External Reviews of the Tajik-Swiss Health Care Reform

Family Medicine Support Project (SINO) and of the Undergraduate Medical Education Reform Project (MEP)

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List of abbreviations and acronyms

AKF  Aga Khan Foundation
AKHS  Aga Khan Health Services
BP  Business Plan
BBP  Basic Benefit Package
CCM  Council Coordination mechanism
CRH  Central Rayon Hospital
FM  Family Medicine
FN  Family Nurse
FP  Family Physician
GIZ  German Corporation for International Assistance
GOT  Government of Tajikistan
M&E  Monitoring and Evaluation
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
HMIS  Health Management Information System
HPAU  Health Policy Analysis Unit
JAHSR  Joint Annual Health sector review
KFW  German Development Bank
MEP  Medical Education Reform Project
MoE  Ministry of Education
MoF  Ministry of Finance
MoH  Ministry of Health
MoU  Memorandum of Understanding
NGO  Non-Governmental Organisation
PGMI  Post-Graduate Medical Institute
PHC  Primary Health Care
PIU  Project Implementation Unit
PRS  Poverty Reduction Strategy
QCHP  Quality health care project
RHC  Rural Health Centre
RCFM  Republican Center for Family Medicine
SCIH  Swiss Centre for International Health
SDC  Swiss Agency for Development and Cooperation
SINO  Swiss Healthcare reform and family medicine support project
STPH  Swiss Tropical and Public Health Institute
SWAp  Sector Wide Approach
TB  Tuberculosis
TOR  Terms of Reference
TSMU  Tajikistan State Medical University
UNICEF  United Nations Children’s Fund
USAID  united states agency for international development
WB  World Bank
WHO  World Health Organisation
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1 Executive Summary

1.1 Findings

(Note: Annex 5 has detailed answers to TOR Questionnaire: See Section 4.1 for rationale)

Both the Medical Education Project (MEP) and the SINO project work in fields of high relevance for improving the Primary Health Care system so that it becomes more responsive and accessible particularly for the rural population. The MEP covers an essential "niche", the discrete world of medical education, which has the long term potential for changing the way primary health care is delivered. The SINO project is important over the medium term for the development and spread of family medicine across the country, and can contribute significantly to improving the quality of primary health care delivery.

While it is too early to report on the impact of the MEP, the project has been effective in changing minds and winning friendship and respect. Expectations of the stakeholders at all levels are positive and, for the time being, the political situation is favourable for continued cooperation, which is not the case in many other Central Asian countries. The interventions of SINO have had a positive effect on the health system, with medical staff and community groups pleased with the inputs and support given. Many limitations faced by SINO are due to the health system itself, for example the slow pace of incorporation of Peer Review Groups and the Business Plans into the regulatory systems of medical education and management respectively.

Sustainability of the MEP is likely due to the strong ownership by the Tajikistan State Medical University (TSMU), the appreciation shown for the MEP inputs so far, and of the openness and understanding of the leadership to the need for change towards international standards. The SINO project is laying a solid foundation through its support for the retraining of family doctors and nurses, the rebuilding and equipping of primary health care facilities, inputs to the discussion on health financing, and the implementation of initiatives valuable for future progress such as the Business Plans, Community Groups and Peer Review Group educational meetings.

The MEP and SINO projects thus have important roles to play in the development of the health care system of Tajikistan. The review team did not find any cause to recommend any major changes in direction, nor did they find any cause for special concern in the governance of the medical education system including the entrance criteria, nor any obvious issues regarding gender inequalities. Instead, it was found that there is plenty of scope to deepen and spread these initiatives, perhaps enhancing the synergies between them more actively. All that is being done has the potential to increase governance transparency and empower rural patients, men and women, especially through the Community Group activities.

The overall focus on Primary Health Care through development of family medicine matches perfectly the priorities of the Government, and is in keeping with the large proportion of the population who live rurally. However, the impact of the project could be enhanced significantly, and three main themes for this emerged from the detailed findings: (1) roll out and sustainability would be helped by (2) linkage to existing relevant institutions, while the quality of service provision would be augmented by increased emphasis on - and sensitivity to - (3) feedback from patients and providers.

In view of these findings, the main recommendations of the external review team are summarized below:
### 1.2 Main Recommendations

#### Recommendations - Summary

**Undergraduate Medical Education**

- Reform of the medical curriculum is an intensive and long term undertaking, and is still in an early phase. This should continue to be a prime focus of any new project, together with support for its effective implementation, perhaps utilising other similar ongoing initiatives in the region.

- Day-to-day guidance of those working to redraft the curriculums should be the ideal for the management of the process of curriculum design.

- Increase the knowledge and understanding of family medicine among the TSMU faculty through cooperation with the family medicine training centers and through feedback from primary health care level on the training needs for undergraduates.

- Continue the process of developing clinical skills teaching among the TSMU faculty and mentoring them.

- Consider redeveloping the undergraduate nurse training program to meet the need for family nurses in the country.

**Graduate Medical Education**

- Explore the possibility of strengthening the family medicine Internatura year for graduates to make it more structured and organized, with the goal to make family medicine a serious alternative for the most talented doctors (see Annex 6 for outline of possible steps).

**Continuous Medical Education**

- Despite the years of input to family medicine training programs, still only a small proportion of the country’s doctors have been retrained, and this should continue if family medicine is to be fully established nationwide.

- Taking the opportunity afforded by the drafting of the National Health Strategy Republic of Tajikistan 2010-2020, coordinated efforts should be made to elaborate a medium term plan for scaling up the training of family medicine staff across the country, assessing how implementation could be further catalysed through the strengthening of the current teaching staff, user organisations, and other parties. Consideration could be given to the inclusion of SINO initiatives such as the Peer Review Groups, Business Plans and other relevant approaches.

- A more proactive approach should be taken to support the FM training centers in their work, perhaps also developing a clear national concept on the training centres needs to be put in place including their role, oversight, number, quality assurance, coverage, etc.

- If acceptable, preparation and plans could be drawn up to involve and update the medical faculty of the TSMU on the current teaching and methods employed by the FM training centers.
• The Peer Review Groups should continue to be promoted, sharing good practices (such as head doctor meetings) and achievements (such as new lessons learned and problems resolved) both at local rayon levels and also on up to the policy level decision-makers.

• To augment this further, efforts to link the Peer Review Groups to the Republican Center for Family Medicine (RCFM) as the responsible institution for Continuous Medical Education should be continued. Thus, the Ministry of Health should consider making this an agreed responsibility of the RCFM, and the RCFM should be supported to fulfill this leadership role.

• A credit system approach with credits for visited peer review groups as Continuous Medical Education is already discussed within SINO and should be followed up.

• Assess whether the "Clinical Excellence Centers" implemented by Aga Khan Foundation have the potential to add value to the concept of Peer Review Groups established by SINO and if these two approaches could be matched.

• Review of the content of the 6-month family nurse retraining program with a view to a possible reduction in its length, and to simultaneously strengthen the undergraduate training.

Management of Health Care

• The Business Plan approach is much appreciated by the health care workers and managers, continuing in areas where the SINO project is now phased out, and holds considerable potential for improved management of the health system. For these reasons, including its sustainability, it should be continued, refining it as needed to ensure maximum efficiency of roll out and replication elsewhere.

• Development of the Plans should include de-linking with any set targets, increasing the emphasis on responding to the needs of the health facilities described in the Plans. In this way the Plans should evolve into a functional "annual operational plan", guiding priorities and strategy not just at the rayon/ oblast levels, but also providing feedback for policy dialogue.

• A successive phase of SINO could aim to work much more closely with the PHC managers to implement such quality improvement aspects of the Business Plans. This might begin to orient the perception of managers towards more understanding of issues faced by the facilities and their responsibility to address them, including issues brought up by the Peer Review and Community Groups.

• The TSMU Public Health Management Department would be a potential partner and multiplier in rolling out and supporting the Business Plan idea and could allow the concept to be incorporated into the curriculum at the TSMU.

• Pursue collaboration with the EU as it plans to invest in an HMIS system on oblast level country wide. Linkage by the project to this might help to strengthen the institutionalisation of the Business Plans and may strengthen the effectiveness of the HMIS project.

• Include more patient-management monitoring indicators (which have no numerical targets applied to them) in the Business Plan in order to better understand the quality of care being delivered and achieved, so that appropriate actions can be taken for improvement.

• Continue SINOs role of assessing and reporting progress and impact on health financing measures.
• The project could play a greater role in advising on logistics and procurement of equipment, ensuring feedback (through the Business Plans) to the relevant authorities and organizations to improve the day-to-day functioning of the family medicine facilities.

Community Groups

• To further extend coverage, SINO could allow doctors and nurses to form new groups themselves instead of doing this only when supported by SINO staff, and to include those medical staff who have not yet been trained in family medicine.

• Involve pilot Rayon Healthy Lifestyle Centers in the management of the Community Groups, and through developing their capacity larger numbers of medical staff can be trained, more Community Groups established and supported, and sustainable institutional support ensured when the project ends.

• New doctors and nurses taking responsibility on their own for new Community Groups should go through a more formalized training/process of reflection on participative facilitation methods.

• SINO may consider deepening its approach by working with Community Groups on health determinants, building on existing examples such as the one on drinking water provision in Batosh.

Coordination with the MoH

• Partnerships with government entities should be fostered and made integral to the work of the Sino project in order to strengthen the project outcomes over the longer term: increasing sustainability, accelerating expansion of activities and coverage of the country; with little overall increase in costs.
2 Background

This report outlines the findings of external reviewers of the current status and possible future directions for the MEP and SINO projects. It comes as the third phase of the SINO ends in June 2012 and the first phase of the MEP concludes in April 2012. It also ties in with the new Swiss Cooperation Strategy for Central Asia (2012-2015), which is currently under elaboration.

From an overall perspective, the SINO and MEP projects are tasked with developing the foundations for reform of the health care system of Tajikistan. This encompasses the initial training of medical students and nurses, and the training and operation of primary health care family medicine facilities, including the collaboration between the facilities and the community. These are challenging but important tasks for the country, and the quality of the training set in place and the numbers able to be covered will set the tone for the future development of the entire health system.

Two external reviews, one for each project, were conducted simultaneously. This choice was motivated for reasons of efficiency: firstly because while the two projects are distinct yet they have medical education in common; and, secondly, by working together the evaluation teams were able to get a broader understanding of the SDC portfolio in the health sector beyond the project to be evaluated. The review took place over two weeks from 17-30 November 2011, and was led by two consultants (hereafter referred to the "Lead Consultants") recruited by evaplan GmbH, the company having been selected through an open tender process.

The main objectives that served to guide the external review are shown below:

- To assess if the two projects were effective (and in some extend cost-effective) in terms of achieving the set objectives, thereby emphasizing results achieved by the two projects (outcome mapping) and pointing out possible shortfalls;
- To assess the relevance of the two projects in terms of needs and identified priorities in the health sector in Tajikistan, as well as with regard to SDC planned strategic framework in the health sector within its new cooperation strategy;
- To assess if the Sino project is sustainable, especially in those areas where Sino support has come to an end over phase 3 (Varzob and Dangara);
- Establish recommendations for possible upcoming projects phases, in particular with regard to:
  - Coherence with and relevant contribution of the projects (outcomes, approaches and lines of intervention) to SDC strategic orientation in the health sector (from 2012 onward) as well as to the Tajik national health strategy 2011-2020 and investments of other actors in the health sector in Tajikistan; give feedback on the results framework of the new country strategy in the light of the findings and recommendations.
  - Synergies and complementarities across the two projects and within the SDC programme in the health sector development in Tajikistan;
  - Possible implementation changes or extension of project activities to improve the systemic functioning of the health sector;
  - Recommended main areas/approaches to focus in order to reduce fragility of the country (thematic and geographic considering conflict sensitiveness)
3 Methodology

The two Lead Consultants worked for two weeks in the country. They were supported by Tobias Schüth from the Swiss Red Cross who has long term experience working on Community Development projects in Kyrgyzstan; Debora Kern recently appointed as health policy adviser of the SDC also accompanied the team in order to familiarise herself with the project; and by Mehrinisso Yuldashova, a local expert who took time off from the KfW Tuberculosis development project on which she primarily works.

The Lead Consultants spent three days prior to the field trip carrying out a desk study of documents submitted by the SINO and MEP projects (Annex 2), and designing a questionnaire for use in the field (Annex 5). They visited the SDC office in Berne to discuss the Terms of Reference (ToR- Annex 7) and to understand the overall goals for the evaluation from the SDC point of view. They also visited the Swiss Tropical and Public Health Institute (STPH) office in Basel and had discussions with the team leaders of the MEP and SINO projects, and received more information on their progress and constraints.

The field trip to Tajikistan involved interviews, observations and discussions with numerous institutions, government authorities particularly the Ministry of Health, donor agencies, medical training and health facilities, and with other relevant organizations. Interviews were held with various stakeholders (Annex 1), supplemented by observations of facilities, document reviews, data analysis, and frequent team discussions to review the findings. Group discussions were held with doctors and nurses, district health care managers, medical education teachers, community leaders and medical students. In general the questionnaire developed prior to the trip based on the Terms of Reference (Annex 7) was used as the primary guide for these interviews, carried out as semi-structured interviews using many open questions.

In view of the future perspectives for the project, hypotheses were formulated by the review team and some of the ideas were then tested with relevant stakeholders to obtain an impression of their feasibility, interest in them, and for critical comments.

The team stayed together for the initial few days to interview stakeholders involved in both MEP and SINO projects in order that all the team members developed a broad overview of both the projects. This allowed future team discussions on all aspects of the project to be more productive since all team members were sufficiently informed to participate, and areas of overlap between the two projects were more readily observed. After this the team split: Peter Campbell was supported by Mehrinisso Yuldashova focusing mostly on the MEP review; while Heinz Henghuber was accompanied by Tobias Schüth and Debora Kern to focus more on the SINO project.

The team visited all six rayons (districts) supported by SINO:

- In the rayons of Torsunzade and Sharinaw where SINO has been working for a few years
- In Vose and Khamadoni where work has only commenced in June 2010.
- SINO activities in Dangara and Varzob were phased out in 2010, and this provided an opportunity to assess the sustainability of the project’s strategy.
4 Findings

4.1 Introduction

The Terms of Reference of the review was adapted to form a questionnaire and summarised answers to each of these questions are detailed in Annex 5. These findings provide the background to the report, and shed important light on the effectiveness, relevance, and sustainability of the current projects. However, the Lead Consultants took the approach that the primary concern of this external review should be the strengthening of the Tajikistan health system as a whole. Therefore the relevant components of the health system are used as the format for the report findings below, incorporating aspects from the questionnaire as relevant.

4.2 What do the SINO/MEP Projects Cover?

Figure 1 below shows the basic components of the health system as they relate to the MEP and SINO projects and this report follows these components in elaborating findings and recommendations. This diagram has been drawn up by the Lead Consultants and, while not comprehensive in its scope, it has been designed to provide a simple and clear outline of the educational and management processes with which MEP and SINO interact, and to highlight necessary feedback loops and possible future directions.

Figure 1 Components of the health system related to SINO and MEP

Both SINO and MEP cover components of the health system related to family medicine. There are linkages between SINO and MEP on both the educational level and management level. The top Management pyramid has been drawn to include both policy/financing issues together with the need for management to understand/take responsibility for health care decision-making. While it could be argued that these are separate functions, the Lead Consultants wish to emphasize that in reality
management of the health system comprises decisions made at every level, from policy makers down to facility managers.

