandatory health insurance system as a means of achieving sustainable universal health coverage, although it remains unclear how the new system will address TB patients and PHC in general.

The NTP coordinator anticipates that the mandatory health insurance system and subsequent shift in financing and incentives will lead to changes in the behaviour of PHC physicians and may address the overuse of TB inpatient services.

Currently, patients with TB/HIV coinfection are required to obtain TB treatment at one location and HIV/AIDS treatment at another. In other words, there is no one-stop shop for patients with TB/HIV coinfection, although the NTP coordinator did not perceive this to be a significant issue in Azerbaijan given the low incidence of coinfection.

During their meetings, the WHO consultants noted that a shift towards integrating TB services into a PHC model was frequently discussed but no firm action to support such integration was identified. Multiple in-country stakeholders stated that a key barrier to proper integration of TB care into the PHC system is that PHC physicians do not support it due to stigma, fear and lack of motivation to assume responsibility for another issue in view of their high workloads.

Financial support for TB medical staff from the GFATM ended at the beginning of 2018. Previously, the salaries of MDR-TB physicians were supplemented by the GFATM and patients received adherence incentives (\$35 per patient per month). SRILD representatives expressed concern that withdrawal of such support may have led to a decrease in motivation among physicians treating MDR-TB patients and to lower adherence and programme participation among patients at a high risk of MDR-TB. Physicians' motivation and patients' adherence should be monitored and, if it is found that both have declined and pose a threat to programme performance (especially in terms of M/XDR-TB), domestic support for such activities should be provided.

The GFATM recently funded a training workshop to upskill PHC physicians in TB, in which 265 PHC physicians and 50 PHC nurses participated. The workshop consisted of a one-day training session implemented by the NTP (it is worth noting that TB specialists receive three days training, only two days more than the PHC physicians who attended); it included modules on screening, diagnosis, treatment, monitoring and follow-up. The workshop resulted in a 30% increase in knowledge of TB among PHC doctors.

The Ministry of Justice has previously engaged and worked very well with NGOs to support prisoners upon release. One such programme was launched in 2010 by the Red Crescent Society and continues to be 100% funded by the GFATM. It is divided into two streams: the first focuses on prisoners still in prisons, and the second focuses on transitioning prisoners with TB back into society and the civilian health care system.

As part of this programme, the Red Crescent Society assumes the management of TB patients before their release to monitor treatment drop-out rates. Currently, 25–30% of prisoners still on TB treatment are released before completion of the treatment, placing them at a very high risk of XDR-TB. To address this, the Ministry of Justice's TB health care workers build trust and positive relations with TB patients with the aim of making it more likely that they continue their treatment upon release. Further, on the day of release, prisoners with TB are taken to their nearest DOT centre and all their details are given to the centre. Monitoring of these TB patients falls under the remit of the Ministry of Justice (as opposed to the civil sector/Ministry of Health). Before the Red Crescent Society started this programme, the post-release drop-out rate was 90%: it is now only 3%.

The follow up programme for released prisoners, currently funded by Global Fund, is thus a vital component of both civilian and penitentiary sector programmes. However, because of budgetary silos and

the division of responsibility between the Ministry of Justice and Ministry of Health, it risks losing its funding following GFATM withdrawal, even though this programme addresses the cohort at highest risk.

Ideally, the government would acknowledge the vital role of this programme and provide 100% of funding support for the relevant NGOs.

## **Recommendations and suggested steps**

### *NTP*

- The NSP should be updated to align it with the Tuberculosis action plan for the WHO European Region 2016–2020.<sup>11</sup>
- The NSP should be updated to include detailed activities and financial figures and develop a clear transition and sustainability plan to guide the country towards full ownership of its TB activities.
- An action plan should be developed to assume 100% of funding, identify gaps in capabilities for managing all consumables and responsibility for cartridge replacement and calibration.
- Personal protection for the public should be optimized to prevent new indigenous cases.

### *TB-REP Working Group*

- The potential gaps in funding should be calculated – at present, these are unknown.

### *Ministry of Health*

- The updated package of TB policy documents should be endorsed.
- Consideration should be given to a more iterative scaling-up process for the mandatory health insurance pilot project. A slower process could better support long-term sustainable financing goals for TB prevention and care.
- An action plan should be developed to support the integration of TB services into PHC in collaboration with the insurance fund to change this topic from one that is frequently discussed to one that is implemented.
- Physicians' motivation and patients' adherence to treatment should be monitored after GFATM support ends (in January 2018). If it is found that both have declined, and that the decline poses a threat to programme performance (especially in terms of M/XDR-TB), domestic funding should be provided.

### *GFATM*

- Short (one to three day) training workshops should continue to be provided after withdrawal, to ensure that future cohorts of medical students benefit from TB training.

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<sup>11</sup> Tuberculosis action plan for the WHO European Region 2016–2020. Copenhagen: WHO Regional Office for Europe; 2015 (EUR/RC65/17 Rev.1).

## Policy and strategies pertaining to TB

The Law on prevention of tuberculosis in the Republic of Azerbaijan was adopted on 2 May 2000 (Annex 3). The Law defines the organizational and legal basis for protecting the population from TB, as well as the rights and responsibilities of people with TB. It is divided into four chapters on: (i) defining service provision to TB patients; (ii) state guarantees for TB care and social protection; (iii) the organization, regulation and financing of TB activities; and (iv) the rights and responsibilities of persons with TB.

In addition to this law, a parliamentary decree stipulates that TB experts in prisons receive higher salaries to overcome the heavy TB-related stigma and subsequent disincentive for physicians to train as TB specialists. Notably, HIV physicians receive a 60% higher salary than TB physicians, even though the risk of HIV transfer is lower than that of TB.

TB prevention and care activities have evolved significantly, and patients receive care according to improved models. This process should, however, be further developed and the law on TB reviewed and updated. In July 2017, following efforts by the WHO TB-REP with supportive involvement of the GFATM, local NGOs and parliament, the president endorsed amendments to the law on TB.

In 2012, the president signed the development concept, Azerbaijan 2020: look into the future,<sup>12</sup> based on Presidential Decree No.1862 of 29 November 2011. The development concept covers the main strategic goals of development policy in all areas of life in the country, including health. Specifically, the development concept plans to develop mechanisms for a dynamic increase in the share of health care allocations relative to GDP and to use these funds more efficiently.

State support for people suffering from social diseases (such as diabetes, haemophilia, oncological diseases, TB and AIDS) or undergoing, haemodialysis will be provided through prophylactic measures, sanitary awareness campaigns and various state programmes to fight drug addiction, alcoholism and smoking. To address infectious diseases, preventive measures will be stepped up and a programme prepared on the development of sanitary and epidemiological services covering the period 2015–2020. In relation to TB care, the sanitary and epidemiological services are responsible for implementing the TB infection control plan countrywide. Currently, it is unclear to what extent these services are involved in the process.

The goal of the NSP is to reduce the socioeconomic burden of TB by 2020 through a significant decline in the incidence and prevalence of and mortality from the disease (including DR-TB). It has three main objectives: (i) to ensure integrated, patient-centred care and prevention; (ii) to pursue bold policies and supportive systems; and (iii) to enable and promote research and innovation.