4.3 Medical Undergraduate Education

Medical education in Tajikistan consists of undergraduate studies at the Tajik State Medical University (TSMU), followed by a graduate year (Internatura) carried out at numerous clinical sites throughout the country, later followed by postgraduate Continuous Medical Education (CME) courses. The latter are carried out mainly by the Postgraduate Medical Institute and also by some departments of the TSMU, in many cases with support by donors for specific program training modules such as for TB, HIV and Maternal and Child Health topics. The Republican Center for Family Medicine has been assigned the responsibility for the Continuous Medical Education of family doctors. Community-based education initiatives have also started, supported particularly by SINO and the Aga Khan Foundation (AKF) health projects.

The Medical Education Project (MEP) has been designed to focus on the undergraduate curriculum, and its position in relation to the system of education is shown below in Figure 2.

*Figure 2: Current Medical Education Aspects of MEP*

4.3.1 Undergraduate Education of Doctors

The MEP is still in an early phase of development and it appears that, in general, the initial steps taken have been highly effective ones for the longer-term partnership with the Tajikistan State Medical University (TSMU). Excellent relationships are being established, including with older members of staff who have apparently been the most resistant to change. It is clear that nearly all TSMU staff are keen to cooperate more with the project, even though this means change and work for them and may not include any extrinsic incentives. Policy level dialogue has supported the development of the teaching program, with legislative changes in progress to allow for a clinical teaching year. This builds upon the already significant legislative achievement to merge paediatric and adult medicine into one joint curriculum for all.
The relevance of the undergraduate reforms being carried out by the MEP is clear from discussions with Family Doctors at each of the sites visited, and from visits to the clinical training sites. Much of what is taught during the 6-month family doctor retraining programs by the SINO project repeats what has been taught at the undergraduate level such as the use of ophthalmoscopes, otoscopes, ECG equipment, examination of children and basic obstetrics/gynaecology. The new emphasis of the TSMU on developing general (undifferentiated) medical graduates is a green light for the MEP project to assist the TSMU teaching staff to develop these skills at the undergraduate level, and this will eventually allow the future family doctor training programs to become more effective in further developing the knowledge, skills and attitudes of this cadre of staff.

However, with the project only really functioning effectively for just over one year, it is far too early to judge any outcomes and impact in terms of changes in the quality and skills of medical graduates, except in the sense that full cooperation and willingness on the part of the TSMU has been established. This is a remarkable achievement in itself, and is not something that has been seen by the Lead Consultants in many other teaching institutions of Central Asia. This is not to say that reforms are not happening elsewhere at the University level, but most are top-down with little interest from the participating institutions to be involved in any deep way. This has led, for example, to curriculum teaching hours being adjusted for different topics, but rarely any changes to the lesson content or methods of teaching. The SDC project is thus in a unique position to guide changes to medical education in a deep and meaningful way that could one day serve as an example for institutions throughout the region.

As a result of study trips abroad, TSMU staff are now pushing ahead to revise the curriculum, and the MEP is supporting them to do this. The emphasis is not just on changes to the structure, topics and hours of the course, but also and more importantly in redefining the learning objectives, the content, and the teaching methods that are employed for each class. The review team understand that similar initiatives are underway in the region, including in Kyrgyzstan, and exchanges between these projects could also help drive this process forward.

The Working Group of the Curriculum Committee, influenced by their study tours to Switzerland and Canada, are moving ahead with the revision of the entire curriculum from Years 1-6, including the development of a final year for clinical skills which has been achieved through excellent policy discussions resulting in high level approval. Each department has selected staff to work on their topics, and the first draft is planned to be finalised by the end of December 2011.

While this demonstrates the commitment of the TSMU to move ahead with the reforms, the enormity of the task cannot be underestimated. This includes both the scope of topics to be covered, and the depth of work necessary to develop effective and meaningful objectives and realignment of teaching priorities more towards family medicine. It will entail a worldview shift in understanding of the teachers towards the requirements of family medicine, with adjustment of teaching topics to focus primarily on the basics of Primary Health Care, and only after that touching upon the more specialist issues. Exams will also need to take this into account.

It is therefore completely understandable that the initial, expected deadline for the first draft of the curriculum to be completed by April 2011 was missed. This demonstrates only a misunderstanding on the part of those making the projection, and does not reflect in any way on the success of the project. In fact, the postponement of the deadline only serves to highlight the likely increased quality of the project, its effort to do the right thing the first time, including aligning it appropriately with the
postgraduate requirements of the Russian Federation where a number of graduates will have to go to achieve specialisation qualifications not currently available in-country.

Having said this, it must also be pointed out that the Curriculum Committee is working alone to develop the first draft with minimal input and guidance from the MEP. At the end of February 2012 this huge collection of topics will become available for review by the project, and this will be an onerous task, not least to preserve good relationships if it is then found that large-scale revisions are still required. In future, it would be far more preferable if the MEP experts could be involved on a continuous and day-to-day basis to work closely with the University staff to review and advise on their work and guide the process so as to be more certain that the end product will be close to international standards with minimal need for burdensome redrafting. The final result of the curriculum development component of the MEP- by the time it reaches the end of its funding period- will simply be the first draft of the curriculum with an initial review by the MEP. This should therefore be viewed as the first phase, with much further work needed to further refine it and then to begin the implementation.

This implementation of the curriculum will in itself require considerable support, as recognised by the TSMU authorities and staff. Many more staff will need to be inducted to the new teaching methods, with a strong emphasis on the needs of family doctors. This will ensure that many aspects currently taught in the SINO-supported 6-month retraining courses are made redundant (ECG interpretation, use of otoscopes/ophthalmoscopes, basic paediatrics and obstetrics/gynaecology). Linking the TSMU faculty to the Republican Center for Family Medicine Training and to the Postgraduate Medical Institute's family medicine training programs will be very helpful to assure more alignment to the primary health care goals of the country. This would be one important reason for merging the MEP and SINO projects in any future phases.

Another reason for such a merger of the two projects is the need to ensure increased feedback (filled/blue arrows in Figure 2 above) from the primary health care level (both from the family medicine training centers and from the town and rural health facilities where SINO is active) in order to adjust the curriculum as necessary to fulfil the training needs of the country’s Primary Health Care staff. Thus, new in-the-field programs such as the WHO’s Integrated Management of Childhood Illness (IMCI) should quickly be brought to the attention of the teachers at undergraduate level, at least through presentation of the information at ongoing faculty staff meetings, and preferably through the a permanent academic body whose role is to assess how to keep the clinical teaching staff updated. In addition, knowledge and skills gaps of new graduates can be identified and the undergraduate program strengthened accordingly. This could also include support for doctors to better manage the Community Group meetings, and to develop skills for group facilitation and leadership, topic identification and teaching.

Clinical skills appear to be the most felt-need of the TSMU according to teachers, students and postgraduate/qualified doctors, and this has been addressed early on by the project through a number of training programs and workshops in cooperation with the University of Calgary, Canada, which are proving to be very popular among the faculty. This has in turn led to increasing interest on the part of the medical faculty at the TSMU and to an agreement to reformat the final year as a training year for clinical skills development. These are excellent achievements, and should be built upon in any forthcoming project extension.

Until now only 30 teachers have received this training in clinical skills teaching out of a total number of staff close to 700: a lot more still needs to be done. In addition, some sort of mentoring process will be useful to sustain these changes in teaching styles and skills, together with increased feedback which
should come not only from the students but also, if feasible, from the 6-month family medicine trainers who have been mentored by international experts in modern teaching techniques and the role of family medicine for a number of years now, and from colleagues at facilities where the graduates find work. Future MEP staff should preferably have such skills and could be drawn in from the family medicine training centers, even if on a part time basis, to support these initiatives.

The TSMU has statutory rights over a number of clinical bases where students go to see patients and learn practical skills, but there can be tension between the rights of the students to learn and the rights of the facility to manage patients without being disturbed by the presence of the students. Until the TSMU has more of its own linked clinics, this tension will remain and its level will continue to be dependent upon the maintenance of good relationships between the institutions. So far the MEP has not played a significant role in this process, but engagement in the graduate Internatura year of study could change this (see 4.4 below).

4.3.2 Undergraduate Education of Nurses

Up until now the emphasis of the MEP has been on the training of doctors. However, the training of nurses capable of carrying out basic family medicine services is also of great importance, since they work in remote areas sometimes as the only and first point of contact for patients.

With the approach of the end of the project and the possibility of starting a new phase, consideration should be given to evaluation and possible support for the redevelopment of the undergraduate nurse training program. One rationale for this relevant to the SINO project lies in the current 6-month retraining program for nurses which costs the same as the 6-month retraining program for doctors.

While the 6-month retraining program itself deserves further evaluation (see later under Section 4.5.3), it is likely that, similar to the retraining topics taught to the doctors, there are many nurse retraining topics that, ideally, should have been taught effectively at the undergraduate level including the use of blood pressure cuffs, carrying out ECGs etc. Attention to this would have two obvious benefits: first, the retraining course may be shortened and funds reallocated to, for example, ensure more nurses/doctors are trained in a shorter period; and secondly, the sustainability of orienting nurses to family medicine would be assured at the state-funded undergraduate level, allowing the development partners scope to support short, focused update-trainings based on ongoing identified needs.

With the understanding and commitment of the relevant institutions, a thorough review of the undergraduate nursing program may indicate that complete curriculum reform is warranted to bring it closer to modern international standards. This would require substantial investment of time and finances similar to the current MEP. If such an undertaking is not feasible, then consideration should be given to more limited review of the undergraduate program in its teaching of the specific clinical training topics that are currently covered in the 6-month training course including taking ECGs, blood pressure measurements, and resuscitation skills. If it could be ensured that these topics are taught effectively then duplication at the postgraduate level would be reduced. Regarding this latter option, the lead consultants consider it likely that this may only require limited equipment provision to the training sites, and short update modules for the clinical teaching staff.

It has not been the mandate of the external review team to evaluate in any great detail the functioning of the nurse training program, but these comments are based on an overview of the situation and on short visits to nurse training facilities and should be followed up to confirm their validity.
Recommendations - Medical Undergraduate Education

- Reform of the medical curriculum is an intensive and long term undertaking, and is still in an early phase. This should continue to be a prime focus of any new project, together with support for its effective implementation, perhaps utilising other similar ongoing initiatives in the region.

- Day-to-day guidance of those working to redraft the curriculums should be the ideal for the management of the process of curriculum design.

- Increase the knowledge and understanding of family medicine among the TSMU faculty through cooperation with the family medicine training centers and through feedback from primary health care level on the training needs for undergraduates.

- Continue the process of developing clinical skills teaching among the TSMU faculty and mentoring them.

- Consider redeveloping the undergraduate nurse training program to meet the need for family nurses in the country.

4.4 Graduate Education (Internatura)

At the bottom of Figure 1 (shown above) the scope of work of the MEP and SINO projects is shown by two brackets. Between them is a gap which encompasses the Graduate (Internatura) level of training. This is the stage at which the medical students have passed their final TSMU exams and are now assigned to complete one year of practical work experience. As things currently stand, one third of the graduates (200 out of 600 graduating in 2010) are mandated to do their Internatura in family medicine. This is a crucial time for them, where they will develop opinions on this speciality and will make decisions on continuing to work in this area or not. If the experience is a good one, they may recommend this to their peers, but if not, the word will soon get around that this is a career to avoid which will lead to reduced numbers of family doctors and continuing human resource problems for Primary Health Care in the country.

It became apparent that no one institution is held entirely responsible for the organisation of the Internatura. This may be due to a number of factors including the lack of managerial time and resources devoted to this. Internatura graduates are not given clear objectives for their year in family medicine. Nor is any substantive guidance, support or expectations provided to the facilities to which they are assigned.

A limited-duration project (see Annex 6 for an outline of the possible steps needed) could be initiated to address these issues, that would require a Working Group or similar - with representatives (including family doctor teachers) from the RCFM, the TSMU, the PGMI, and the Ministry of Health - to carry out a survey of needs and expectations. Working with international experts, there would be development of suitable objectives, protocols, and learning expectations. These might include checking off the successful performance of certain duties and activities e.g. documentation of various types of cases seen, contraception counselling and Intra-Uterine Device insertion, and minor operations and procedures performed etc. Improved linkage of Internatura students to family medicine
teaching centers would be very valuable, perhaps with an emphasis on the graduates taking part in some of the teaching in the latter part of their year. Specific staff could be assigned (and empowered through a standardised induction process and provision with written guidance) to be mentors with regular one-to-one meetings to go over issues and ensure all objectives and expectations are being met. At the least this mentor should be named staff from the facility in which the graduate works, and preferably be a teacher from the clinical training center.

Such a structured and disciplined year would go a long way toward improving morale and motivation for family medicine, the goal of the SDC projects and highly supportive to meeting the needs of the country. Input would not need to be long term and, once processes are set in place and adapted as needed depending on good feedback mechanisms from both the graduates and their mentors, improvements would be continued under the relevant institution who would now be empowered to carry out this function effectively. Such steps could be initiated immediately at sites where family medicine Internatura candidates are being sent, but would probably be most effective at those sites where there are available mentors already fully trained and practicing modern family medicine principles.

**Recommendations - Medical Graduate Education**

- Explore the possibility of strengthening the family medicine Internatura year for graduates to make it more structured and organized, with the goal to make family medicine a serious alternative for the most talented doctors.

### 4.5 Family Medicine Clinics and Continuing Medical Education:

The **Continuous Medical Education strategy** for the country has, until now, had the long term objective to expand family medicine trained-staff nationwide through the 6-month courses held by the family medicine training centers and the postgraduate nursing courses. The extent of scale up of these activities is dependent on the funding level assigned by the development partners. Additional activities such as the Peer Review Group meetings promoted by SINO and other development partners have not yet been included in the official strategy.

The new **National Health Strategy** is being developed, and the fifth draft includes an emphasis on Licensing and Accreditation and empowerment of Family doctors. There is little detail about any training programs, and only a general comment to "Improve proficiency of healthcare workers based on further development of continuing medical education system for healthcare professionals including family medicine practice" (p.48; National Health Strategy Republic of Tajikistan 2010-2020; Fifth Draft 12.05.2010).

Taking the opportunity afforded by the drafting of this health strategy paper, efforts should be made to elaborate a medium term plan for scaling up the training of family medicine staff across the country, assessing how implementation could be catalysed through the strengthening of the current human resources team, user organisations, and other parties. Based on the results of SINO work, such **policy discussions** could also lead to the inclusion of initiatives as the Peer Review Groups and other relevant strategies such as the Business Plans.
4.5.1 Family Doctor Training Course

SINO has provided substantial support for the development and operational costs for the family medicine training centers in Tursunzade, Shahrinav, Dangara and more limited assistance for the Republican Center for Family Medicine. In order to re-orient the county’s health care system towards primary care the retraining of medical staff, and doctors in particular, is of vital importance and it makes sense to continue this initiative. The review team were impressed with the organisation of the courses, the commitment of the teachers, and the enthusiasm of the students. A number of the centers are situated in busy policlinics where the doctors have the opportunity to see their own patients, and this is excellent and increases the longer term sustainability of the centers: any future training sites should be developed on this model. Day-to-day logistical support is required, such as continual replacement of broken items, updating of computers, restocking of necessary supplies, and SINO appears to be highly appreciated for its responsiveness to these requests.

The family doctor teachers explained that there is little in the way of ongoing support for them, with minimal coordination between the staff at the various training sites (including those funded by other partners such as the World Bank and the Aga Khan Foundation), little work on improvement of the curriculum or of the exam questions or assessment techniques, and a lack of further training as teachers and as family doctors. Ideally, the development partners should cooperate closely together on these issues and work in a proactive - rather than reactive - way with the relevant Tajikistan institutes to ensure that family medicine gains more in prestige with every passing day.

A current example of the need for such involvement was shown in the comments from one trainer: she said that they needed more presentation equipment but were afraid to ask since it seemed as though this was imposing on the generosity of the partners. Another issue that was made clear at a number of review team’s meetings was the strong preference of both teachers and trainees for the diagnostic bags to be given at the start of the course. It is understandable that SINO has only given out the medical diagnostic bags to the retraining doctors at the end of their course, in order to provide a carrot for successful completion of the courses. However, taking the viewpoint of the staff and students into account, a pilot study could be made where these are given out early on and the results followed to ascertain for any increase in the drop-out rate or reduction in the end-of-course assessment results.

With the full complement of staff now re-trained in some of the rayons where the centers are situated, there is a question about the future role of these family medicine training centers: should they continue to retrain the family doctors who would have to travel from other rayons, or should they be relocated closer to the newly selected rayons? The review team were not able to go into detail to ascertain the best options, but suggest that this become an open question linked to the future overall aims and scope of the project. Training centers near the capital make transport more easy, increase the attraction of the program for rural trainees, and probably also help retention of teaching staff. However, they can also be utilised as sites for the provision of Internatura training for the medical university graduates: this should be promoted in any event. A clear national concept on the training centres needs to be put in place including their role, oversight, number, quality assurance, coverage, etc.

The future scope of the project would need to be assessed carefully before the next phase. Progress so far is steady, but there is pressure to increase the number of doctors’ trained to cover more areas of the country. While this should not be done so fast that there is a loss of quality, it might also be worthwhile to consider establishing the courses as shorter modules running over an extended length of time e.g. 1-2 years. This would have two advantages: first, more doctors could be enrolled on the course simultaneously; and second, the training centers would begin to develop naturally into sites of
continuous education offering some courses for more specialised skills. They would not simply be viewed as sites for a one-off retraining program with no role to play when the full complement of doctors are retrained. However, such short courses could be difficult to achieve logistically and, over the longer term, may not result in the training of any more staff than are currently being served.

As discussed in the section above on undergraduate medical education, there is little familiarity of the Tajikistan State Medical University (TSMU) teaching staff with the family medicine retraining program managed by either the Post Graduate Institute (PGI) or by the Republican Center for Family Medicine. While this is particularly an issue that needs to be initiated from the side of the TSMU, consideration should be given by the family medicine training centers as to how to present their work, and what would be the best ways to encourage interest and participation by the university faculty. It is clear that testing them is not to be recommended, and perhaps a schedule could be drawn up by which small groups (e.g. 1-3 TSMU staff) spend a certain amount of time visiting the family medicine training center.

A two pronged approach to this is advisable. One the one hand, interest in the work of the postgraduate FM training centers should be aroused in the TSMU faculty by the MEP, perhaps including invitations to the PGI and RCFM to share about their work; and on the other hand an invitation to the TSMU staff to attend a series of Open Days or Workshops including meals at the teaching facilities. Questions for the TSMU guests to answer and/or topics to evaluate concerning their visit would be prepared and tested beforehand. A side-effect of this work could be to improve coordination between the Postgraduate Medical Institute and the Republican Center for Family Medicine. Involvement of the PGM and RCFM family medicine teaching staff could be encouraged by paid contracts with them for the additional work needed to work together to develop the program.

4.5.2 Peer Review Groups

The Peer Review Groups were established as a component of Continuous Medical Education (CME) for family doctors. The Peer Review Groups were highly appreciated by the family doctors interviewed. Mostly clinical and disease topics are covered within the group meetings, while management or health system issues seem to be rarely discussed. The meetings are held monthly, with transport costs supplied by SINO. However, Peer Review Groups were not well sustained in the two rayons where SINO phased out (Dangara and Varzob). At the level of larger health centers, peer review activities were being carried out among the local staff (doctors and nurses), but with no input from doctors from other clinics in the Rayon whose transport costs were no longer funded. Although the amounts paid for transport were relatively small, they were considerable in relation to the official salary paid to the family doctors. Another contributing factor for the demise of the peer group meetings is that the Ministry of Health has not yet adopted the idea of the Peer Review Groups as a necessary part of the educational process for medical staff.

Peer Review Group meetings visited demonstrated the abilities of the doctors to give professional presentations and to facilitate open discussions on topics of interest and relevance. The family doctors interviewed confirmed their enthusiasm for, and the usefulness of, these groups. Internationally, these are considered to be an integral part of professional development programs, and their promotion in Tajikistan should be encouraged and promoted to the Ministry. However, as long as transport costs have to be paid this will not be an attractive proposition. At the very least the head doctors should be encouraged to continue to meet on the days they officially attend the meetings with the Rayon health managers.
It was noted that there were marked differences in attitudes towards the Peer Review Groups between the various Rayon leaders with some antagonistic to these new concepts. Others actively promoted them by holding shorter rayon management meetings on the day of the month selected for the peer review group to meet. Such involvement and thoughtfulness should be openly appreciated in policy discussions on these issues.

In parallel to these strategies, support should be given to the Republican Centre for Family Medicine since it has been assigned responsibility for the Continuous Medical Education of family doctors to be more involved in the nurturing of the groups. The project should see such support as an integral part of its activities, forging relationships with key members of staff, cooperating with them in discussions for the further development of the peer group meetings, and even bringing them to see and support the peer group meetings of the family doctors in the rural areas.

As a longer term goal, a type of credit system might be developed, for which family doctors could receive credits for attending the group meetings. This would help to increase central support for the initiative, and could provide synergy with the Continuous Medical Education strategy for the family doctors of the country. SINO management is already discussing this issue and has begun work on it, although it is likely that full implementation will require significant logistical management and is something that will only be achieved over the longer term.

On meeting with the Aga Khan Foundation health project staff, the review team learned about the "Clinical Excellence Centers" that have been established. These centers, which have a library, internet access, updated resources, and monthly clinical presentations by doctors, have the potential to add value to the concept of Peer Review Groups established by SINO, such as through sharing lessons from best practices. It would be worthwhile to assess what commonalities there are between the two and how these may be linked or, at least, lessons learned from both sides for the mutual benefit of the health training process.

4.5.3 Family Nurse Training Course

SINO funds a 6-month retraining program for the family nurses, equal to that of the doctors. As commendable as this is, it is also a considerable expense to be covered by the project. Put in perspective, since the depth of their knowledge and skills is not equivalent, nurses worldwide are generally not expected to train for the same length of time at undergraduate level as doctors. Is there really a need for the length of postgraduate training to be the same?

A visit to one of the retraining centers was helpful to highlight the scope of the course which covers many very basic topics including the taking of an ECG, blood pressure measurements and emergency resuscitation. Many of these topics are not particular to the practice of family medicine, and it is not clear why they are not already the expected skills required of the current undergraduate courses, from which the future primary healthcare nurses will eventually emerge. In view of the expectations of the authorities for the accelerated roll-out of family medicine to other rayons of the country, considerable impetus could be given - even with existing funding levels - if the nurse retraining course could be shortened and funds reallocated for the retraining of more nurses and doctors. Sino could carry out a review of the postgraduate course with consideration for transferring some of the current topics to the undergraduate nurse training schools which might require some support to strengthen their role (see Section 4.3.2 above).
Recommendations - Continuous Medical Education

- Despite the years of input to family medicine training programs, still only a small proportion of the country's doctors have been retrained, and this should continue if family medicine is to be fully established nationwide.

- Taking the opportunity afforded by the drafting of the National Health Strategy Republic of Tajikistan 2010-2020, coordinated efforts should be made to elaborate a medium term plan for scaling up the training of family medicine staff across the country, assessing how implementation could be further catalysed through the strengthening of the current teaching staff, user organisations, and other parties. Consideration could be given to the inclusion of SINO initiatives such as the Peer Review Groups, Business Plans and other relevant approaches.

- A more proactive approach should be taken to support the FM training centers in their work, perhaps also developing a clear national concept on the training centres needs to be put in place including their role, oversight, number, quality assurance, coverage, etc.

- If acceptable, preparation and plans could be drawn up to involve and update the medical faculty of the TSMU on the current teaching and methods employed by the FM training centers.

- The Peer Review Groups should continue to be promoted, sharing good practices (such as head doctor meetings) and achievements (such as new lessons learned and problems resolved) both at local rayon levels and also on up to the policy level decision-makers.

- To augment this further, Peer Review Groups could be linked to the Republican Center for Family Medicine as the responsible institution for Continuous Medical Education.

- A credit system approach with credits for visited peer review groups as Continuous Medical Education is already discussed within SINO and should be followed up.

- Assess whether the "Clinical Excellence Centers" implemented by Aga Khan Foundation have the potential to add value to the concept of Peer Review Groups established by SINO and if these two approaches could be matched.

- Review of the content of the 6-month family nurse retraining program with a view to a possible reduction in its length, and to simultaneously strengthen the undergraduate training.

4.6 Management of Health Care (Primary and Secondary Levels)

The overview of SINO input in relation to the health care system of Tajikistan is shown in Figure 3 below. The filled (red) arrows in the diagram illustrate the feedback loops which, in the opinion of the external review team, are necessary for the effective functioning of the entire system. Thus the care provided by the facilities towards patient outcomes should produce feedback ideas for improvement which, fed into the Business Plans, should provide information up to the management at all levels of the system. The managers should then be responsive to these issues to understand and further develop the capacity of the providers.
4.6.1 Business Plans

The Business Plans implemented by SINO are elaborated annually by the Rural Health Centres. This is done by the heads of the family medicine facilities and by the Primary Health Care Managers at Rayon level. This approach has been promoted by project Sino and is appreciated by those interviewed. Although the term "Business Plan" is in reality a form of district planning, the title has apparently helped in promoting the ideas of a more formal budgeting and organisational process.

In the rayons where Sino activities have been phased out, family doctors and heads of the health centres continue to use the Business Plans and are in the process preparing new ones for 2012. They are confident using the plans and appreciate the transparency and empowerment they now feel at understanding their budget allocations and the ability to have an input into priority setting within their (very low) maintenance budget. Their managers at rayon level require the plans from the facilities since they form a good basis for budget setting and are useful to show the effectiveness and functioning of the facilities. Although not formally adopted by the health system, the Business Plans find acceptance beyond the rayon level: the head of the health sector reform of the MoH, Dr Saifutdinov, mentioned thoughts of using them countrywide and asked indirectly for support of SINO for nationwide roll out. Further refinements (e.g. simplification, shortening) to the Business Plan could ensure it becomes efficient to roll out rapidly, even taken up by other projects (USAID, WB) that work with Primary Health Care facilities. Existing local champions could be supported to promote and teach its use.

While the Business Plans hold great potential for the future of the health care in the country, they are also a threat to improvement if misunderstood. The ability of the facility staff to understand their budget allocation definitely empowers them to push for the use of available funds to address agreed issues. While this is limited in practice by the generally low level of funding for health, it is an excellent step
forward, like a candle in the dark, that should be nurtured. It is also useful to increase transparency because, with the budget understood by staff, it will be more difficult for higher level managers to divert funds away for other purposes, worthwhile or not. The plans also promote a proactive approach to management: first, by identifying issues and linking them to financial support and, second, by encouraging measurement of certain indicators that could help increase understanding of limitations to the provision of optimal care.

However, the threats to appropriate implementation are very real. The prevailing managerial culture is to use the indicators as a means to push the facilities to do better, and rely on the threat of punishment for failure to attain the agreed targets. The Business Plans themselves define the indicators as targets, indirectly encouraging this approach. While it can be argued that the setting of "achievable" targets will promote a better response, there is an opposite consequence. Targets have always been present in the former Soviet Union and used as a stick by which to drive the system forward. However, with no support for dealing with the issues that hinder real improvement - which are usually inherent within the system itself and not within the power of lower level staff to influence - the result is that the data is "adjusted" to meet the desired level and avoid the need for punishment. Thus it has become a byword of the system that the gathered statistics are not to be relied upon, leading even the SINO project to collect its own data independent of the official collection mechanisms.

The authenticity of this thinking was reinforced during the feedback session on the findings of the review team with the SINO project staff. When asked if the current Business Plan indicators/targets could be linked to punishment if not achieved, the local SINO staff members were quick to agree. A prime example of this comes from statistics of attendance rates, which can be manipulated to produce the desired results because staff feel under threat of punishment. Even though this is used as one of the main indicators for increased access to health care throughout the whole health system it can easily become compromised and unreliable for this purpose. While strict control and constant monitoring (and associated expenses) can be used to contain this problem, there would be no problem if a numerical target was not set in the first place.

The Business Plans should become a normal tool in the hands of the Rayon managers but they should not include any numerical targets which may so easily be used to instil fear and deliver unreliable data. If numerical target expectations are excluded, there will be no reason (i.e. punishment) for facility staff to adjust the numbers, and no way for them to tell what they should be adjusted to. In addition, it is worth noting that targets are often simply (educated) guesses about what might be achieved and may not be realistic. Also, having set targets it is difficult to adjust them if there are unforeseen changes in the circumstances of the facility/authority/population during implementation.

Instead, indicators must be agreed and measured, but merely in the form of collected numbers showing "How many..?" and "How often..?" This data can then form the basis to plot run-charts etc to assess progress - or not - of the project activities. With truthful information no longer linked in the minds of health workers to consequences, managers (including SINO) can begin to correctly analyse the effects of project activities on patient care, and actual problems can begin to be identified and addressed in a correct manner. This should be done with a supportive and understanding attitude rather than reactionary and punitive. If any targets have to be set, they should only be held internally by the SINO project and interpreted as "best guess expectations".

There is little evidence that the information gathered from the plans is linked to concerted action to address the issues set as priorities, and much less so for other issues deemed to be of less importance. A number of examples of poor performance of the health system were explained to the
external review team by facility staff, but it appeared that these issues were not often addressed through the Business Plan approach. For example, pregnant women are unable to receive a blood test for syphilis locally at the family medicine facility, and instead have to pay for travel all the way into Dushanbe to get this done. If so, what is the value to these women of the rural clinic if they have to travel anyway into the center where they could receive their antenatal care? Similarly for sputum TB tests of the population. These examples could form the basis for small improvement projects coordinated at the rayon or oblast levels. Could visiting laboratory technicians come every so often to do the tests, or could some sort of taxi service for transporting the samples be organised?

A successive phase of SINO could aim to work much more closely with the Rayon health managers to implement such quality improvement aspects of the Business Plans, and begin to change the perception of management as being about authoritarian dominance and control to, instead, one of understanding and support. This correlates with the recommendation of the Midterm Review (February 2011) for increased capacity building, mentoring systems, and more regular and standardized exchanges among Primary Health Care managers. SINO could provide seed funds (e.g. as grants) to assist the health care managers and facility heads to carry out such initiatives in combination with their allocated budgets. This co-financing would have the added benefit of allowing SINO to be "accepted at the managerial table". It would also strengthen the Business Plans to function effectively as true "Annual Operational Plans" resolving issues (priority or not) at health centres and rural facilities and, eventually, at the oblast level. They could then be built into a mechanism for feedback into policy dialogue and decisions on health care financing. Involvement in this process may allow scrutiny of the budgets to enable their efficient use and lobbying by the managers for increased funding.

This would help to address an apparent complaint by the Ministry of Finance (MoF) that funds are often returned by the MoH at the end of each financial year. Good management of these funds through the understanding and use of the Business Plans may reduce this problem, but analysis is needed to know from exactly what funds the money is being returned. An option could be to discuss possible support by the development partners for a junior MoF official to undertake a study with SINO to find out why the MoH is returning funds at the year's end. This will help the MoF to see things from the perspective of the MoH, and ideas may be generated to help the MoH to improve their functioning.