A sustainability plan is annexed to the NSP: it provides a comprehensive table of activities categorized according to the objectives and subobjectives, and indicating the institution responsible for implementation and source of funding (domestic or GFATM). The table indicates the year the government should take over the financing of activities that are currently supported by the donor. Most activities supported by the GFATM were supposed to become the responsibility of the government in 2018; however, no information on the status of implementation of the sustainability plan is available. It is not clear if the NSP has been approved/endorsed by the Ministry of Health or any other government authority.

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<sup>12</sup> "Azerbaijan 2020: look into the future" concept of development. Presidential Decree No. 1862, 29 November 2011. ([http://www.president.az/files/future\\_en.pdf](http://www.president.az/files/future_en.pdf), accessed 9 August 2018)

The NSP also includes a total estimated budget including sources of funding and funding gaps. Financial information on the programme budget also needs to be revised in the light of the currency depreciation, inflation rates and expected funding based on a new application to the new GFATM funding model for the next three years.

TB treatment guidelines (all forms) have been updated and protocols on bedaquiline and delamanid developed according to the latest WHO recommendations. The SRILD, as the main implementer of the NTP, is working on updating other guidelines (on TB diagnosis, paediatric TB, latent TB/prevention).

The Working Group on Sustainability and Transition (from donor to domestic funding) was recently created under the leadership of Ministry of Health. The Working Group will review the NSP in the context of implementation of the sustainability action plan. It will also use the updated national guides as a basis for a new Ministry of Health decree which will regulate the TB services, including criteria for hospitalization and length of stay. One of the tasks of the Working Group will be to discuss and evaluate the results of financing of the TB services by mandatory health insurance fund in two pilot sites, Mingachevir city and Yevlakh district, as envisaged by TB-REP.

NGOs are prohibited from procuring drugs in Azerbaijan but can provide medical services. The Red Crescent Society has employed 100 nurses to deliver medicines to rural and remote areas of the country. However, the process of securing grants for NGOs is complex, requiring approval from the health, justice and finance ministries. There are two stages of registration, and even once these have been approved, the external donor is required to have an office in the country. Therefore, the original grant in 2016 was delayed. On two occasions, grants for \$40 000 from the TB Euro Coalition/TB-REP (\$80 000 in total) had to be returned because the donor did not have an office in the country.

## **Recommendations**

### *Ministry of Health*

- The Working Group on Sustainability and Transition should revise and update the sustainability plan in the NSP, and the updated action plan should be endorsed by the relevant authorities.
- The budget for TB activities should be revised and recalculated, taking account of the new GFATM grant for 2018–2020.
- The law on TB should be revised and changed to take account of and reflect budgetary realities.

### *NTP/SRILD*

- All guidelines and protocols for medical practitioners should be updated and submitted to the Ministry of Health.
- Efforts should be made to ensure that supervisory visits continue after GFATM withdrawal, and they should be built into the NSP.

### *Multiple stakeholders (Ministries of Health, Labour and Social Protection, Justice)*

- A list of services should be drawn up that the ministries wish to commission NGOs to perform to support the procurement of goods and services from such organizations.

*Ministry of Health and Centre of Innovations and Procurement, in conjunction with GFATM and the WHO Regional Office for Europe*



- Formal agreement should be reached to work towards ensuring that the government does not lose access to the GFATM procurement platform after the transition to domestic procurement.

## **Financing and planning**

Azerbaijan has significantly increased health expenditure in recent years, from \$722 277 659 in 2013 to \$775 078 996 in 2017. The national budget for TB prevention and care was increased by an estimated 15% per year during the 2012–2014 period. However, post-2015 data should be revisited following the currency devaluation, particularly in terms of the consequences for drug procurement on the international market and affordability.

Since GFATM support for TB began, the country has observed a generally strong upward trend in laboratory-confirmed pulmonary TB (both detected and treated), with the TB notification rate (new and relapsed) steadily increasing from 45.9 per 100 000 population in 2003 to 62.2 per 100 000 population in 2013. In the year 2015–2016, the country began to observe a decline in the total number of TB cases.

According to information from the NTP, the total budget necessary for implementation of the NSP throughout its lifespan (2016–2020) is \$160 421 593, of which 84% is for the civilian services and 16% for the penitentiary system.

## **Donor support**

GFATM support for TB began in 2006, with \$55 183 182 signed for, \$50 621 764 committed and \$47 917 237 disbursed to date. Therefore, the recently requested sum of \$6 529 446 to be spread over three years (2019–2021) represents a significant decrease in donor support and an immediate call to action for the Ministry of Health to clearly define a budgeted action plan with timelines for takeover and allocation of responsibilities. See Annex 4 for details of GFATM funding for 2016–2017 and expected funding for 2018–2020.

On 15 February 2017, the Country Coordinating Mechanism of Azerbaijan applied for \$6 529 446 in GFATM support for TB to cover the period from 1 January 2018 to 31 December 2020. The funding request is aimed at creating a steady foundation to address the burden of TB and prevent the continuing spread of M/XDR-TB by means of:

- supporting proper M/XDR-TB detection and diagnostics;
- ensuring effective treatment for all TB patients, including access to proper pre-XDR-TB and XDR-TB treatment; and
- speeding up implementation of patient-oriented TB and MDR-TB case management based on ambulatory models.

Considering the country's epidemiological context, the request focuses on the key populations most affected by TB: prisoners, HIV patients and groups at a high risk of HIV, migrants, and low-income individuals in urban areas.

The programme, which seeks to prepare Azerbaijan to transition to government funding, will be in line with the recommendations of the health reform pilots that started in January 2017 in Mingachevir city and Yevlakh district for introducing mandatory health insurance and optimizing the costs of interventions.

The final year of GFATM support is 2021. Between now and then, the government plans to work with the GFATM to reduce TB mortality by at least 35% and reduce TB incidence by at least 20% by 2020

(compared with 2015). Of the two remaining (active) GFATM grants in Azerbaijan, one is for HIV and the other for TB. For the TB grant, Maintaining access and quality of essential M/XDR-TB management interventions, \$17 483 647 was signed for, \$12 929 328 committed and \$10 227 106 disbursed.

There is no assessment of the need for these activities or consideration of the size, nature or consequence of gaps that may emerge after the GFATM withdrawal, nor is there a clear action plan to guide the domestic takeover of these activities.

The current GFATM-supported programme focuses on the M/XDR-TB detection and procurement of M/XDR-TB diagnostics and drugs; it is regularly reviewed by the regional Green Light Committee. Despite the late start of the current programme in the last quarter of 2016 and the critical report released by the Committee in May 2017, it has been rapidly catching up and has achieved substantial progress. It has focused on providing treatment to DR-TB patients and has been successful in reaching the core targets of the programme. In particular:

- treatment regimens have been reviewed and correspond to the new TB treatment protocol approved by the Board Committee of the Ministry of Health in 2017, which fully corresponds to the WHO DR-TB treatment protocol of 2016;
- HIV/TB integration improved in 2016: of 99 registered HIV-positive TB patients, 78 started antiretroviral therapy during TB treatment, and the proportion of registered new and relapsed TB patients with a documented HIV status was 95%;
- a commitment was obtained from the government to fully fund anti-MDR-TB drugs from 2018;
- civil society started operating a psychosocial care and support programme in five high-burden regions which will allow treatment adherence and outcomes to improve; and
- fully equipped treatment facilities and regional Green Light Committee approval to start XDR-TB treatment in TB dispensaries Nos 6 and 9 allowed for the treatment, 182 patients (121 XDR-TB and 61 pre-XDR-TB) and the start of treatment for all patients in both facilities since June 2017.

### **Domestic support**

The NSP focuses on strengthening the detection of M/XDR-TB as well as ensuring the effectiveness of treatment for all TB patients.

The government has been effectively building up its co-financing of TB activities, with increasing commitment and funding for these activities and for the national TB response. From 2018, it will start to take over funding for diagnostics (including GeneXpert and mycobacteria growth indicator tube assays: to 30% of total costs in 2019 and 60% in 2020) and will fully fund drug procurement for all MDR-TB patients, as well as patient enabler programmes through government programmes for low-income families or those with disabilities. This corresponds to a projected 90% government contribution in 2020.

### **Civilian sector**

Since 2011, the Ministry of Health has been covering the running costs of TB-related services for the civilian sector, including human resources, infrastructure, utilities and FLDs.

In 2013, the first year of co-funding, the Ministry of Health procured 41.7% of SLDs for patients with DR-TB. The remaining needs were covered by GFATM grants until September 2015.

## **Penitentiary sector**

Within the penitentiary system, no TB funding is earmarked in the health budget. Based on current figures, approximately 50% of the Ministry of Justice's health budget will be allocated for TB, HIV and TB/HIV patients in following GFATM withdrawal. In other words, 50% of the Ministry of Justice's health budget for prisoners will be spent on 5–10% of the prison population. This is of particular concern given the increasing rate of hepatitis C in the country. In view of this and the heavy burden of M/XDR-TB in the country's prisons, a budgeted action plan should be drawn up to ensure that capacity exists to treat both diseases in the Ministry of Justice's health budget.

The Ministry of Justice has been funding 100% of FLDs for use in the penitentiary system since 2014.

In 2016, there was a delay in the GFATM disbursement, and the Ministry of Justice began to procure 100% of SLDs for MDR-TB. In 2017, the Ministry of Justice and the GFATM reverted to a 50:50 cofinancing agreement for SLDs, although the Ministry of Justice is exploring options for completely phasing out reliance on the GFATM for SLDs ahead of schedule. GFATM remains responsible for funding 100% of the Ministry's procurement of anti-XDR-TB drugs.

Promisingly, the Ministry of Justice has already assumed 100% responsibility for utilities, ventilation, service maintenance and medical personnel costs and has successfully assumed responsibility for 100% of microscopy and consumable costs, while expenses for GeneXpert functioning are fully covered by the Global Fund. It considers itself prepared to take over 100% of all TB activities within the penitentiary system from 2020 onwards. The representative of the Ministry of Justice stated that the Ministry would be happy to provide a detailed presentation/case study to show how effective its approach has been and explain the key pillars supporting its success.

It is worth noting that, unlike most other countries being considered in the six countries included in this project, Azerbaijan's Ministry of Justice is an autonomous entity, carrying out all procurement and staff management activities and bearing full responsibility for TB within the penitentiary system.

In terms of treatment capacity and allocative efficiency, there is a surplus of TB beds within the penitentiary system. Specific figures are:

- 900 beds in the prison hospital's TB clinic (220 of these are day-beds for post-treatment recuperation);
- 320 patients are registered with TB; and
- 60% of those with DR-TB are have RR-TB, 50 of whom have XDR-TB.

Unfortunately, neither the Ministry of Health nor Ministry of Justice have a TB-specific national health account that allows the cost categories to be analysed in more detail than the categories of human resources, anti-TB drugs, other non-pharmaceutical health products and other costs. Azerbaijan has no other external funding sources.

The government is committed to using additional resources for: SLDs for RR-TB patients; diagnostics (contributing to the costs of mycobacteria growth indicator tube culture and drug-susceptibility testing); expansion of the NRLs to accommodate the increasing workload; strengthening of diagnosis of extrapulmonary TB and bacteriologically negative TB using radiological and other methods; improvements in screening TB contacts, in particular those of children and young mothers; and strengthening of TB intensive care measures in the TB facilities.

## **Recommendations**

### *Ministry of Health*

- The national budget for TB prevention and care should be revised following the currency devaluation and taking account of the new GFATM grant for 2018–2020, particularly in terms of drug procurement on the international market and affordability.
- A budgeted action plan with timelines should be clearly defined for takeover and allocation of responsibilities.
- A TB-specific national health account should be developed for the Ministry of Health to allow analysis of TB cost categories in greater detail.

### *Ministry of Justice*

- A budgeted action plan should be developed to ensure that the Ministry of Justice's health budget has capacity to treat the increasing rates of hepatitis C together with the heavy burden of M/XDR-TB in the country's prisons.
- Best practices should be researched, and a shortlist compiled of available options to support the Ministry of Justice's intention to completely phase out reliance on the GFATM for SLDs ahead of schedule.
- A budgeted action plan should be developed to support the Ministry of Justice's intention to completely phase out reliance on the GFATM for SLDs ahead of schedule.
- A short PowerPoint presentation should be prepared to be used as a best practice case study highlighting the Ministry of Justice's pillars of success so that other countries included in the group of six countries considered in this project can learn from their experiences.
- The number of beds should be reviewed based on needs and the possibility of reducing or reprofiling them in line with gradually moving the care model to ambulatory prevention and care.
- A TB-specific national health account should be developed for the Ministry of Justice to allow a more detailed analysis of TB cost categories.

## **Medicine procurement**

Azerbaijan has been procuring FLDs with domestic funding since 2012. SLDs were provided by the GFATM until 2018. No treatment with new and reprogrammed drugs was available for XDR-TB and pre-XDR-TB patients. Starting from 2018, domestic funds will be used for SLD procurement and the GFATM will provide treatment for XDR-TB and pre-XDR-TB patients.

Different entities are responsible for anti-TB drug procurement for the civilian population and the prison sector: the Centre of Innovations and Procurement purchases anti-TB drugs for the civilian population, while the Ministry of Justice purchases medications for TB patients in the prison system.

The SRILD/NTP is responsible for forecasting the number of patients and calculating the drugs needed for different treatment regimens. Forecasting is based on information from the regions and the prevalence of MDR-TB and RR-TB cases. Currently, the NTP estimates that the proportion of MDR-TB is 12% among new cases and 28% among retreatment cases. The total number of MDR/RR-TB cases registered

in the country and reported to WHO was 925 in 2016, with XDR-TB diagnosed in 77 cases.<sup>13</sup> Enrollment of XDR/pre-XDR-TB patients to treatment has already started. The plan is to provide care for 155 patients in the civilian sector and 25 patients in the prison system with XDR/pre-XDR-TB by the end of 2018.

The delay in the launch of the 2016 programme funded by GFATM (funds were disbursed at the end of October 2016) caused a delay in the procurement of rapid diagnostics, sputum transportation, supervision and quality assurance for the laboratory network. In 2016 and the first quarter of 2017, there was almost no use of rapid diagnostic and sputum culture testing in the rayons. Procurement of all laboratory reagents was postponed until the first quarter of 2017, only a few sputum samples were sent to the NRLs, and sputum transportation happened once a month or even less frequently.<sup>3</sup> The impact that delayed fund disbursement and subsequently delayed procurement had on programmatic performance should be documented as a case study to illustrate what can happen when the funding application and negotiation phase is not adequately managed.