It would be highly appropriate to work with a local institution to further develop the roll-out and sustainability of the Business Plan concept. To assess the current capacity for such a role, the team approached the TSMU Public Health Management Department. The staff in the department showed enthusiasm in this idea. Although the managerial experience of the department is limited, the potential benefits of involving them - even in a limited role - are many. Not only would their visits and cooperation in the field increase the longer term prospects of the initiative, but their involvement in good management processes would provide them with invaluable insights which could be reflected in their teaching of the future managers, both at the postgraduate and, to a more limited extent, at the undergraduate level at the TSMU.

EuropeAid is in the process of planning a nationwide Health Management Information Systems (HMIS) project in Tajikistan at the oblast level with a value of several million Euros. Linkage by the project to this might help to strengthen the institutionalisation of the Business Plans and these may mutually benefit the effectiveness of the HMIS to achieve tangible results.
4.6.2 Monitoring the Quality of Care Delivered to Patients

Among the outputs expected of the Sino project is improved capacity to monitor and evaluate the quality of care being provided to the patients. This is already being done through the regular visits of a Swiss consultant who spends time working with individual family doctors in their clinics. This is a difficult and time intensive process, but in many ways is probably the most effective mechanism possible and could help to raise the performance of the clinical staff in the early stages of reform. Such supplementation of the system of visits by commissions to the facilities is unlikely to be sustainable over the longer term, and other mechanisms should be sought.

One mechanism that could be added to this that involve less time and expense would be to use the Business Plan initiative. Certain key treatment measures could be included in the indicators' section of the plan, such as the number of patients correctly diagnosed with hypertension/anaemia whose treatment, after a certain period of time, results in a normalised blood pressure/haemoglobin level. Information could be gleaned from regular analysis of patient history and prescription records. Nurses could be involved to collate the information on a monthly basis, chart it to show the results graphically, and perhaps even share the results with the Community Groups. Over time different indicators could be analysed with results being fed back to higher management (even policy-maker) levels to address system issues that are proving to be obstacles to improvement.

4.6.3 Increasing Patient Access to Medicines

The review team was highly impressed by the work of the Aga Khan Foundation (AKF) to establish and maintain a revolving fund for the provision of basic medications to the population at little more than cost price. A pilot project carried out by SINO has earlier been discontinued for a number of reasons including the lack of sustainability due to reliance on the project for importation (a similar concern for the Aga Khan project), and the complicated and managerially intensive work required. An Asian Development Bank project to increase the national capacity of the medicine procurement mechanisms did not succeed to bring any lasting improvements, highlighting the difficulty of operating in this area.

Efforts to increase synergies between the work of the Aga Khan Foundation and medicine procurement agencies/ institutions serving the SINO pilot sites would be valuable if time and resources allow.

4.6.4 Health Care Financing

There are a number of initiatives underway to reform the financial management of the health care system, with leadership provided by the MoH through the Health Finance Working Group supported strongly by the USAID-funded Quality Health Care Project and by the World Bank. According to these stakeholders, SINO is a leading contributor to the Group, and plays an important and politically sensitive role in feeding back evidence on the Basic Benefit Package and corresponding payment exemptions due to its facility level approach and from the surveys it has undertaken. SINO's unique role in cooperation in this area is highly valuable for the development of the health system as a whole and should be continued. There is little to recommend that this role be increased, not only because other partners have strong regional experience in this but also because of SINO's trusted position as "outcome neutral", allowing it privileged access to sensitive facility data.
4.6.5 Infrastructure and Maintenance

The rehabilitation of the health facilities with the provision of basic medical equipment and office furniture is essential to the practice of attractive family medicine. The family doctors interviewed were grateful for SINO input on this, since it increases the motivation of the health staff, endows the facility with credibility from the viewpoint of the patients, and contributes to improving the quality of care. The staff were in agreement with the strategy to carry out the rehabilitation work while they were away completing the 6-month training program. It was therefore clear that rehabilitation is an integral part of the package to reinforce primary healthcare services and should continue to be included as part of SINO’s contribution.

Equipment maintenance remains problematical. In two health centres visited in Dangara and Varzob the electrical generators (not SDC funded) had broken down some time ago, and the required pumps and filters could not be obtained despite attempts to do so. The fridge for vaccines at one of the sites was not functioning. In view of the irregular availability of electricity the fridges should have been of the chest-opening type to conserve the temperature better, as installed in projects managed by UNICEF, rather than the front-opening type currently supplied. These issues mean that vaccines cannot be stored even overnight, and must be given immediately on delivery: a headache for cold-chain logistics increasing the possibility of failure effective vaccination. Also, microscopes which rely on electricity for their light source, could not be used for laboratory tests: could a simple battery backup be used for this if the generator is not available?

While it was evident that budgets for maintenance and repairs of equipment and facilities are limited and lobbying efforts should continue to increase this, small funds were available and in the above cases the problems resulted mainly from insufficient logistical support and lack of understanding on the part of those carrying out procurement. With its activities focused at this ground level, SINO has an important role to play in this and could work on such logistical and procurement issues with the PHC managers as part of its involvement in the implementation and management of the Business Plans, perhaps co-funding some initiatives in order to catalyse the supporting role of the managers.

Recommendations - Management of Health Care

- The Business Plan approach is much appreciated by the health care workers and managers, continuing in areas where the SINO project is now phased out, and holds considerable potential for improved management of the health system. For these reasons, it should be continued, refining it as needed to ensure maximum efficiency of roll out and replication elsewhere.

- Development of the Plans should include de-linking with any set targets, and increasing the emphasis on responding to the needs of the health facilities described in the Plans. In this way the Plans should evolve into a functional "annual operational plan", guiding priorities and strategy not just at the rayon and oblast levels, but also providing feedback for policy level dialogue.

- A successive phase of SINO could aim to work much more closely with the PHC managers to implement such quality improvement aspects of the Business Plans. This might begin to orient the perception of managers towards more understanding of issues
faced by the facilities and their responsibility to address them, including issues brought up by the Peer Review and Community Groups.

- The TSMU Public Health Management Department would be a potential partner and multiplier in rolling out and supporting the Business Plan idea and could allow the concept to be incorporated into the curriculum at the TSMU.

- Pursue possible collaboration with the EU as it plans to invest in an HMIS system on oblast level country wide. Linkage by the project to this might help to strengthen the institutionalisation of the Business Plans and may strengthen the effectiveness of the HMIS project.

- Include more patient-management monitoring indicators (which have no numerical targets applied to them) in the Business Plan in order to better understand the quality of care being delivered and achieved, so that appropriate actions can be taken for improvement.

- Continue SINOs role of assessing and reporting progress and impact on health financing measures.

- The project could play a greater role in advising on logistics and procurement of equipment, ensuring feedback (through the Business Plans) to the relevant authorities and organizations to improve the day-to-day functioning of the family medicine facilities.

4.7 Community Group Component

4.7.1 Background

In previous phases the SINO project has tested several ways of engaging in health promotion and of involving communities in promoting health. The project has now settled on an approach that links community groups and family doctors/nurses. Its goals are to disseminate health-related information among the population on topics relevant to them and to establish/improve a link between family doctors and nurses and communities. Community Groups (CG) are formed by inviting “active individuals” - selected by the family doctors and nurses - to a meeting and asking them whether they would be interested in regular meetings to learn about health issues and to help spread what they learned among their community. In a second meeting the group identifies the most burdensome diseases with help of a Participatory Rural Appraisal (PRA) tool. One of the diseases is chosen as the topic for the following three months. The family doctors and nurses prepare a lecture on this topic for the next meeting and discuss it with the group in an interactive way. Lectures may be spread across several meetings. The members of the Community Groups then talk to others about what they have learned. Typical occasions for that are gatherings of people for weddings, meetings, and mosque prayers, as well as individual interactions with neighbours, relatives, etc. After three months a new topic is chosen to work on for the next three months, through a renewed Participatory Rural Appraisal process.

Apart from the Community Groups of "active individuals" there are also so-called Expert Patients. These are people who were treated for a disease and can talk to others about their experience,
helping to detect other patients because they know the symptoms and encouraging them to seek and complete treatment. So far there are Expert Patients on tuberculosis and brucellosis.

4.7.2 Current Function of Community Groups

There are 14 groups in the four pilot rayons (Varzob, Tursunsade, Shahrinav, Dhangara) covering between 7 and 35% of villages in their rayons\(^1\). In the new rayons only one Community Group has been established so far, in September 2011 in Vose, because the first batch of family doctors had finished their re-training only in summer of this year.

One Community Group meeting was attended in Batosh village of Tursunsade (another one in Varzob was planned but the village had been relocated recently). The group were in very good spirit, motivated, well aware of their tasks and knowledgeable about health topics that had been discussed. They seemed to have a good connection with the family doctors and nurses who were present. They obviously felt respected as partners, not used as an audience of passive listeners. They related examples of success stories including case detection (a case of Tuberculosis and a case of Hepatitis A) owing to what they had learned in the group. They talked about increased awareness of people on issues like iodized salt and boiling drinking water. Without prompting, they mentioned increased understanding and support of family medicine among themselves and among the community.

Importantly, the group also told us that they lobbied husbands, Mahalla committee and others to solve the drinking water issue in the village (people currently take their drinking water from open canals), resulting in the Hakumat agreeing to place the issue on top of their investments priorities for 2012. This is an example of a Community Group venturing beyond their role of information dissemination towards a broader role of agent of change addressing health determinants. The family doctor and nurses interviewed after the meeting said they liked these meetings and found them very useful compared with their previous health education activities. They find the people much more involved and interested and said they help them to reach more people than they ever could. Also, they find the interaction with Community Groups is more rewarding for themselves as they receive positive feedback on their efforts.

In Karon village of Varzob rayon the family doctor had met with the Community Group four times since the ending of Sino project’s support in March 2011. SINO project’s work with Community Groups is well appreciated by officials at rayon level (including the Primary Health Care managers) and republican level (Director of the Republican Centre for Family Medicine).

All this corresponds well with findings in Sino’s progress and consultancy reports. These reports speak also of an interactive, sometimes creative (role plays) facilitation style of family doctors and nurses, something the team could not observe but find credible. All this speaks of the great skills of those in SINO in charge of community work to relate to community members, motivate them and help family doctors and nurses to establish a relationship as partners with Community Groups.

\(^1\) Final Phase 2 report, May 2009 (Project Sino Report No. 11).
4.7.3 Coverage by the Community Groups

The main question that comes to mind in assessing Sino project’s community component is the coverage. If one adds up the number of Rural Health Centres (63) and Health Houses (120) in the four rayons where Sino project worked in phase II there are at least 183 villages in these rayons. Sino project has established Community Groups in 14 of them, which means that so far less than 10% of villages are covered. Two factors seem to explain this. Firstly, Sino project staff form the groups and try to be present in at least three meetings per quarter in each Community Group and this limits the number of groups they can serve. Secondly, Community Groups are only formed in settlements where doctors have undergone the re-training as family medicine physicians.

Sino itself sees the need to extend coverage. The obvious way to do that is to train doctors and nurses to form new groups by themselves, instead of doing this only when supported by SINO staff. This has already been recommended by the consultant Till Mostowlansky in April 2011\(^2\). Doctors and nurses without family medicine retraining should be included so that all villages in a rayon can be covered at once. Nurses and feldshers should be enabled to form groups and facilitate sessions without doctors in order to provide coverage for the small villages where there are no doctors. (In Gushari village of Varzob nurses and feldshers seemed very interested to build Community Groups in their villages). If doctors and nurses are called together for a training on Community Group formation in batches of 10-15 then all villages of a rayon - and all rayons covered by Sino - could have Community Groups in a matter of a few months.

A national discussion could be facilitated to make decisions on which model of community health should be replicated (Aga Khan, SINO, etc.) and how (scaling up strategy). This would entail greater coordination between donors, and then alignment. In Kyrgyzstan, it took many years for the village health committees and the public health promotion system to be strengthened and established for sustainability, but the results are showing the value of this approach. More exchanges between projects in Kyrgyzstan and Tajikistan could be enriching.

4.7.4 Sustainability of the Model

Another question is whether the model will be sustained after Sino project’s exit from an area. Although the family doctor in Karon village of Varzob had met four times with the local Community Group in the last half year after Sino project’s exit it is too early to make conclusions. Conducive to sustainability is the fact that the job description of family doctors and nurses require them to do prevention work with communities, and the Sino project’s model is more attractive to medical personnel than the kind of lectures they gave previously. But family doctors and nurses have not learned to facilitate the identification of health priorities (with Participatory Rural Appraisal, this was always done by Sino staff) nor to form new groups. Also, without Sino project it is not clear who will support the family doctors and nurses with additional information or brochures on the medical subjects they teach and provide feedback or new ideas on how to teach and facilitate.

To increase the institutionalisation of Sino project’s approach to community involvement we recommend engaging the Rayon Healthy Lifestyle Centres (RHLC). The goal would be two-fold. On one hand the Lifestyle Centers could take over the functions of the Sino staff and continue to provide

\(^2\) See Project Sino report No. 90, April 2011.
that function after the project’s closure. And on the other hand such engagement would be a chance to develop the capacity of the centers in such work with communities.

SINO has tried to cooperate with Healthy Lifestyle Centers previously but abandoned it because of their very weak structure and different approach to health promotion. A significant amount of time has passed since then and it appeared to the review team that structures have become stronger in recent years and all rayons have now established such centers (according to the Deputy Director of the Republican Healthy Lifestyle Center), or they have extended their staff base.

The deputy director of the Republican Healthy Lifestyle Centre explained that in the frame of the new (second) “Programme on Formation of Healthy Lifestyles”, which runs from 2011-2020, Rayon Healthy Lifestyle Centres will be formed in all those rayons where they were missing up to now. The director Rayon Healthy Lifestyle Centre in Vose said that in April 2011 his centre became independent of the hospital and that the number of his staff was increased from 2 to 10, which provides some confirmation of the information received from the republican level.

Regarding the different approach, the review team can only confirm that in talks with Republican and Rayon Healthy Lifestyle Centers it became clear that they have a very narrow understanding of their mission and activities, which consist exclusively in having all medical personnel deliver lectures and in monitoring the number of lectures delivered per topic.

According to the limited information obtained by the review team, it seems that whilst a few projects use the distribution channels of the Healthy Lifestyle Centers, no project works to develop their capacity to promote health in a broader way other than through lectures. SINO could make a first step in that direction. By engaging the Healthy Lifestyle Centers in their work, SINO can open their eyes to a more meaningful way of interacting with communities.

In meetings with the directors of Healthy Lifestyle Centers they were very interested to cooperate with SINO project and seemed genuinely interested in receiving guidance and support to improve what they do. While it could be that they may still not be open for a new approach, the impression of the review team was that this should be tried again, perhaps starting with a Director who shows enthusiasm to be involved and could become a champion for such a collaboration. Of course, they are also interested to receive equipment (computers, copiers, internet access, etc.) and renovation support and SINO project should consider aspects of this as part of their capacity development. The Healthy Lifestyle Center in Shahrinav under its enterprising director has, for example, developed information material on some topics for medical personnel to use in their lectures and has even attempted surveys to determine the effect of their work.

The review team acknowledge the potential difficulty of working with the Healthy Lifestyle Centers, and the need for adequate functionality and capacity at each site, and their willingness to buy into the participatory rural approach which integrates (not vertically) the activities within family medicine services. But despite these concerns, it was clear from the people spoken to that if SINO took the directors of rayon Healthy Lifestyle Centers to meetings with Community Groups most of them would immediately become convinced.

Of course, their traditional views will not vanish over night and they have their structural constraints that partly contradict changes in the approach. But lectures by doctors/nurses in Community Groups easily meet the official requirements expected of the rayon Healthy Lifestyle Centers to organise and report; so changes may not have to appear large in the beginning. By adopting a "try-it-and-see" approach, there is much to be gained if it succeeds. Capacity will be built up at the rayon Healthy
Lifestyle Centers, there will be increased sustainability of the Community Group model through the increased involvement of the centers, and expansion of the model may prove to be easier to achieve with their involvement.