The Medicines Regulatory Authority is represented by the AEC, which is responsible for marketing authorization/registration, quality control, issuance of permission for licensing pharmacies, pharmacovigilance and pharmaceutical sector control. According to local regulations, medicines can be imported if they are registered in the country, WHO prequalified and included in the list of orphan drugs or essential medicines.

Azerbaijan is experienced in procuring SLDs in both the civilian and prison sectors. In 2014, the country procured almost 50% of all medications needed to treat DR-TB cases. The government was not, however, able to continue providing SLDs due to economic challenges; shortages in drug supply have also occurred in the past. Currently, there is no shortage of anti-TB drug provision in the country. Drugs for side-effects have been procured with domestic funds since 2013.

## **Recommendations and suggested steps**

### *Ministry of Health, Ministry of Justice*

- The procurement and uninterrupted provision of high-quality drugs should be ensured for all TB patients, whatever the source of funding.
- Consideration should be given to the gradual takeover of financial responsibility for the procurement of drugs for XDR-TB patients by the end of 2020 and its inclusion in the revised transition plan.

### *SRILD/NTP*

- The SRILD should take the lead in collaborating with and coordinating all stakeholders (Centre of Innovation and Procurement, GFATM PIU, AEC, Ministry of Justice) to support the goal of transitioning to domestic funding.

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<sup>13</sup> Tuberculosis country profiles [website]. Geneva: World Health Organization; 2018 (<http://www.who.int/tb/data/en/>, accessed 11 July 2018).

## *GFATM PIU*

- The impact that delayed fund disbursement and subsequent delayed procurement had on programmatic performance should be documented as a case study to illustrate what can happen when the funding application and negotiation phase is not adequately managed.

## **Quality, safety and standards**

In addition to the remit outlined above, the AEC is also responsible for assessing and upholding the quality, safety and standards of drugs and medical devices. A guiding principle is found in the domestic regulation, which stipulates that medicines can only be imported if they are registered in the country, WHO prequalified and included in the list of orphan drugs or essential medicines.

The most significant issue on the topic of quality, safety and standards is not lack of regulation but that the existing regulation may serve as a barrier to importing anti-M/XDR-TB drugs (or at least those not yet registered in Azerbaijan). This could be an issue if the winning tender is for drugs that have not been registered or WHO prequalified prior to the GFATM handover.

Ultimately, WHO prequalified drugs can be legally imported even when unregistered, as stipulated in the Law of the Azerbaijan Republic “About medicinal products”. A further provision states that drugs can be imported without registration provided they are imported for non-commercial purposes (that is, for humanitarian reasons), which includes the GFATM and explains why unregistered anti-XDR-TB drugs are currently imported. Given that anti-XDR-TB drugs will be imported by the GFATM only until 2020, it is vital that the Ministry of Health and NTP collaborate with the AEC and GFATM PIU to ensure that drugs from the selected manufacturers have been registered and that all necessary drugs are ready for importation following GFATM withdrawal.

The AEC is entirely self-funding and relies on registration fees for income. Currently, it requires additional funding for laboratory equipment to ensure that its services can continue. Registration fees are \$600 for an originator and \$400 for a generic drug.

In theory, the drug registration process should take a maximum of six months. However, if the AEC has questions, the clock stops until the applicant responds. In practice, this process can last for a year, which emphasizes the need for stakeholders to commence the registration process for anti-XDR-TB drugs.

## **Recommendations**

*Multiple stakeholders (Ministry of Health, GFATM PIU, AEC)*

- The stakeholders should ensure that drugs from the selected manufacturers have been preregistered and that all necessary drugs can be imported following GFATM withdrawal.

## **Health system strengthening: service delivery and links with other interventions**

The formal structure of the health care system is highly centralized and hierarchical (Semashko model), and many of its key features were retained after the country became independent. Most decisions about key health policy initiatives are made at the national level. Formally, the Ministry of Health has ultimate

responsibility for management of the health system. The private sector is licensed by the Ministry of Health and private service provision is a growing feature of the system.<sup>14</sup> Providers of parallel health services outside the influence of the Ministry of Health include those subordinated to and financed through other line ministries or state enterprises. However, the other ministries and the private sector play little or no role in TB prevention and care. An exception is the Ministry of Justice, which has overall responsibility for prison health, including TB prevention and care.

According to the development concept, Azerbaijan 2020: look into the future, a mandatory medical insurance system will be implemented, paving the way for effective procedures for providing quality medical services and protecting patient rights. As a result of health care reforms, the mainly hospital-oriented assistance will be replaced by first aid medicine and suitable conditions created for enhancing family doctor practices. Consistent measures will also be taken to improve outpatient medical services.

The State Agency on Mandatory Health Insurance was established under the Cabinet of Ministers by President in Order No. 2592, dated 27 December 2007. The regulation and structure of the State Agency were also approved by the president in Decree No. 765, dated 15 February 2016.<sup>15</sup>

Mandatory health insurance is a solidarity-based social project designed to improve health care financing and ensure universal and sustainable health insurance guaranteeing the delivery of safe, quality and efficient health care services to the public. It will offer a basic benefits package to the population, which will be under constant review in the light of public needs.

The president decree on measures for ensuring implementation activities of mandatory health insurance pilot project in Mingachevir and Yevlakh was signed on 29 November 2017. The decree aimed to align health care services in accordance with modern requirements, improve the quality of health service provision to the population, and ensure the implementation of mandatory health insurance by developing a new economic basis for the existing health care financing mechanism. The plan is to scale up this mandatory health insurance system throughout the country by the end of 2019.

WHO TB-REP, which aims to optimize TB services, is also focusing on these two pilot sites. The project aims to implement people-centred TB services and promote an ambulatory- and home-based model of care with adequate financing of service providers. As a first step, a KAP study has been conducted by the project to identify the obstacles and needs for transition from inpatient to outpatient TB treatment.

The GFATM plans to pilot results-based financing in PHC. Health care facilities implementing the pilot will be paid for every patient who receives DOT in outpatient settings; additional incentives will be paid to health facilities for their performance regarding patients' adherence to treatment.

PHC facilities and staff will play an important role in the successful scale-up of outpatient treatment. Therefore, to prepare them, the exact tasks for TB services and training should be defined. In 2017, 265 PHC doctors and 175 nurses were trained in TB issues with support from the GFATM. The GFATM will continue to support training sessions through 2018 and onwards, although with a smaller budget.

## **Recommendations**

### *Ministry of Health*

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<sup>14</sup> Ibrahimov F, Ibrahimova A, Kehler J, Richardson E. Azerbaijan: Health system review. Geneva: World Health Organization; 2010 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/118156/E94132.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/118156/E94132.pdf), accessed 11 August 2018).

<sup>15</sup> Baku: Azerbaijan State Agency of Mandatory Health Insurance; 2018 (<http://its.gov.az/en>, accessed 11 July 2018).

- The results from and experiences of the mandatory health insurance pilot projects in Mingachevir and Yevlakh should be closely monitored regarding TB services, while extending coverage.
- Results from the GFATM pilot project on results-based payment to PHC facilities should be analysed and compared with results from the mandatory health insurance pilots so that an optimal financing mechanism can be implemented for TB service provision.
- Funds saved during the reforms should be reinvested in TB activities.
- Indicators should be determined for PHC staff carrying out TB activities.
- Consideration should be given to continuation of support for training activities with the team from the NTP (in addition to GFATM support) after the end of donor support.
- The results of the KAP study on outpatient treatment of TB, conducted by Health Management Consulting, should be considered while the outpatient model of treatment is expanded.

## **TB prevention and care in prisons**

The Ministry of Justice is fully responsible for the prevention, treatment and care of TB in the penitentiary system. The Medical Department of the Ministry of Justice manages the Special Treatment Institution for Detainees with TB, established in 1995 with the support of the International Committee of the Red Cross (ICRC). During the 1995–1998 period, the ICRC actively participated in implementing the DOTS (directly observed treatment, short course) project in the central penitentiary hospital. From 2011, the ICRC has phased out of the TB project. The principal recipient of the current GFATM grant is the Ministry of Health, with the Ministry of Justice a subrecipient.

The Special Treatment Institution for Detainees with TB treats all prisoners with all forms of TB. The Institution has a third-level TB laboratory, equipped with rapid molecular testing facilities, which performs all tasks for sputum culture and drug sensitivity testing for all inmates and those with suspected TB in the penitentiary system, including for FLDs and SLDs. The Ministry of Justice is responsible for procurement of the drugs and laboratory consumables, including SLDs. The GFATM provides drugs for XDR-TB/pre-XDR-TB treatment.

Treatment adherence of former prisoners released while in TB treatment is very high. This is attributed to effective involvement of the NGO Support to Health, which is supported by the GFATM. NGO staff establish contact with patients in prison before their release and provide them with information on the importance of continuing their treatment and the services available in the civilian sector. After release, NGO members follow up patients, help them to establish contact with the treatment facilities and provide them with additional assistance according to need.

The Special Treatment Institution for Detainees with TB has a training centre which carries out all kinds of training relating to TB such as in M/XDR-TB, infection control and management of TB in penitentiaries for staff of the Ministry of Justice and for other countries. The training curricula and content fully comply with WHO modules and recommendations.

## **Recommendations**

### *Ministry of Justice*

- The Ministry of Justice should undertake advocacy towards the government regarding the financing of NGOs' activities relating to the follow-up of former prisoners with TB.



- A gradual increase in the budget should be considered to cover the cost of procuring anti-XDR-TB drugs and laboratory consumables.

#### *Ministry of Health*

- Consideration should be given to the budget for NGOs' activities relating to TB, and the legal basis for procurement/purchase of services provided by NGOs should be prepared.
- Representatives of the Ministry of Justice should be included in the Working Group on Sustainability and Transition.

## **Supervision, monitoring and surveillance**

The SRILD is the lead agency in the implementation of TB activities countrywide and thus represents the NTP. It is the national centre for TB clinical management, responsible for supervising the specialized TB services, training TB medical personnel and monitoring the quality of services, including field supervision and routine recording and reporting on TB. Staff members of SRILD are appointed as coordinators of the following areas of TB prevention and care: treatment, monitoring and evaluation, drug management and laboratory services. All NTP staff are supported with monthly incentives from the GFATM.

Central supervision of peripheral facilities is conducted by a dedicated monitoring and supervision team. An appointed responsible person (coordinator) for monitoring and evaluation at the NTP manages the activities of 10 supervisors/coordinators appointed at the central level. The coordinators are from different TB facilities in Baku and carry out monthly supervisory visits in 67 rayons of the 10 economic regions of the country. The facilities to be visited are defined in advance. Each coordinator supervises all fields of facility activities (drug management, treatment, infection control, laboratory) and passes the information to the NTP, where the data are analysed and discussed.

The GFATM has been covering the expenses of the monitoring/supervisory visits and providing incentives to the monitoring and evaluation team for their performance. Recently, this support has been suspended but a concept note submitted to the GFATM envisaged that the support will be continued after signing for a new grant and continuation of activities.

Information on new TB cases only is entered in the electronic integrated disease surveillance system, which is operated by the Ministry of Health and also contains information on other infectious diseases. In addition, the E-TB Manager system, which contains information on all TB cases (new and retreatment), is also implemented for monitoring TB surveillance. These two systems are interoperable, and information entered in the electronic disease surveillance system is submitted to E-TB Manager. E-TB Manager currently has only a patient information module. For the drug management component, the NTP staff are keen to use the Quant program for anti-TB drug forecasting, quantification and early warning. The TB information surveillance system consists of both paper-based and electronic information entered in the database at regional level and analysed and processed at central level.

The GFATM intends that the new grant should support the development of laboratory modules for the existing program and provide training for regional staff in the further implementation of E-TB Manager.

The NRLs are also part of the SRILD. The NRL network in the country consists of 69 first-level laboratories and five second-level laboratories. A total of 16 GeneXpert MTB/RIF<sup>16</sup> platforms and two HAIN tests available in the country. The cost of consumables for microscopy and Löwenstein–Jensen culture is covered by domestic funds. The GFATM covers the cost of reagents, supplies for rapid molecular testing (HAIN, GeneXpert MTB/RIF) and expenses for GeneXpert MTB/RIF calibration.

The system for transporting laboratory specimens is divided into two components: (i) from rayon laboratories/sputum collection points to regional laboratories, paid for by local governments; and (ii) from regional laboratories to the NRLs, paid for by the GFATM.

Training in TB topics is one of the tasks of SRILD/NTP staff. In 2017, 916 medical personnel were trained, including TB and PHC staff. Training activities were supported by the GFATM and are being considered for continuation with the new grant.

The reduction in the case notification rate between 2015 and 2016 was partly attributed to the delay in launching the GFATM programme in 2016 (the funds were not disbursed until the end of October 2016), resulting in delays in the procurement of rapid diagnostics, sputum transportation, and supervision and quality assurance of the laboratory network. In 2016 and the first quarter of 2017, there was practically no use of rapid diagnostics and sputum culture tests in the rayons. Procurement of all laboratory reagents was postponed until the first quarter of 2017, only a few sputum samples were sent to the NRLs, and sputum was only transported once a month or even less frequently.

## **Recommendations and suggested steps:**

### *Ministry of Labour and Social Protection, Ministry of Health*

- Consideration should be given to legal provision for a salary increase for NTP staff as national coordinators for implementation of the NTP national level activities.

### *Ministry of Health, Working Group on Sustainability and Transition*

- The updated NSP should reflect the gradual takeover of expenses for supervisory/ monitoring visits, laboratory consumables and equipment maintenance, training sessions for TB and PHC staff, and specimen transport from regional to central level.

### *GFATM and the government*

- Supervisory visits should continue after GFATM withdrawal and built into the updated NSP.

## **Communications and advocacy**

The Country Coordinating Mechanism is well coordinated, and all NGOs visited during the mission are members (Annex 2). The Country Coordinating Mechanism is the only platform for including civil society organizations in decision-making in Azerbaijan. Notwithstanding this, all NGOs demonstrated

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<sup>16</sup> For detecting *Mycobacterium tuberculosis* (MTB) and resistance to rifampin (RIF).

excellent knowledge of the policy-making processes and had driven successful TB programmes, contributing enormously to the success of the NTP.

Programmes and activities delivered by the NGOs include mobile outreach (such as nurses delivering anti-MDR-TB drugs to patients who are otherwise unable to access health services), psychosocial support, round-table meetings with education/training on TB for World TB Day, public awareness campaigns communicating that TB can be cured, a patient hotline and patient-focused pamphlets addressing stigma and seeking to increase testing.

The Red Crescent Society has strongly advocated to parliament, although the main objective was to prioritize issues rather than mobilize resources. A TB coalition was established in September 2011 to raise the priority status of TB among decision-makers in parliament.