Cooperating with the Rayon Healthy Lifestyle Centers could involve the following elements:

- Sino invite directors and selected staff from the centers to all their meetings with Community Groups. They will like what they see and intuitively understand the advantage of such an approach over pure lecturing. The centers allocate 2-4 staff who will be responsible for this work and will be trained.

- Healthy Lifestyle Center staff train doctors and nurses on Community Group formation (with Sino staff present) and supervise/support the weakest trainees during the Community Group formation.

- Participatory Rural Appraisal results from all Community Groups are compiled at rayon level resulting in a list of priorities for the whole rayon. This list provides the issues to work on with communities for the coming years. Sino project supports the centers to develop information material (or to collect them from other sources) and didactic tools on the issues on this list.

- The material is given to doctors and nurses for use in their sessions with Community Groups. This would ensure the consistency and quality of key messages. This compiled list would replace the quarterly Participatory Rural Appraisal sessions with each Community Group that are held now. Apart from epidemics, disease priorities do not change quarterly and seasonal variations are known and can be reflected in the yearly plan. Flexibility and responsiveness can still be ensured by asking Community Groups at each session whether there is something of particular interest to them at this time, on which the doctor can then prepare a session.

- Quality is ensured by supervisory visits of Healthy Lifestyle Center staff to some Community Group sessions and by (e.g. half-yearly) meetings of doctors and nurses to share experience and best ideas and to give new inputs.

- Healthy Lifestyle Centers are encouraged to use their new skills in other parts of their work.

- Oblast and Republican level Healthy Lifestyle Center leaders are informed early on about this process and invited for field visits to expose them to this kind of work.

- Surveys on a few key issues from the priority list at baseline and after an appropriate time could provide an indication of the effectiveness of the model. They should be kept simple and developed and executed together with the Healthy Lifestyle Centers. They should contain basic questions such as whether the interviewees have heard about the Community Group in their village, whether they heard somebody talking about the issues, what they remember, and whether they have changed their behaviour in any way.

Obviously, it would be wise to test this process in one batch of one rayon to learn how best to do it; especially, how much supervision is needed to ensure quality? This could be done in the remaining time of Sino phase III.

Depending on the success of piloting this process it may, over time, become a model that the Republican Healthy Lifestyle Center may want to adopt as a standard and promote with other donors while the Republican Centre for Family Medicine may want to include a module on this in the retraining
of family doctors/nurses and into the postgraduate training of family doctors. The director of the Republican Centre for Family Medicine, Tahmina Jabharova, proposed as much, and also recommended that the project should work with the Healthy Lifestyle Centers.

But this is an outlook that depends on proving that the Community Group model can be fully implemented by doctors, nurses and the Healthy Lifestyle Centers. In any case, the key element of this model - that Primary Health Care doctors and nurses, supported by the centers, provide sessions for community groups on topics selected by them - may become the common denominator that all projects working with communities in Tajikistan can fit into their different approaches.

This process would need budgeting for transportation costs of Healthy Lifestyle Center staff to the villages (taxis) and of doctors and nurses to trainings and meetings. The project should also have a budget for printing of information material that will be developed and for equipment and minor repair work of the centers.

4.7.5 Quality of Community Group Teaching

A third question concerns the **quality of their teaching**. The review team did not have a chance to assess the content of lectures but because each family doctor prepares his/her own lectures it would be reasonable to expect them to differ; it seems possible then that some would not meet certain standards. SINO staff themselves mentioned some doubts about the quality of content in some cases.

Concerns here would be two-fold. First, when lecturing lay-people, doctors tend to offer a lot of detailed medical facts and it is possible that the few key messages of real importance could be buried among much less important information and therefore not well understood, quickly forgotten or, worse, misunderstood. Second, doctors may teach things that are not supported by evidence. We saw photos of a lecture where the family doctor taught the group to prepare chlorine solution. When asked, "What for?" the answer given was that this is to clean door handles and surfaces to prevent diarrhea. While this may be indicated in an epidemic situation in treatment facilities (and we failed to ask the specific circumstances of this lecture) it points to the need to assess whether the lectures need more guidance on their content.

The **training of Healthy Lifestyle Center staff and of doctors and nurses** should include a module on how to behave with community members. Presently, the presence of competent SINO staff with their non-dominant, respectful ways ensures that trustful relations on an equal level are quickly established in the new groups; such appreciative relationships are an essential source of sustained motivation for volunteers. Though it is likely that doctors learn these skills from SINO staff by imitation, new doctors and nurses on their own with new groups should go through a more formalised training/process of reflection on their own dominant behaviour that so often is an obstacle to empowering community groups (so prevalent in medical staff vis-à-vis lay people/patients).

For larger villages one may consider more than one Community Groups to increase the effectiveness of information distribution.

- Expert Patients could be invited to be part of the Community Groups. In the end both have one goal: being part of a group helps Expert Patients to sustain their motivation, and they learn about more than one disease.
- Once a functioning process has been established, SINO may consider re-importing it into the old rayons Varzob and Dhangara so that there, too, all villages can benefit from health information.

- The compiled Participatory Rural Appraisal results can be shown to other bodies at the rayon level. This could include the Rayon Health Care Manager, the Primary Health Care manager and the intersectoral council for consideration in their planning.

4.7.6 Impact of the Community Groups

Lastly, the effect of SINO’s community work on awareness and behaviour of the general population is not known, apart from anecdotal evidence. While there is little doubt that Community Groups members have learnt a lot about preventive behaviour and that many of them also apply it, it is not known how many households/people are reached by the Community Groups efforts to spread this knowledge, how much of it is retained by the people who hear it, nor what effect that has on their behaviour.

The SINO project may consider deepening its approach with Community Groups by working on health determinants. Building on existing examples such as the one cited on drinking water provision in Batosh it may not be too far from what some mature groups are already starting to do. The project could include an additional Participatory Rural Appraisal session on health determinants in the village. It would rank them by importance and identify those that the Community Groups has a chance to influence.

After selecting one health determinant to start with the group would brainstorm how this could be addressed and make a simple plan on who does what (in the example given the plan would have spelled out who lobbies whom on the drinking water issue). Part of the regular sessions would be used to review progress. If this is kept very simple it can and should be facilitated by doctors and nurses as done in the other sessions; their involvement can be helpful also to link to authorities.

The SINO project may also consider holding a fund to which Community Groups can apply for small grants (e.g. up to $1000) to help address such determinants but this is not essential. (As Community Groups are not juridical entities funds would probably have to go through other bodies).

It would be important to complement this problem-based approach with a strength-based approach that asks for existing examples of what the group or individuals or other people in the village have done to improve life in the village. This can range from helping a family in need to organising a festival or planting a few trees. Combined with new ideas this can provide a range of things the Community Groups can do with no or very little funds. The success of these small initiatives increases bonding and motivation and helps both to address bigger issues and to cope with the frustration that can develop if the big issues cannot be solved.

Fraud with iodized salt seems widespread in Tajikistan. Producers label salt as iodized even if it is not. Once a whole rayon has been covered with Community Groups, SINO project can imitate the strategy developed in Kyrgyzstan to cope with this problem. Community Groups would be given test kits for iodated salt and asked to check some packets in all shops that sell salt to sensitise shop owners and, most importantly, give them each a test kit so that they can check the salt at wholesale markets before buying it. This drives out fraudsters from the market and can quickly raise the coverage with iodized salt in households. This could be commenced now with the existing groups, but because there are so few the effect will likely be limited to only these villages.
Recommendations - Community Groups

- To further extend coverage, SINO could allow doctors and nurses to form new groups themselves instead of doing this only when supported by SINO staff, and to include those medical staff who have not yet been trained in family medicine.

- Involve pilot Rayon Healthy Lifestyle Centers in the management of the Community Groups, and through developing their capacity larger numbers of medical staff can be trained, more Community Groups established and supported, and sustainable institutional support ensured when the project ends.

- New doctors and nurses taking responsibility on their own for new Community Groups should go through a more formalized training/process of reflection on participative facilitation methods.

- SINO may consider deepening its approach by working with Community Groups on health determinants, building on existing examples such as the one on drinking water provision in Batosh.

4.8 SINO Coordination with the MoH

In all the areas in which SINO is active, there is input to policy dialogue through position papers, publication of study results such as on the health financing issues, and regularly through involvement in Working Groups and contacts with MoH officials responsible for overseeing the project initiatives. The review team analyzed the Aid Coordination framework and linkages and this is summarized in Annex 4.

This review highlights a number of areas in which increased coordination between SINO and government entities could further increase its partnership with government institutions. Such opportunities include developing cooperation with the TSMU Public Health Management Department combined with closer work with Rayon and Oblast Health Managers on the Business Plan initiative; increasing the involvement of the Healthy Lifestyle Centers in the Community Group activities; active sharing of training methodologies between the TSMU and the 6-month family medicine retraining courses; and review of the 6-month family nurse re-training program in coordination with the undergraduate nurse education institutions.

The more such partnerships are developed and made integral to the work of the SINO project, the more the project will be strengthened. This will result in longer term sustainability as local institutions would increasingly take on more responsibility. Once these institutions are prepared there could be acceleration of the expansion of activities and coverage of the country, and all of this for little overall increase in costs. An illustration of how this could have an immediate impact on policy dialogue with the MoH is shown by the fact that the head of the TSMU Public Health Management Department holds a combined position as Head of Health Policy in the MoH. Such linkages and relationships would only develop more over time as cooperation with these various institutions flourishes.

The midterm review carried out by STPH recommended exploring options for the project SINO office to move physically closer to the MoH. While this could be helpful, the coordination opportunities
described above do not require such physical proximity and such a move may, in fact, prove to be problematical. The experience of the Health Policy analysis team of the WHO - based in the MoH premises - highlighted the problem that project staff located there may be placed under pressure to carry out certain activities not part of their mandate or plans, and may be drawn into political conflicts within the institution.

### Recommendations - Coordination with the MoH

- Partnerships with government entities should be fostered and made integral to the work of the SINO project in order to strengthen the project outcomes over the longer term: increasing sustainability, accelerating expansion of activities and coverage of the country; with little overall increase in costs.
5 Conclusions

The MEP and SINO projects have important roles to play in the development of the health care system of Tajikistan, and the review team did not find any cause to recommend any major changes in direction. Instead, there is plenty of scope to deepen and spread these initiatives, perhaps enhancing the synergies between them through merging them into one program, with MEP becoming in effect a component of SINO, requiring only one Memorandum of Understanding process with the Government.

The overall focus on Primary Health Care through development of family medicine matches perfectly the priorities of the Government, and is in keeping with the large proportion of the population who live rurally. However, the impact of the project could be enhanced significantly. In particular, roll out and sustainability would be helped by increased linkage to existing relevant institutions, while the quality of service provision would be augmented by increased emphasis on -and sensitivity to- feedback from patients and providers.

Thus three cross-cutting themes emerge from MEP and SINO which are relevant to the various levels of the health care system. These themes are Roll Out, Institutional Links and Feedback Loops, and they are tabulated below:

Table 1: Cross Cutting Themes

<table>
<thead>
<tr>
<th>1. Rollout</th>
<th>Undergraduate Education</th>
<th>Graduate Education (Internatura)</th>
<th>Continuing Medical Education</th>
<th>PHC Management &amp; Service Delivery</th>
<th>Community Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Link to MoH, TSMU and RCFM to strengthen this for family doctors</td>
<td>- Linkage of CME courses (incl 6-month FM course) with TSMU program</td>
<td>- To new areas</td>
<td>- To new areas</td>
<td>- In new areas (+/- old areas)</td>
<td></td>
</tr>
<tr>
<td>2. Institutional Links</td>
<td>- Continuing updating of curriculum at TSMU.</td>
<td>- Possible review and updating of curriculum at nurse schools</td>
<td>- Better links with existing FM training centers</td>
<td>- With the TSMU Public Health Management Department (PGMI Management Department), MoH/MoF Policy Makers</td>
<td>- Greater role of doctors/nurses</td>
</tr>
<tr>
<td>3. Feedback Loops</td>
<td>- Increased student (and staff) feedback on implementation of new teaching techniques</td>
<td>- From 6-month family medicine training programs</td>
<td>- Needs of 6/12 FM teachers met proactively CME courses with TSMU program</td>
<td>- Experience from Peer Review Groups fed into Business Plans</td>
<td>- Patient and staff needs fed back to medical education curriculum &amp; Public Health Management Curriculum</td>
</tr>
</tbody>
</table>
5.1 Roll out

Geographical roll out of all the above-mentioned components of the SINO model of family medicine to more rayons should be possible. The review team did not see any particular need to spend extra time deepening the work before attempting further expansion, but view it rather as a process of evolution as the work of the project continues.

This roll out may need to be combined with development of new family doctor/nurse training centres, and should include accompany measures such as Peer Review Groups and introduction of the Business Plans. Matched to this could be a phase-out from Toursunzade and Sharinaw carried out step-by-step as it was done with Vose and Khamadoni and perhaps some modifications (shortening) of the nurse training program. SINO could assist the MoH to gather an overview on family medicine implementation throughout the country and to identify priorities for next rayons.

A discussion to cover conflict-affected rayons in Rasht valley should be continued within SDC and then with the Tajik government. While rolling out into the new rayons lessons learnt from the previous pilot rayons and recommendations contained in this report should be used to adapt the program activities accordingly. As information is shared regularly with Aga Khan Foundation, a comparison of lessons learnt from their program could add new aspects to both programs with mutual incorporation of lessons learned.

The report has identified a number of potential strategies to increase the number of Community Groups in the "old" rayons as well as the newly supported ones.

5.2 Institutional links

A stronger emphasis on linking the project activities to national institutions will bring a number of benefits to the project. While initially this may prove to be relatively slow, difficult and with some additional costs, the benefits are likely to make these modest investments worthwhile resulting in increased sustainability, a strengthened health care system with empowered national staff and, over time, more extensive and faster roll out.

Examples of linkages have been described in detail and include drawing the undergraduate faculty closer to the postgraduate family medicine training centers, supporting the Republican Center for Family Medicine and the TSMU to enhance the organisation of the Internatura year, cooperating with the TSMU Public Health Management Department on development of the Business Plans, and inclusion of the Healthy Lifestyle Centers into the work of the Community Groups.

5.3 Feedback loops for results

In a project that is so extensive it is easy to focus on achieving all the expected inputs such as revising curriculums and conducting training courses, rebuilding facilities, introducing Business Plans and developing Community Groups. However, the continued effectiveness of each of these inputs is highly dependent upon receiving and acting on information feedback from the implementers and the receivers of the support. The recommendations related to the nurturing of such feedback loops by both the MEP and SINO projects has been described above under the relevant headings of the "Findings" (Section 4 of the report).
The need for such feedback was particularly evident in the implementation of the Business Plans in the phased out rayons of Dangara and Varzob. While the Plans are of value for understanding and managing the budgets and promote the measurement of indicators, they did not appear to be used as a serious mechanism by which the facilities could feedback to the authorities the restraints they feel under or to pinpoint areas of need faced by the medical staff and their patients. The review team found that the resolution to the problems frequently faced at the facility level lay within the responsibility of management. Enhanced and open feedback from project activities as part of the function of management would help to maximize impact and enhance the quality of care and patient satisfaction. But support (from SINO/MEP) would also be needed to help the managers take on this role, which is so much in contrast to the current mentality of control and punishment. It may be useful for SINO/MEP to carefully consider their own positions in this regard.

Other feedback-loop ideas would be for modern teaching knowledge and skills developed for the CME short courses (including those carried out with donor support such as IMCI) to be aligned with the medical education curriculums at undergraduate and graduate levels. This would mean that the medical faculty are kept up-to-date about the latest guidelines and are provided with materials that they could use in their teaching programs, catalyzing this process by ensuring that exams reflect this need to keep the clinical part of the courses. Experience from Community Groups and Peer Review Groups could also feed into the Business Plans and the annual planning process. This would potentially enhance management understanding at higher levels and, ideally, would feed into strategic decisions at oblast and even MoH levels.

The full spectrum of SINO/MEP activities including these feedback loops are shown in Figure 4 below. Lessons learned and issues (un)resolved are fed back from the medical facility staff and patients to the two components of the health system, the medical educators and the health care management. Taken seriously and with an understanding and supportive attitude, this feedback is the key to bringing about improvements to the system that reflect the real needs on the ground, not simply the perceived needs according to the managers, policy makers or, even, the donors.

Figure 4: Components related to SINO and MEP and its feedback loops
5.4 Proposed Future Priorities

The external review team see a number of directions forward to enhance the effectiveness of the project that will not require any major changes in strategy or outlook, and most of which would not be costly to implement.

First, endow the Business Plan with more focus on addressing issues of feedback, and doing this through active development of a partnership with an Institute such as the TSMU Public Health Management Department as an explicit objective of the project. Second, enhancement of the work of the Community Groups, training Doctors to carry out the work independently and linking to the Healthy Lifestyle Centers. Third, provide more pro-active support for the development of the family doctor training centers, possibly including a review of the curriculum. Fourth, enhance the organisation of the Internatura for family doctors. Fifth, link the Peer Review Groups more to the Republican Center for Family Medicine. And sixth, continue the development of the undergraduate medical education, particularly assisting in the finalisation and implementation of the reformed curriculum.

A new direction for the project would be to assess the 6-month family nurse training curriculum and evaluate the possibility to strengthen/reform at least aspects of the current undergraduate program.

And, finally, the overarching question of how far and how fast to roll out the strategy across the rest of the country. The answer to this should be dependent not only on the future funding amount, but also on the development of the options proposed in this report including assessment of the nursing situation, linkage of project components more strongly to existing institutions, and pushing for earlier autonomy of staff leading the Community Group work in new areas. Consideration could be given for rolling out selected sets of project activities such as the Community Group work, or the Business Plans, but this would not directly address the underlying urgency of the National Health Strategy to develop family medicine across the country. The advantages and disadvantages of directing the family medicine training centers to teach short clinical modules to the medical staff in more rayons has been discussed earlier in section 4.5.1.
Annexes
## ANNEX 1 Programme of the Mission and People Met

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Place</th>
<th>People met and other remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thursday</strong></td>
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<tr>
<td>17.11.2011</td>
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<tr>
<td><strong>Thursday</strong></td>
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<tr>
<td>17.11.2011</td>
<td>9:00 – 12:00</td>
<td>SINO Office</td>
<td>Briefing with long term technical advisor; Meeting with Project SINO Staff, Joao Costa Project SINO</td>
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<tr>
<td>17.11.2011</td>
<td>13:00 – 15:00</td>
<td>TSMU</td>
<td>MEP coordinator Aziz Nabijanov, Nargis Muqsudova (Head of International Office TSMU)</td>
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<tr>
<td>17.11.2011</td>
<td>15:30 – 17:00</td>
<td>EC Delegation</td>
<td>EC EuropeAid: Ileana Mitrescu, Programme Manager</td>
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<td><strong>Saturday</strong></td>
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<tr>
<td>19.11.2011</td>
<td>09:00 – 17:00</td>
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<td>Visit to Varzob RHC (Ziddi, Gushary and Chorbog) Meeting with Family Doctors, Family Nurses, Community members</td>
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<td><strong>Sunday</strong></td>
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<tr>
<td>20.11.2011</td>
<td>Free Day</td>
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<td>Team discussion and collecting results, reading</td>
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<tr>
<td><strong>Monday</strong></td>
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</tr>
<tr>
<td>21.11.2011</td>
<td>9:00 - 11:00</td>
<td>SINO</td>
<td>Reviewing Business Plans</td>
</tr>
<tr>
<td>21.11.2011</td>
<td>11:15 - 12:30</td>
<td>WHO</td>
<td>WHO, Dr. Pavel Ursu, Head of Country Office</td>
</tr>
<tr>
<td>21.11.2011</td>
<td>14:00 – 15:00</td>
<td>TSMU</td>
<td>Meeting with the Rector of TSMU, Dr. A. Kurbanov, Kurbonov Said, Vice Rector for Academic Affairs</td>
</tr>
<tr>
<td>21.11.2011</td>
<td>15:00 - 17:30</td>
<td></td>
<td>Meeting with the Working Group of TSMU,</td>
</tr>
<tr>
<td>21.11.2011</td>
<td>18:00</td>
<td>MoH</td>
<td>Meeting with the Head of Health Care Reform Department of the MOH, Dr Saifutdinov</td>
</tr>
</tbody>
</table>

Note: Location: Mercury Hotel, Tolstoy 09, Dushanbe

**Thursday 17.11.2011**
- Peter Campbell, Debora Kern, Tobias Schüth Arrival at 05:00 am
- Travel from CH-IST-DYU
- Pick up and transfer by office driver Akhmed,
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Place</th>
<th>People met and other remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>8:30 - 12:00</td>
<td>PGMI</td>
<td>Meeting with the staff of Postgraduate Medical Institute</td>
</tr>
<tr>
<td>22.11.2011</td>
<td>13:15 - 14:30</td>
<td>MoH</td>
<td>Meeting with Health Policy Analysis Unit, Benoit Mathviet Health Policy Advisor</td>
</tr>
<tr>
<td></td>
<td>15:00 - 16:45</td>
<td>World Bank</td>
<td>Meeting with Project Resp. Health, Sarvionoz Barfieva, Programme Coordinator Health Tajikistan, Wezi Msisha, Health Specialist Central Asia</td>
</tr>
<tr>
<td></td>
<td>17:00 - 18:30</td>
<td>RCFM</td>
<td>Meeting with Republican Center for Family Centre</td>
</tr>
<tr>
<td></td>
<td>18:30</td>
<td>La Grande Dame</td>
<td>USAID Health Care Quality Project, implemented by Abt Associates, Alisher Makhmudov, Project Manager</td>
</tr>
<tr>
<td>Weds</td>
<td>8:30 - 9:30</td>
<td>Shahrinaw</td>
<td>Travel to Shahrinaw</td>
</tr>
<tr>
<td>23.11.2011</td>
<td>9:30 - 10:30</td>
<td>Shahrinaw</td>
<td>Meeting with the Rayzdrav</td>
</tr>
<tr>
<td></td>
<td>10:35 - 11:30</td>
<td>Shahrinaw</td>
<td>Meeting with the head of the primary health care</td>
</tr>
<tr>
<td></td>
<td>11:35 - 12:30</td>
<td>Shahrinaw</td>
<td>Clinical training basis</td>
</tr>
<tr>
<td></td>
<td>12:40 - 14:00</td>
<td>Shahrinaw</td>
<td>Lunch</td>
</tr>
<tr>
<td></td>
<td>14:10 - 15:00</td>
<td></td>
<td>Travel to Toursunzade</td>
</tr>
<tr>
<td></td>
<td>15:20 - 15:40</td>
<td>Toursunzade</td>
<td>Meeting with the head of the primary health care and Rayzdrav</td>
</tr>
<tr>
<td></td>
<td>15:45 - 16:30</td>
<td>Toursunzade</td>
<td>Toursunzade Clinical Training Centre</td>
</tr>
<tr>
<td></td>
<td>15:45 - 16:30</td>
<td>Toursunzade</td>
<td>Community group meeting</td>
</tr>
<tr>
<td></td>
<td>16:35 - 17:30</td>
<td></td>
<td>Travel to Dushanbe</td>
</tr>
<tr>
<td>Thursday</td>
<td>8:30 - 12:00</td>
<td>Field visit to Khatlon</td>
<td>Trip Dushanbe - Vose (South of Tajikistan) Lunch upon arrival</td>
</tr>
<tr>
<td>24.11.2011</td>
<td>13:00 - 14:00</td>
<td>Vose</td>
<td>Meeting PHC manager and visit polyclinic, Head Rayon Health department Asoev R, Negmatov S - Hospital Director, Tagoev Boynazar PHC-Manager</td>
</tr>
<tr>
<td>SINO Group</td>
<td>14:30 - 15:15</td>
<td>Vose</td>
<td>Visit a renovated RHC &amp; Community Group</td>
</tr>
<tr>
<td></td>
<td>15:30 - 16:30</td>
<td>Vose</td>
<td>Visit a non-renovated RHC &amp; Community Group</td>
</tr>
<tr>
<td>MEP Group</td>
<td>8:30 - 16:30</td>
<td>Dushanbe</td>
<td>Visiting Departments in TSMU</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Place</td>
<td>People met and other remarks</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td><strong>Friday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.11.2011</td>
<td>8:30 - 9:30</td>
<td>Khamadoni</td>
<td>Meeting PHC manager and visit polyclinic</td>
</tr>
<tr>
<td></td>
<td>9:30 - 10:30</td>
<td>Khamadoni</td>
<td>Visit a renovated RHC &amp; Community Group</td>
</tr>
<tr>
<td></td>
<td>10:30 - 11:30</td>
<td>Khamadoni</td>
<td>Visit a non-renovated RHC &amp; Community Gp</td>
</tr>
<tr>
<td></td>
<td>14:30 - 15:00</td>
<td>Dangara</td>
<td>Visit to Clinical Training Centre in Dangara.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shamsov Khizmatullo-Head doctor of CHR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ashurov S-Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Murodov Pulod Head of Family Doctor Training Centre</td>
</tr>
<tr>
<td></td>
<td>15:00 - 17:30</td>
<td></td>
<td>Trip from Dangara to Dushanbe</td>
</tr>
<tr>
<td><strong>SINO Group:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.11.2011</td>
<td></td>
<td></td>
<td>Continue field visit Khatlon</td>
</tr>
<tr>
<td><strong>MEP Group:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.30 - 17.30</td>
<td>Dushanbe</td>
<td></td>
<td>Visiting TSMU Departments and Clinical Practice Sites</td>
</tr>
<tr>
<td><strong>Saturday</strong></td>
<td>9:00</td>
<td>KFW/(EPOS)</td>
<td>Meeting with KFW, Mehri Yuldasheva Consultant (EPOS), Farukh Kasymov, Local Consultant KfW</td>
</tr>
<tr>
<td>26.11.2011</td>
<td>10:00 - 15:00</td>
<td></td>
<td>Meeting with the political advisor of MEP</td>
</tr>
<tr>
<td><strong>Sunday</strong></td>
<td>Free day</td>
<td></td>
<td>Preparing Workshops, presentations, report writing, conclusions among the team</td>
</tr>
<tr>
<td>27.11.2011</td>
<td>9:00 - 10:30</td>
<td>Dushanbe</td>
<td>Meeting with Aga Khan Foundation/AKHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rudoba Rakhmatova, Senior Program Manager Health</td>
</tr>
<tr>
<td></td>
<td>10:45 - 12:00</td>
<td>Dushanbe</td>
<td>Meeting with GIZ Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dr. Evelina Toteva, Principal Technical Advisor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tajikistan, Manzura Mirsaidova, Project Coordinator</td>
</tr>
<tr>
<td></td>
<td>12:30 - 13:30</td>
<td>SCO canteen</td>
<td>Lunch, Tbc by Aziz</td>
</tr>
<tr>
<td></td>
<td>14:00 - 15:15</td>
<td>Dushanbe</td>
<td>Meeting with the legal advisor of MEP</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Place</td>
<td>People met and other remarks</td>
</tr>
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<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tuesday</td>
<td>9:00 – 10:00</td>
<td>Dushanbe</td>
<td>Meeting with Family Medicine Clinic</td>
</tr>
<tr>
<td></td>
<td>10:00 – 12:00</td>
<td>Dushanbe</td>
<td>Preparation for the workshop with SINO staff</td>
</tr>
<tr>
<td>29.11.2011</td>
<td>13:15 – 14:45</td>
<td>Dushanbe</td>
<td>Debriefing Workshop with SINO staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mouazamma Djamalova, Joao Costa, Abdujabborov, Abdualimova Khanifa</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gulomova Zulfia, Hamidova Zarofat, Jaborova Delia, Karimova Gulzira, Toshmatova Husnida</td>
</tr>
<tr>
<td></td>
<td>15:00 – 17:30</td>
<td>SCO office, Dushanbe</td>
<td>Preparation for the workshop with stakeholders, internal work</td>
</tr>
<tr>
<td>Weds</td>
<td>9:00 – 16:00</td>
<td>Dushanbe</td>
<td>Debriefing Workshop with stakeholders</td>
</tr>
<tr>
<td>30.11.2011</td>
<td>17:45</td>
<td>SCO office, Dushanbe</td>
<td>Conclusion of the day, internal work</td>
</tr>
<tr>
<td>Thursday</td>
<td>3:30 to airport</td>
<td>Dushanbe - Istanbul</td>
<td>Departure Flight</td>
</tr>
<tr>
<td>1.12.2011</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ANNEX 2  List of Documents Reviewed