Given that the current allocation of GFATM support is significantly less than previous allocations and that NGOs only received a small proportion of the funding to start with, the current allocation will reduce the ability of NGOs to continue providing services. Over the 2018–2020 period, NGOs will receive approximately 0.6% of Azerbaijan's total GFATM allocation; in the case of the Red Crescent Society, this is a third of the previous annual allocation.

One NGO, Hayat, has focused on TB, drug/addiction and HIV, particularly among refugees and internally displaced people since 1993. From 2008 to 2012, Hayat received financial support from the government for a project addressing TB outbreak in the rural southern region. This included support from the Ministry of Health in the form of a vehicle with fluoroscopy capabilities, which enabled fluoroscopy tests to be carried out on 2000 people and led to the identification of 112 TB cases.

The same vehicle was then used to tour areas known to have a high proportion of refugees, internally displaced people and low-income earners. This vehicle was supported by the GFATM in 2012–2013 but has been unfunded since. Recently, Hayat discovered that TB is increasing in the northern region and, although ready to implement the project, lacks the funding to do so.

Given the lack of mobile outreach in rural Azerbaijan, there is likely to have been a gap in screening, diagnosis and treatment of refugees and internally displaced people since the end of Hayat's project.

Another NGO, Support to Health, has collaborated with the NTP, ICRC, Ministry of Health and Ministry of Justice to follow up over 690 TB patients released from prison. Support to Health stated that each year approximately 100 TB patients are released from prison with incomplete treatment regimens – this is where they focus their efforts and where they need extra support to help prevent M/XDR-TB.

In other efforts, Support to Health has supported TB-REP with a KAP study and with capacity-building and advocacy training for NGO staff. The study identified the role that stigma plays in perpetuating MDR-TB in rural areas; this is particularly the case for female patients, who avoid TB testing centres because of stigma and the negative impact it has on their potential to marry. It also highlighted barriers to the implementation of patient-centred care, the vital inclusion of (and gap in) support for patient adherence to treatment and all social aspects of TB, especially homelessness.

Support to Health formed a coalition with an AIDS NGO and patient organizations to share information and meet members of parliament.

The Azerbaijan Health Communication Association (a partner organization of the Office of the United Nations High Commissioner for Refugees) works at community level with refugees and asylum-seekers from countries such as Afghanistan, the Russian Federation (including Chechnya) and Syria. The Association applies a patient-oriented approach, targeting patients living in the community. It conducted a KAP study and found that TB patients found it easier to talk to NGOs than to doctors or government agencies.

The Association highlighted the need to update the 2002 law on TB to enable NGOs to conduct advocacy and disclosed an issue with grant registration that prevented them from accessing available funds (as previously highlighted in this document).

## Recommendations and suggested steps

### GFATM

- In 2018, the central penitentiary hospital and development partners (the GFATM and WHO) should provide resource mobilization and advocacy training to improve the skills of civil society organizations to ensure that their advocacy efforts are as effective as possible.
- Alternative forms of funding should be identified to support NGOs working with former prisoners with TB to prevent the spread of M/XDR-TB from this risk group, since government funding is extremely unlikely.
- Priority should be given to funding the work of Support to Health with former prisoners with TB with the aim of preventing the spread of M/XDR-TB from this risk group.
- Lobby the government for the 2000 law on TB to be updated to enable greater participation of NGOs in TB care and ensure that the process for registering grants is seamless and does not preclude programme implementation.

## Table of recommendations and suggested steps

Area	Action	Timeline	Responsible agency
Socioeconomic and geopolitical context	Continue the dialogue between the Working Group (including the MoF, MoH and insurance agency) and the NTP to increase efforts to establish realistic budget allocations and priorities in the light of Azerbaijan's declining gross national income	Q2 2018	MoF, MoH, NTP
	Based on the revised realistic budget allocations and priorities from the Ministries of Finance and Health, the NTP should revise the activities and targets planned under the NSP and reprioritize activities in the light of the declining gross national income	Q3 2018	NTP
	Update the NSP to align with WHO's Tuberculosis action plan for the WHO European Region 2016–2020 <sup>17</sup>	Q4 2018	NTP
Health care system and NTP	Update the NSP to include detailed activities and financial figures and develop a clear transition and sustainability plan to guide the country towards full ownership of its TB activities	Q4 2018 (after first results from Mingachevir and Yevlakh pilots)	NTP
	Calculate the size of the potential financial gaps (currently there are none)	Begin Q4 2018; ongoing	Tuberculosis Regional Eastern European and Central Asian Project (TB-REP) Working Group
Financing and	Develop a budgeted action plan to ensure capacity in	Q1 2019	MoJ

<sup>17</sup> Tuberculosis action plan for the WHO European Region 2016–2020. Copenhagen: WHO Regional Office for Europe; 2015 (EUR/RC65/17 Rev.1).

Area	Action	Timeline	Responsible agency
planning	the MoJ's health budget to treat the increasing rates of hepatitis C alongside the heavy burden of multidrug- and extensively drug-resistant-TB (M/XDR-TB) in prisons		
	Revise the national budget for TB prevention and care in light of the post-devaluation currency landscape and the new GFATM grant for 2018–2020, particularly in terms of drug procurement and affordability	Start as soon as possible, ongoing	MoH
	Review the number of beds based on needs and the possibility of reducing or reprofiling them	Ongoing	MoJ
Policy and strategies relating to TB	Update and submit to the MoH all guidelines and protocols for medical practitioners	In process, to be accomplished by Q4 2018	NTP, Scientific Research Institute of Lung Disease (SRILD; and MoH)
	Seek to ensure that supervisory visits continue after GFATM withdrawal. Build this into the NSP	Q4 2018	GFATM (in close communication with the NTP)
	Formally agree to work towards ensuring that the government does not lose access to the GFATM procurement platform after the transition to domestic procurement	Engagement should begin in Q3 2018 and be agreed by end 2018	MoH, GFATM
	Reflect in an updated NSP the gradual takeover of expenses for supervision/monitoring visits, laboratory consumables and maintenance of equipment, training sessions for TB and PHC staff, and transport of specimens from the regional to central level	Commence immediately, ongoing until 2020	MoH
Procurement of medicines	Ensure procurement and uninterrupted provision of high-quality drugs to all TB patients in the country, whatever the source of funding	Commencing immediately, ongoing	MoH, MoJ
	Consider the gradual takeover of financial responsibilities for procurement of drugs for XDR-TB patients by the end of 2020. Reflect the action in the renewed transition plan	Commence 2019	MoH, MoJ
	Document the impact that delayed fund disbursement and subsequent delayed procurement had on programmatic performance as a case study to illustrate what can happen when the funding application and negotiation phase is not adequately managed	End 2018	GFATM Programme Implementation Unit (PIU)
Quality, safety and standards	Ensure that all necessary drugs have been preregistered and are ready for importation following GFATM withdrawal	Commencing immediately, ongoing	Analytical Expertise Centre (AEC), GFATM PIU, MoH
Service delivery and linking with other interventions/ health system strengthening	Provide technical assistance to the MoH Working Group on Sustainability and Transition (MoH WGST) on optimization of services with adequate financing mechanism	End 2018	MoH WGST
Evidence-based TB policy and practice	Analyse results from the GFATM pilot project on results-based payment to PHC facilities along with the results from mandatory health insurance pilots in Mingachevir and Yevlakh to inform an optimal financing mechanism for TB service provision	By end 2018 or following availability of results from pilot sites	GFATM, MoH WGST
	Determine performance indicators for PHC staff performing TB activities	Q3 2018	MoH WGST

Area	Action	Timeline	Responsible agency
Communications and advocacy	Consider the knowledge, attitude and practice (KAP) study results on outpatient treatment of TB, conducted by Health Management Consulting, while expanding outpatient model of treatment	Q3 2018	MoH WGST
	Provide resource mobilization and advocacy training to upskill civil society organizations to ensure their advocacy efforts are as effective as possible	Q4 2018	GFATM
	Identify alternative forms of funding to support NGOs working with former prisoners with TB to prevent the spread of M/XDR-TB from this risk group	Q4 2018/Q1 2019	GFATM PIU

## Annex 1. List of stakeholders met

Date	Institution	Name, position
3 April 2018	WHO Country Office	Javahir Suleymanova, National Professional Officer
	SRILD	Hagigat Gadirova, Director
	SRILD staff, NTP	Aziz Musaev, Treatment Coordinator
		Sevinj Taghieva, Monitoring and Evaluation Coordinator
		Vafa Shakhtatinskaia, TB Drug Manager
		Rafic Abuzarov, Head, NRL
4 April 2018	Ministry of Health	Viktor Gasimov, Head, Sanitary-Epidemiological sector, NTP manager
	AEC	Murad Suleimanov, Director
	Medical Department, Ministry of Justice	Rafael Mekhtiyev, Head, Medical Department, Ministry of Justice
		Fizuli Huseinov, Head, Department of Medical Management
		Famil Mammadov, Senior TB Inspector, Main Medical Department, Ministry of Justice,
		Natavan Alikhanova, TB coordinator PIU/GFATM, Ministry of Justice
Civil society organizations/NGOs		Irada Akhundova, Scientific and Research Institute of Lung Disease (SRILD)
		Garakhanova Matanat, Sabina Mahbubi-Iran, Azerbaijan Red Crescent Society
		Lala Iskanderova, Nezifa Sattarova, Organization of TB Doctors and Pulmonologists
		Jamila Safarova, Hayat
		Fuad Mammadov, Office of the United Nations Commissioner for Refugees

5 April Ministry of Health, GFATM PIU Naila Aliyeva, GFATM TB Programme Coordinator  
2018

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## **Annex 2. Meeting agenda**

### **Tuesday 3 April 2018**

- 10:00–11:00 Professor Hagigad Gadirova, Director, SRILD
- 11:00–13:00 NTP staff: Treatment & Prevention Coordinator; Monitoring & Evaluation Coordinator; Drug Supply
- 15:30 Dr Viktor Gasimov, Head, Sanitary-Epidemiological Sector, Ministry of Health, NTP Manager

### **Wednesday 4 April 2018**

- 10:00–11:30 Mr Rafael Mekhtiyev, Head, Medical Department, Ministry of Justice;  
Dr Fizuli Huseinov, Head, Medical Management Unit, Ministry of Justice;  
Mr Famil Mammadov, Senior TB inspector, Ministry of Justice;  
Dr Natavan Alikhanova, TB coordinator, GFATM PIU, Ministry of Justice
- 12:00–13:00 Mr Murad Suleymanov, Director, ACE

### **Thursday 5 April 2018**

- 10:30–12:30 Meetings with NGOs:  
Support to Health  
Hayat  
Assistance of Health care Development  
Azerbaijan Health Communication Association  
Azerbaijan Red Crescent Society
- 14:30–16:00 Director and TB project staff, PIU/GFATM

## **Annex 3. The Law of the Republic of Azerbaijan “About Fight with Tuberculosis in the Republic of Azerbaijan”**

This law defines the organizational and legal basis for protection of the population from TB and the rights and responsibilities of persons with TB.

### **CHAPTER I. General provisions**

#### ***Article 1. Anti-TB measures and their implementation principles***

Anti-TB measures (sanitation-health and anti-epidemic measures, examination, diagnostics, treatment, prevention and rehabilitation) in the Republic of Azerbaijan are implemented in accordance with the rules defined in this Law and other relevant normative legal acts. Anti-TB measures are implemented for all citizens and permanent residents of the Republic of Azerbaijan without citizenship on an equal basis in compliance with legislation, humanism, human and citizen rights. In the Republic of Azerbaijan, the examination and treatment of foreigners who apply for medical aid to anti-TB health facilities is implemented in accordance with the rules defined in legislation.

#### **Article 2. Anti-TB legislation in the Republic of Azerbaijan**

Anti-TB legislation in the Republic of Azerbaijan consists of this Law, other normative legal acts and international treaties to which the Republic of Azerbaijan is a party. Other legislative acts of the Republic of Azerbaijan in the area of TB prevention and care cannot limit the rights of citizens envisaged in this Law.

#### **Article 3. Applicability**

This Law is applicable to all citizens of the Republic of Azerbaijan, permanent residents of the Republic of Azerbaijan without citizenship and all legal entities regardless of organizational and legal form.

### **CHAPTER II. Types of state-guaranteed anti-TB care and social protection**

#### **Article 4. Measures of state-guaranteed anti-TB care**

Anti-TB care is ensured through the following measures:

- establishment of facilities providing ambulatory, inpatient and sanatorium care;
- organization of education for children receiving TB treatment in anti-TB hospitals and sanatoria;
- organization of work therapy in anti-TB dispensaries;
- establishment of institutions with light working conditions to ensure employment of persons with TB (particularly for workers with hard and especially harmful working conditions and disabled persons);
- setting of compulsory staff position quotas for disabled persons with TB in public institutions, agencies and organizations;
- establishment of special health care facilities for long-term stays at the state's expense for persons with chronic forms of TB who lose their social connections; and
- implementation of other necessary measures for the social protection of persons suffering from TB.



To provide anti-TB care, the state guarantees the following:

- adoption and implementation of the National Programme on Tuberculosis Prevention in the Republic of Azerbaijan;
- acute anti-TB care;
- provision of expertise regarding TB;
- social and domestic care, including provision of priority isolated housing for persons with infectious forms of TB, ensuring employment for persons suffering from TB and its consequences;
- specific prevention of TB, ambulatory, inpatient and sanatorium consultative-diagnostic, treatment and rehabilitation care in public health care facilities;
- provision of specialized medical aid to persons with TB in penitentiary facilities;
- definition of tax exemptions for public institutions, organizations and agencies providing employment for persons disabled due to TB; and
- reimbursement of health losses to persons with TB during the provision of health care in accordance with legislation.

***Article 5. Individuals and legal entities providing anti-TB care***

Anti-TB care is provided by physician-phthisiatricians with higher education practising on the basis of special authorizations issued in accordance with the rules set in the legislation of the Republic of Azerbaijan and specialized public, municipal and private health care facilities with special authorization from the relevant executive body to provide this type of care. Regardless of ownership forms, in all anti-TB facilities, patient registration and recording is conducted in accordance with the rules set by the relevant executive body.

***Article 6. Types and rules for provision of anti-TB care***

Types of anti-TB care are shown in a health facility's statute or special authorization issued in accordance with the rules set in the legislation. A patient should be informed about this. Anti-TB ambulatory-polyclinic care, preventive and anti-epidemic measures, inpatient and ambulatory treatment as well as rehabilitation measures (including those in hospital settings) are provided in accordance with the rules defined by the relevant executive body.