2. Mid-term review SINO phase 3 Jan 2011, final version
3. Annex 1. Tajik Concept of Reform of Medical Education - draft
4. Annexe 1. Draft Logical Framework of the Undergraduate Medical Education Project
5. Antrag Zusatzkredit, Tajik-Swiss Health Reform and Family Medicine Support Project, Ph. 3, Tajikistan
8. Sector analyses in view of the selection of future priority domains of intervention in the framework of the Swedish Cooperation Strategy for Central Asia 2012-2015, Tajikistan
9. Eintretensantrag, Medical Education Project, Tajikistan
10. Eröffnungskredit, Medical Education Project, Tajikistan
11. Eröffnungskredit, Tajik-Swiss Health Reform and Family Medicine Support Project, Phase 3
12. Hauptkredit 1 zum Eröffnungskredit, Medical Education Project, Tajikistan
13. Hauptkredit Teil 2 zum Eröffnungskredit, Medical Education Reform Project, Phase 1, Tajikistan
14. Hauptkredit z. Eröffnungskredit, Support Primary Health Care, Ph. 3, Tajikistan
15. Hauptkredit z. Eröffnungskredit, Support Primary Health Care, Ph. 3, Tajikistan
16. Health REVISED second drafting round
17. Concept of Reform of Medical and Pharmaceutical Education in the Republic of Tajikistan
18. Baseline assessment of medical education at Tajikistan State Medical University And their Ministries of Health and Education, Calgary University, 28 Apr 2010.
19. MEP Proposal by STPH phase 1, final version
22. Vulnerability Assessment of SDC/SECO Development Programme in Tajikistan, Feb 2010
23. SDC Medical Education Tajikistan Calgary University mission report -final, 02 Apr 2011
24. SDC Medical education Project Annual Report 2010 revised final, 21 May 2011
25. SDC MEP Tajikistan Project Proposal, 8 Jun 2010 final version
27. SDC MEP Tajikistan Project Proposal, 8 Jun 2010 final version
30. SINO Project document phase 3 final version, 10 Jun 2009
31. Staatsvertrag, Medical Education Reform Project undergraduate level, Phase 1
32. Staatsvertrag, Swiss Health Reform and Family Medicine 2009 - 2012, Tajikistan
33. Tajikistan Context Analysis 2011
34. Health Strategy Republic of Tajikistan 2010-2020), 5th draft, 12 May 2010
36. Implementation mechanism to the National health Strategy of the Republic of Tajikistan for the period 2010-2020 years
<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>39)</td>
<td>Drafted strategic orientation (results framework) for the health care sector in Tajikistan</td>
</tr>
<tr>
<td>40)</td>
<td>Central Asia and Tajikistan context analysis (2010)</td>
</tr>
<tr>
<td>41)</td>
<td>Sector analysis for the SDC Health care programme in Tajikistan (2011)</td>
</tr>
<tr>
<td>42)</td>
<td>National Poverty Reduction Strategy 2010-2012</td>
</tr>
<tr>
<td>44)</td>
<td>Patient Experience with Family Medicine Services in rural Tajikistan, Nov 2011, Joelle Schwarz</td>
</tr>
<tr>
<td>45)</td>
<td>Phase 2 SINO project document Russian, final reduced, March 2006</td>
</tr>
<tr>
<td>46)</td>
<td>Phase 2 SINO project document, final full version March 2006</td>
</tr>
<tr>
<td>47)</td>
<td>Phase 2 SINO project document, final reduced version, March 2006</td>
</tr>
<tr>
<td>48)</td>
<td>External review SINO phase 2 final version, 7 Sept 2008</td>
</tr>
<tr>
<td>49)</td>
<td>External review SINO phase finance section final, 3 Nov 09</td>
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<tr>
<td>50)</td>
<td>Progress report SINO April to Sept 06, 12 Oct 06.</td>
</tr>
<tr>
<td>51)</td>
<td>Progress report SINO April 06 to Mar 07 annexe 1, 23 Apr 2007</td>
</tr>
<tr>
<td>52)</td>
<td>Progress report SINO April 06 to Mar 07 annexe 2, 23 Apr 2007</td>
</tr>
<tr>
<td>53)</td>
<td>Progress report SINO April 06 to Mar 07, 30 Apr 2007</td>
</tr>
<tr>
<td>54)</td>
<td>Progress report SINO April to Sept 07, 22 Oct 2007</td>
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<td>55)</td>
<td>Progress report SINO April 07 to March 08, 30 Apr 2008</td>
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<tr>
<td>56)</td>
<td>Progress report SINO April to Sept 08 Final, 17 Nov 2008</td>
</tr>
<tr>
<td>57)</td>
<td>Progress report SINO phase 2 draft, 27 May 2009</td>
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<td>58)</td>
<td>Continuous education approach April 2006, final version</td>
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<td>59)</td>
<td>Drug revolving funds April 2006, final version</td>
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<tr>
<td>60)</td>
<td>Health financing review May 2006, final version</td>
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<td>61)</td>
<td>Health Human Resources CPG August 2006, final version</td>
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<td>62)</td>
<td>CEA July 2006, final version</td>
</tr>
<tr>
<td>63)</td>
<td>TB Jul 2007, draft version</td>
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<td>64)</td>
<td>TB Jul 2007, final version</td>
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<td>65)</td>
<td>Maintenance and equipment Oct 2006, final version</td>
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<td>66)</td>
<td>Maintenance and equipment Oct 2006, final version</td>
</tr>
<tr>
<td>67)</td>
<td>Health financing review Oct 2006, final version</td>
</tr>
<tr>
<td>68)</td>
<td>Community and health promotion Oct 2006, final version</td>
</tr>
<tr>
<td>69)</td>
<td>CEA Jan 2007, final version</td>
</tr>
<tr>
<td>70)</td>
<td>Mid-term review Nov 2007, final version</td>
</tr>
<tr>
<td>71)</td>
<td>SWAp and health financing review Jun 2007</td>
</tr>
<tr>
<td>72)</td>
<td>SWAp and health financing review Jun 2007, final version</td>
</tr>
<tr>
<td>73)</td>
<td>Study tour June07, final version</td>
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<td>74)</td>
<td>CEA July 2007, final version</td>
</tr>
<tr>
<td>75)</td>
<td>Strengthening skills in family medicine Oct 2007, draft version</td>
</tr>
<tr>
<td>76)</td>
<td>Malaria appraisal Sept 2007, final version</td>
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<tr>
<td>77)</td>
<td>Community and health promotion Sept 2007, draft version</td>
</tr>
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<td>78)</td>
<td>CEA November 2007, final version</td>
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<td>79)</td>
<td>Health financing Nov 2007, final version</td>
</tr>
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<td>80)</td>
<td>TB review Jan 2008 annex 5a reporting, final version</td>
</tr>
<tr>
<td>81)</td>
<td>TB review Jan 2008 annex 5b reporting, final version</td>
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<tr>
<td>82)</td>
<td>TB review Jan 2008 annex 6 reporting, final version</td>
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<td>83)</td>
<td>TB review Jan 2008, final version</td>
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<td>84)</td>
<td>Drug revolving funds January 2008, draft version</td>
</tr>
<tr>
<td>85)</td>
<td>Management training April 2008, final version</td>
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</table>
86) Strengthening skills annex 3.xls
87) Strengthening skills in clinical practice Feb 2008, final version
88) TB food complements March 2008, final.doc
89) CEA May 2008, final version
90) Referral practices May 2008, final version
91) Health financing review May 2008, final version
92) Financial Management Support June 2008, final version
93) ToR TB sputum examination Jan 2009, final version
94) Strengthening skills in family medicine III Oct 08, final version
95) Prevalence goitre helminths presentation, 26 Mar 2009
96) Prevalence goitre helminths report draft, 3Apr 2009
97) CEA Dec 2008, final version
98) Vocational training Family Medicine Feb 2009, final version
99) Family Medicine training Feb 2009, final version
100) Progress report short SINO April to June 2009
101) Progress report SINO April to December 09 final, 1 Mar 2010
102) Progress report SINO April 09 to June 10 final version, 3 Nov 2010
103) Progress report financial data 01.04.09 - 31.12.10, 18Fe.xls
104) Progress report SINO July to December 2010, 21 Feb 2011
105) Work plan 2009 - 2010, 15 Sept 2009
108) Policy brief Purchasing Models Russian, 9 Dec 2009
109) Policy brief Purchasing Models, 9 Dec 2009
110) Policy brief Public and Private Russian, 3 Sept 2010
111) Policy brief Purchasing Models Russian, 25 Aug 2010
112) Policy brief Public and Private provision of Health Care, 25 Aug 10
113) Policy brief retraining for Family Medicine, 26 May 2011
114) BBP implementation report 2009 Final version, 2 Jun 2010
115) BBP implementation report 2009 Final version, 2 Jun 2010
116) Strengthening skills in family medicine Oct 09, final version
118) CME Feb 2010, 2 Mar 2010
119) Review financial admin April 2010, 27 May 2010
120) Prevalence goitre helminths study report update, 19 Mar 2010
121) Strengthening skills in family medicine VI May 2010, final version
122) Mid-term review phase 3 Jan 2011 annex 3, draft version
123) Review financial admin Oct 2010, final version
124) Strengthening skills in family medicine VI Oct 2010.doc
125) CME Nov 2010, final version
126) Community participation review March 2011, final version
127) Strengthening skills in family medicine VIII May 2011 final version
130) Patient satisfaction report Oct 2011, draft version
### ANNEX 3  Stakeholder Analysis

The following table provides an overview of the roles of the most relevant stakeholders and their contributions to the project:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Interest/Commitment to Project</th>
<th>Capacity for change (and possible contribution to project)</th>
<th>Actions of project to strengthen capacity of stakeholder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients and Community health groups</td>
<td>Have an interest in improved access to quality health care, for which the project is aiming at.</td>
<td>Contribution to the project via active participation in community health groups. Capacity of Change deriving from health behaviour change from learning in Community groups (e.g., iodine in salt against goitre)</td>
<td>SINO initiates and supports the community health groups to strengthen health knowledge and empower the people in the communities in their health seeking behaviour.</td>
</tr>
<tr>
<td>TSMU - Tajik State Medical University</td>
<td>High interest in project part MEP. Commitment to MEP and change of curriculum given. Contribution by MEP is well appreciated.</td>
<td>Leadership (Dr Kurbanov) is prepared for change in the curriculum and open for discussion for contributions from the project.</td>
<td>MEP Leadership and the member of the working group have got technical exchange with Swiss and Canadian experts on their task and study tours took place. TSMU received in kind contribution (clinical lab equipments) for improved training facilities.</td>
</tr>
<tr>
<td>Ministry of Health (MoH)</td>
<td>High interest in SINO and MEP. Committed to both projects and very grateful to the results of both projects. Sometimes reluctant to support policies and reforms (particularly on HC financing).</td>
<td>Generally speaking health sector reform changes are difficult due to potential political implications and influence within MoH. Fully support the family medicine approach and MEP though.</td>
<td>SINO give direct policy and strategy support through discussions, policy briefs and evidence delivered from surveys from the pilot rayons (districts).</td>
</tr>
<tr>
<td>Postgraduate Medical Institute (PGMI)</td>
<td>Receives contract and financing from project SINO for training. Therefore has high interest on Project SINO. Is highly committed to Trainings for SINO.</td>
<td>PGMI does not get along well with the Rep. Centre and TSMU. Personal relationships, but also competition (for Rep. Centre) implied by Donors is feeding into this. Contribution to overall synchronization of Medical education is limited by this isolation. However they are highly contributing to quality of training for SINO. PGMI perceived as stronger in clinical training than Rep. Centre of Family Medicine.</td>
<td>SINO gives support and funding for trainings of Family doctors and Family nurses. Trainers receive a top up or are paid by SINO. Students receive per diem. Books, training material, presentation material etc. was funded by SINO.</td>
</tr>
<tr>
<td>Republican Centre for Family Medicine (RCFM)</td>
<td>Receives contract and financing from project SINO for training. Therefore has high interest on Project SINO. Is highly committed to Trainings for SINO.</td>
<td>RCFM does not get along well with the PGMI. Personal relationships, but also competition implied by Donors is feeding into this. Contribution to overall synchronization of Medical education is limited by this isolation. However they are contributing to quality of training for SINO.</td>
<td>SINO gives support and funding for trainings of Family doctors and Family nurses. Trainers receive a top up or are paid by SINO. Students receive per diem. Books, training material, presentation material etc. was funded by SINO.</td>
</tr>
<tr>
<td>Primary Healthcare Managers (Rayon level)</td>
<td>The PHC Managers have a high interest in Project SINO, as it supports their objectives and their funding base (equipment, rehab, trained doctors and</td>
<td>Capacity to change and contribution is varying by individual PHC Manager and by the space they get from superior oblast level or MoH.</td>
<td>Business plans and peer review groups, equipment and rehabilitation of infrastructure SINO undertakes directly strengthen the capacity base for PHC managers. Managerial</td>
</tr>
</tbody>
</table>

3 Overview was requested by SDC
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Interest/Commitment to Project</th>
<th>Capacity for change (and possible contribution to project)</th>
<th>Actions of project to strengthen capacity of stakeholder</th>
</tr>
</thead>
<tbody>
<tr>
<td>nurses)</td>
<td>They are grateful and committed to the project.</td>
<td></td>
<td>training for them might be taken into consideration for future project activities.</td>
</tr>
<tr>
<td>Rayzdrav level (superior of PHC Manager at rayon level)</td>
<td>High interest in Project SINO, as it supports their objectives and indirectly their funding base (equipment, rehab, trained doctors and nurses). They are far less into the details than the PHC managers.</td>
<td>Capacity to change and contribution is varying by individual Rayzdrav Manager and by the space they get from superior oblast level or MoH. They are more politically oriented than the PHC managers.</td>
<td>Investment by SINO in PHC strengthens the political position of the Rayzdravs.</td>
</tr>
<tr>
<td>Family Doctors/ Family Nurses</td>
<td>Very high interest in training and all other activities (peer review groups, rehab. of facilities, donation equipment etc.) of SINO. They are ready for change and are the main contributors or carriers of the project, particularly from a sustainability perspective.</td>
<td></td>
<td>Almost all activities SINO performs are strengthening the capacity of Family doctors and nurses, but particularly the 6-month training.</td>
</tr>
<tr>
<td>WHO</td>
<td>High interest in project and its results. Evidence and experience derived from the project is directly feeding into the policy advice by the partners and MoH. SINO is perceived as one of the important pillars for policy discussion as they provide evidence on the reform implementation.</td>
<td>WHO and SINO often pull together on the same policy directions in discussion with MoH. WHO supports the Family Medicine strategy.</td>
<td>WHO reported high impact of SINO on policy discussion and formulation of policy. This might be weakened temporarily when the SINO project manager has to be replaced.</td>
</tr>
<tr>
<td>AKHS - Aga Khan Health Services</td>
<td>AKHS is partially funded by SDC and they are doing very similar programs than SINO. They are doing rehabilitation of infrastructure, training of Family doctors and Family Nurses, and community health promotion in Family Medicine. They are very interested in SINO for sharing experience and evidence.</td>
<td>Sharing of their experience important for SINO and CME. Clinical excellence centres established by AKHS in the oblasts and districts should feed into CME strategy and corresponding discussion. This is a different concept, which can be conceptualised together with the peer review groups of SINO. Different approach to health promotion with health promoters instead of community health groups. Supports SINO in policy dialogue.</td>
<td>Evidence, surveys and experience derived from the SINO project is shared with Aga Khan and can feed into their similar programs.</td>
</tr>
<tr>
<td>EC</td>
<td>High interest in project and its results. Evidence and experience derived from the project is directly feeding into the programming of EC.</td>
<td>EC is interested in collaboration with SDC and interested to share projects with pooled funding (SDC funding for EC projects, but maybe also interested in co-fund scaling up of SINO activities.) Future HMIS project by EC may have cross cutting issues with business plan efforts of SINO.</td>
<td>Evidence and experience derived from the project is directly feeding into the programming of EC. EC reported high impact of SINO on policy discussion and strategies. This might be weakened temporarily when the SINO project manager has to be replaced.</td>
</tr>
<tr>
<td>World Bank</td>
<td>Interested in project and its results. Evidence (e.g. on BBP) and experience derived from the project is feeding into programming of World Bank. Also active in community health and infra structure rehabilitation.</td>
<td>World bank is also funding training, infrastructure building and rehabilitation. World Bank could be a potential partner in scaling up SINO project. WB is collaborating with SINO on small things on PHC level like lab technology and are using the SINO developed Business plan. WB is also funding training activities.</td>
<td>Evidence, surveys and experience derived from SINO project is may feeding into the programming of World Bank. Project Management mainly based in Washington DC, local project management much weaker than with SINO. WB interested in survey of budget flows within the rayons undertaken by SINO at present.</td>
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<tr>
<td>USAID</td>
<td>Interested in project and its</td>
<td>USAID does Training for Trainers in TB,</td>
<td>Evidence, surveys and experience</td>
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<tr>
<td>Stakeholder</td>
<td>Interest/Commitment to Project</td>
<td>Capacity for change (and possible contribution to project)</td>
<td>Actions of project to strengthen capacity of stakeholder</td>
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<tr>
<td>(Implement-ting: Abt Associates)</td>
<td>results. Evidence (e.g. on BBP) and experience derived from the project may feed into programming of USAID.</td>
<td>HIV, MCH, also using PGMI and Rep. Centre. USAID is also active in PHC and doing training for Family doctors. They could be a potential partner on capacity building of training facilities and eventually for a scaling up of SINO.</td>
<td>derived from the project may feed into the programming of USAID.</td>
</tr>
<tr>
<td>KW (Implementing: EPOS Consultants)</td>
<td>Medium interest in the project. Interested in SINO project results.</td>
<td>So far not much overlap with SINO activities. KW projects quite stand alone vertical activities (TB and MCH). They are involved in training, but do not use PGMI or RCFM. Interested in sharing training material. Potential link to MEP for Hospital training.</td>
<td>Light impact of feeding evidence and information from experience and surveys performed by SINO.</td>
</tr>
<tr>
<td>GIZ</td>
<td>Medium interest in the project. Interested in the ANC part of Family Medicine done by SINO. Very vertically oriented with focus on MCH.</td>
<td>Could contribute on ANC standards for trainings (PGMI) and practice in Family medicine facilities. Have influence on MCH content in curriculum of university education (MEP).</td>
<td>Some evidence and experience derived from the project are given to GIZ. GIZ is mainly focussed on the MCH components though and is not looking further.</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>Hold responsibility for TSMU undergraduate curriculum and of nursing undergraduate education and quality of the courses</td>
<td>Since TSMU are moving forward, the MoE appear willing to support such initiatives.</td>
<td>Involvement in discussions and progress of curriculum reforms</td>
</tr>
</tbody>
</table>
ANNEX 4  Aid Coordination in Tajikistan

The government of Tajikistan has produced several guiding documents in order to achieve sustainable economic growth and reduce poverty and inequity. The *National Development Strategy 2008-15* sets the overall framework for this and related to it are the *Poverty Reduction Strategies* (PRS, current version 2010-12).