***Article 7. Types of ambulatory anti-TB care***

Anti-TB ambulatory care is provided in the form of treatment-diagnostic care and outpatient follow-up in accordance with the rules defined by the relevant executive body. Treatment-diagnostic care for persons with TB is provided by physicians-phthisiatricians based on an individual's visit or referral from a treatment-prevention facility, or based on a parent's or legal guardian's application for underage children. Outpatient follow-up is conducted regardless of the TB patient's consent and includes regular follow-up of the disease process by the physician-phthisiatrician and necessary medical and social aid. Compulsory outpatient follow-up is also applicable to persons at a high risk of TB.

### ***Article 8. Anti-TB inpatient care***

TB patients who discharge mycobacteria are mandatorily hospitalized. Hospitalization of persons with suspected TB and patients who do not pose a threat to others takes place on the basis of medical indications.

The need for hospitalization is defined by the following factors:

- there is a direct threat to the patient's life and the people around;
- severe deterioration in the patient's health due to worsening of his/her general condition;
- inability to independently perform key life activities due to severity of the disease.

Patients who pose an epidemiological threat to the people around them are hospitalized mandatorily in accordance with the rules defined by the relevant executive body. Patients in the penitentiary system who fail to cease discharging mycobacteria following one year of treatment are housed separately from other prisoners. TB patients released from the penitentiary system or returning from military service are registered in anti-TB health facilities in their place of residence within 10 days under the supervision of the relevant executive body.

### ***Article 9. Provisions and benefits for physicians-phthisiatricians and other specialists and workers providing anti-TB care***

Provisions and benefits for physicians-phthisiatricians and other specialists and workers working in anti-TB health facilities are defined by legislation. Salary additions and mandatory insurance for physicians-phthisiatricians and other specialists and workers working in anti-TB health facilities are defined by legislation. If physicians-phthisiatricians and other specialists and workers working in anti-TB health facilities contract TB while carrying out their work, this condition is considered an occupational disease.

## **CHAPTER III. Organization, regulation and financing of anti-TB measures**

### ***Article 10. Organization of anti-TB measures***

In the Republic of Azerbaijan, anti-TB measures are implemented in accordance with the rules defined by the relevant executive body. TB-related resolutions of the relevant executive body are mandatory for all treatment-prevention facilities regardless of their ownership form and subordination. Organization of anti-TB care is ensured based on long-term comprehensive programmes approved by the relevant executive body. Supervision of the activities of anti-TB health facilities is implemented by the relevant executive body.

### ***Article 11. Registration and recording in the field of fighting TB***

All detected TB-related cases require mandatory registration and recording at anti-TB health facilities in accordance with the rules defined by legislation. The relevant executive body must be immediately notified about this. If an autopsy reveals that the person had TB, notification must be sent to the relevant executive body.

### ***Article 12. Financing of anti-TB measures***

The activities of anti-TB health facilities are funded through state and local budgets, mandatory health insurance and other sources not prohibited by law.

## **CHAPTER IV. Protection of the population from TB. Rights and responsibilities of persons with TB**

### ***Article 13. Protection of population from TB***

The list of occupations prohibited for persons with the risk of transmitting TB to others is defined by the relevant executive body. After being hired and working in those occupations, persons with the risk of transmitting TB to others undergo mandatory X-ray or fluorography examinations at predefined intervals. It is prohibited to place persons with the risk of transmitting TB in dormitories and apartments with multiple tenants. Persons living in dormitories or apartments with multiple tenants must be hospitalized immediately if they develop TB. Patients who fail to cease discharging mycobacteria following one year of treatment are provided with separate housing. Persons provided with an apartment out of their turn or first as a result of discharging mycobacteria are prohibited from selling, leasing out or using those apartments with the purpose of making a profit or exchange them for less comfortable ones. Special long-stay hospitals are organized to accommodate persons with TB who pose a threat to others and do not have a permanent residence, and the rules for their referral and admission to such facilities are defined by the relevant executive body.

### ***Article 14. Rights of persons with TB***

Persons with TB possess all rights and freedoms provided by the Constitution of the Republic of Azerbaijan. When receiving anti-TB care, persons with TB have the following rights:

- to receive detailed information about their rights related to anti-TB care, disease specifics and methods of treatment utilized;
- to receive a full volume of indicated health care in ambulatory, hospital and sanatorium-resort settings; and
- in cases of first-time TB or its recurrence, to be on sick leave for up to 12 months starting from the first day of loss of working ability considering medicosocial and epidemiological indicators.

If the ability to work is lost due to TB, wages are paid at 100% regardless of work experience. The issues related to extension of a sick leave due to temporary loss of working ability beyond the defined limits or determination of permanent loss of working ability are considered by the relevant executive body. During the treatment period, non-working persons with TB receive an allowance. The rules and conditions for provision of an allowance are defined by the relevant executive body. The work positions of persons who temporarily lose their working ability due to TB are kept for 12 months. Travel expenses of persons with TB related to hospital and sanatorium treatment are reimbursed by state and local budgets. A patient must be informed about the reasons and purpose for admission to an anti-TB health facility and the facility's internal rules. Patients under 16 years of age undergoing treatment or examination in an anti-TB facility have a right to education in accordance with the rules defined by legislation.

### ***Article 15. Responsibilities of persons with TB***

Persons with TB must:

- comply with all treatment and health measures prescribed by area physician-phthisiatrician and sanitary-hygienic requirements set for this group of patients;

- visit an anti-TB facility based on a physician's invitation; and
- register with an area anti-TB facility within 10 days if the permanent residence is changed.

***Article 16. Rules for submitting complaints related to provision of anti-TB care***

Complaints about actions infringing the rights and interests of citizens during provision of anti-TB care (incorrect determination of the duration of sick leave, non-provision of free medicines during ambulatory treatment, refusal to provide hospital and sanatorium care or to reimburse a patient's travel expenses associated with treatment) are considered in accordance with the rules defined by the legislation of the Republic of Azerbaijan.

***Article 17. Responsibility for violation of this Law***

Individuals and legal entities guilty of violating this Law bear responsibility in accordance with the legislation of the Republic of Azerbaijan.

***Article 18. International collaboration***

International collaboration in the field of fighting TB is implemented based on international treaties to which the Republic of Azerbaijan is a party. In case of contradictions between this Law and the international treaties to which the Republic of Azerbaijan is a party, those international treaties shall prevail.

**Heydar Aliyev**

**President of the Republic of Azerbaijan**

Baku City, 2 May 2000

## Annex 4. GFATM funding for 2016–2017 and expected funding for 2018–2020

Activity	2016–2017 (\$11 million)	2018–2020 (\$6.5 million)
Procurement of SLDs	+	–
Procurement of Group 5 anti-TB drugs (for XDR-TB treatment)	–	+
Laboratory consumables for rapid molecular tests (GeneXpert MTB-Rif, HAIN)	+	+
Transport of specimens from regions to Baku	+	+
Training for TB and PHC staff	+	+
Support for NTP staff	+	+
Support for supervision/monitoring visits	+	+
Further implementation of E-TB Manager	+	+
Outreach service and provision of psychosocial support to XDR-TB patients (NGO)	+	+
Follow-up of ex-prisoners (NGO)	+	+
Provision of treatment enablers for DR-TB patients	+	–

## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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