The *Joint Country Partnership Strategy*, signed in 2009, contains common principles of cooperation and adapts some of the internationally agreed aid effectiveness agenda to the Tajik context such as the coordination mechanism, ownership, harmonization, alignment and predictability.

In 2010 a *Development Forum* was held which was chaired by the Prime Minister. The purpose of the forum was to assess progress and discuss priorities as outlined in the Poverty Reduction Strategy. An *Action Plan* was approved with definitions of the main priority areas, a timeframe and the responsibilities of each line ministry.

In the health sector there are three objectives: 1. Adopt and start implementation of the National Health Strategy’s Action Plan, 2. Maintain increased state budget allocation for health (6.1%) with expansion and full implementation of Per-Capita financing and 3. Consolidate public health spending through “pooling” in at least one oblast, including through introduction of Per Capita financing of primary health care and case-based financing of hospital services. The Action Plan has led to sector implementation plans which are jointly reviewed by the government and development partners during the year.

The national structure of the aid coordination among donors is organized according to the clusters of the PRS, whereas the *Development Coordination Council* is the overarching entity. This Council is supposed not only to facilitate the information exchange and collaboration within the development partner community, but also to foster dialogue with the government. The Working Groups of the Sector and the Cluster are chaired by the government and the donors are represented.

*Figure 5: Development Coordination Council Organizational Chart (Aug 2011)*

(Source: untji.org)
Coordination within the health sector

The Action Plan 2010-13 translates the expected strategic goals of the Health Sector Strategic Plan 2010-20 into practice and builds the assessment framework. The progress achieved and the challenges to be overcome form the basis for the discussion in the Joint Annual Health Sector Review (JAHSR). This took place for the first time in 2011 and was perceived as a very positive step forward by all stakeholders. Beside the MoF, MoH, MoE and the related institutions, all bi- and multilateral donors of the sector have been present, including public-private stakeholders such as GFATM and GAVI. From the Civil Society side, there international NGOs have been present but no local civil society organisations, patient organizations or Trade Unions.

During the year, the Council Coordination Mechanism (CCM) builds the overarching political platform for exchange, discussion and monitoring. The members of the Council also participate in the Joint Annual Health Sector Review and the Council Working Groups should report on their results and challenges. Technical level exchange is organized along the four thematic pillars of the HSSP 2010-20: Governance, Service Delivery, Resources and Health Financing. Sub-working groups are being formed (e.g. the Action Plan for Family Medicine 2011-15), but not all are yet approved (eg. Human Resource Strategy 2011-15).

Both technical levels (Working and Sub-Working Groups) are not yet fully operational. The exception is the Health Financing Working Group which is co-chaired by USAID and where the members are formally appointed. In parallel with this new structure, there is the existence of former coordination groups, such as the Mother and Child Health Council, which is chaired by the Deputy Minister and UNICEF/GIZ.

The fragmentation of the health sector remains challenging and there is willingness from the donor side to move as fast as possible to a future structure such as shown in Figure 6 below:

Figure 5:
ANNEX 5  Detailed Responses to Evaluation Questionnaire

The following table is based on the questionnaire that was developed as part of the proposal from evaplan GmbH to undertake the External Review. Each of the issues was evaluated during the visit to Tajikistan, and findings related to each are given below. The questionnaire was important for guiding the external review team in their work, and it has been used to provide the background information that is the basis of the formal report.

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Specific Issues</th>
<th>MEP</th>
<th>SINO</th>
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<tr>
<td>SINO Key Questions</td>
<td>Overall: Is there increased access to better resources and managed PHC services?</td>
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<td>Patient data in supported rayons shows an increase in number of attendances per capita. However, data from other rayons were not available for comparison.</td>
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<td>Is the population more mobilized to play an active role in health promotion?</td>
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<td>PHC services</td>
<td>Access and quality: What are the evidences of better access and improved quality of PHC services (including referral patterns) in pilot districts?</td>
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<td></td>
<td>We used the definition of Access as: <em>Availability, acceptability, affordability, adequacy, accessibility</em></td>
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<td>Patient data in supported rayons shows an increase in number of attendances per capita. Access has changed in terms of availability and accessibility, as family doctors are able to diagnose (and eventually treat) diseases and patients (children, mothers), they could not assist before. For the population accessibility has improved in having geographically closer services. Community members interviewed during the evaluation stated trust in their family doctors. The continuous patient satisfaction survey conducted by STPH since a few years shows that patients assessed their experience with utilizing the family medicine services very positively. Acceptable distance from home to facility, acceptable waiting time, acceptable cleanliness and privacy during visits were reported. 99% of patients were very satisfied or satisfied with the care received by the family doctor and the family nurse. Over a span of six years similar positive results were reported. Increasing contacts with the family doctor (attendance rate) and increasing referrals were reported over the years reflecting the improved usage by and improved access for the population. It should be noted that many business plans contain specific targets for access. In the context of FSU countries this makes it likely that the numbers reported are done in a way to show success and avoid punishment or censure by the authorities. Therefore statistics like attendance rate from health centres may have a tendency to be overstated.</td>
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<td>In the clinics visited, we could not observe increased availability of medicines, vaccines or tests. Donated equipment (such as gynaecological chairs) may have a positive impact on availability, but overall maintenance and repairs, availability of tests and lab material, vaccines (e.g. rabies) was a big issue. The reasons for this are mainly lack of money in the system to support the system (once donors are not supporting it), but also management weaknesses throughout the system.</td>
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<td>Family doctors reported they could deal with more conditions than before (e.g. paediatrics, gynaecology) and could assist more patients or cases directly. But patients have still to travel to larger facilities for some routine tests e.g. Wasserman Reaction for syphilis testing in pregnancy, TB sputum tests.</td>
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<tr>
<td><strong>MoH involvement</strong></td>
<td>Is the MoH sufficiently involved to overcome obstacles in improving the access and quality of the PHC services in pilot districts?</td>
<td></td>
<td></td>
<td>We observed that lack of money within the health sector budget is one of the main reasons for the low support given to the health centres, e.g. Maintenance cannot be performed as there is no sufficient budget for it. MoH at all levels is involved, but not sufficiently to support the primary health centres. The other main reason for failure to support the clinics is the authoritarian managerial style which seeks to control and pressure staff for results instead of seeking understanding and providing support. Business plans have helped promote discussions and empowered the heads of the facilities slightly. Even so, the authoritarian managerial style remains embedded.</td>
</tr>
<tr>
<td><strong>Retraining of Drs/nurses</strong></td>
<td>Adequate action: Is the project adequate in responding to the re-training needs of doctors and nurses in project's pilot districts?</td>
<td></td>
<td></td>
<td>All doctors interviewed were very positive and grateful for the training and felt strengthened in their skills. Doctors repeatedly mentioned the lack of practical training possibilities, mainly at university level, but also during the 6-month course. Some mentioned the lack of possibility that short courses in CME topics would be helpful.</td>
</tr>
<tr>
<td><strong>Quality of teaching at Training Basis</strong></td>
<td>What can be said about the Clinical Training Basis, the quality of their teaching and the harmonization and sustainability of their operations within the broader health workforce development?</td>
<td></td>
<td></td>
<td>There are numerous training centres across the country supported by different donors. Some are more effective than others, and this difference is particularly noticeable between the PGMI based in the busy Policlinic 8 compared to the very tiny policlinic at the Republican Center for Family Medicine. The other site visited in Tursunzade appeared to be functioning well, with good integration with a large and busy policlinic. The Shahrinaw Nurse Training Centre allowed access to the hospital and policlinic, but it was not clear how much hands on practice the nurses received. Staff were adamant that they had good skills by the end of the course, including taking blood pressures and carrying out ECG tests. The longer-term sustainability will depend on the MoH support, but those training centres established at busy policlinics do allow the teaching staff to see their own patients, and this in turn can provide them with some additional financial support. Medical Education at University needs to be aligned with CME training modules, including those carried out with donor support. The quality of teaching is monitored by STPH, mainly with short-term experts. Teaching rooms visited were acceptable. Equipment was available. The instruments in the diagnostic bag for family doctors were received at the end of training, and it may be useful for these to be made available earlier during the course. The quality of some items was questionable especially the otoscope and ophthalmoscope. Nurses were not continuing to receive textbooks: these could ideally be provided to each PHC clinic, not to each individual nurse.</td>
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<tr>
<td><strong>Mentoring system</strong></td>
<td>Is the mentoring system of family doctors appropriate and sufficient to improve the quality of care?</td>
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<td></td>
<td>The mentoring system is not piloted yet.</td>
</tr>
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<td>Thematic Area</td>
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<tr>
<td><strong>Quality circles</strong></td>
<td>What is the sustainability of quality circles at family medicine level?</td>
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<td></td>
<td>Although very appreciated by the Family Doctors interviewed, peer-review groups no longer happen in some of the ex-pilot rayons, where SINO phased out and stopped paying transport allowance for the Family doctors. Only at the local PHC centre level quality some circles are carried out with the doctors or nurses of the centre only. No sustainability as MoH has not incorporated the Peer Review groups in their practice and does not pay transport allowance for the meetings. Matching the peer-reviews with the weekly head doctor meetings from the start might contribute to a potential solution, and will require time to be allocated for this by the PHC managers.</td>
</tr>
<tr>
<td><strong>CME especially peer review groups</strong></td>
<td>Effectiveness: How effectively are continuous medical education measures initiated and sustained by project Sino, especially the peer-review groups?</td>
<td></td>
<td></td>
<td>All peer-review group meetings visited and attended showed clear contribution to quality improvement of knowledge of Family doctors. All family doctors interviewed confirmed the usefulness of peer review groups and quality circles. CME: 6-month Family Medicine courses for family doctors and nurses have been established in a number of pilot rayons and these are functioning well with support of the SINO project to pay the costs of training the participants.</td>
</tr>
<tr>
<td><strong>Community groups</strong></td>
<td>Effectiveness of response: How effectively concerns of community groups have been taken up?</td>
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<td>The team visited one community group session and talked to several community group members. Themes for community group sessions were brought up by the community in discussion with their family doctors (e.g. Brucellosis after several cases of Brucellosis in the village, same for Hepatitis A in another group). Community interviewed was very content with their own community groups and felt empowered on health issues. One community group visited (20 women) could recount several success stories, where their increased knowledge helped in health issues (iodine in salt, referral of village members etc.). One woman was a teacher, who teaches school children on the health issues she has learned in the community groups. In another group they mentioned the change of practice and caution with animals to prevent brucellosis.</td>
</tr>
<tr>
<td><strong>Related to family medicine training</strong></td>
<td>Have these activities been related to family medicine strengthening?</td>
<td></td>
<td></td>
<td>The activities have been related to family medicine. The role of family doctors and nurses in the village was strengthened according to interviewed doctors and nurses and community groups.</td>
</tr>
<tr>
<td><strong>Empowering citizens</strong></td>
<td>Is the Sino’s approach to community participation adequate to empower effectively citizens, and in particular young women, so that they take more responsibility for their health and work in partnership with local health authorities?</td>
<td></td>
<td></td>
<td>The community group visited in Bastosh (Toursunzade) could mention examples, where their behavior has changed (iodine salt). Women stated they feel “empowered” in their knowledge in health and could act as multiplier on information. Contact to family doctors and family nurses has improved.</td>
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<td>Thematic Area</td>
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<td><strong>Sustainable:</strong> Is the SINO health community model sustainable?</td>
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<td><strong>Key for sustainability is the incorporation of activities into the system by MoH.</strong> As MoH sets the doctors targets on community contacts, the community groups provide an acceptable and effective alternative method to meet these goals. Therefore they may be sustainable. In the phased out rayons Dangara and Varzob, community groups were still active. They have met on a 3monthly basis since then.</td>
</tr>
<tr>
<td><strong>PHC infrastructure</strong></td>
<td><strong>Impact on maintenance:</strong> What is the project’s impact on changing maintenance practices of PHC infrastructures?</td>
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<td>We could not find evidence for changes in maintenance practices. There is very little budget for maintenance and repairs of equipment and facilities. However, the business plans now give the Family doctors an overview of the budget for their facilities and this has the potential to influence priority decisions within the (very low) maintenance budget. SINO supports to interact with the management of the Business Plans will be crucial to leverage this potential.</td>
</tr>
<tr>
<td><strong>Sustainable:</strong> Are the project’s mechanisms adequate to keep appropriate and sustainable maintenance practices at district and national levels?</td>
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<td>Apart from the transparency of maintenance budgets in the business plans mentioned, there was no sustainable impact to observe. In two health centres visited in Dangara and Varzob for instance, the generators were broken for a long period and in one the fridge for vaccines did not work. Much has to do with the government budget allocations for health, outside the scope of the current project to address.</td>
</tr>
<tr>
<td><strong>PHC planning/management</strong></td>
<td><strong>Evidence/beneficiaries of improvement:</strong> What are the evidences for and who benefit from better planning and management of PHC services at pilot rayon level?</td>
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<td>The family doctors/heads of health centres of phased out rayons still use the Business Plans and are preparing new ones for 2012. They felt confident with the plans and appreciate the transparency they have now on budget issues and numbers. They felt empowered at being able to have an input on their budgets and the priorities. Before this, they had no information on budgets for their health centres. As the MoH has incorporated the business plan concept in their activities, there is sustainability.</td>
</tr>
<tr>
<td><strong>Model tools for Mx/Financing:</strong></td>
<td><strong>Which interventions or tools of the project are models for this positive development and for enhanced accountability and transparency regarding health expenses?</strong></td>
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<td>Please see comments on business plans above and recommendations on business plans.</td>
</tr>
<tr>
<td><strong>Stakeholders</strong> (esp Rayon Mx Team)</td>
<td><strong>Involvement in business plans:</strong> What is the degree of implication of different stakeholder groups, in particular the rayon management team, in the development of evidence based business plans?</td>
<td></td>
<td></td>
<td>The family doctors/heads of facilities give input and fill out their own business plans. Data is aggregated at rayon level by the rayon PHC manager and is coordinated there. Details on priorities and numbers are discussed between PHC manager and heads of clinics.</td>
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<tr>
<td><strong>Sustainable:</strong> Is this commitment sufficient to ensure sustainability after project phase-out in a district?</td>
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<td>As the MoH has incorporated the business plan concept in their activities, there is sustainability. However, the team felt that the Business Plan content and details should be reviewed and revised. This is because: 1. Indicators include target amounts, and this can be detrimental to receiving truthful information 2. There appears to be too little detail on specific future actions that could be planned each year to address felt needs of Drs and their patients. 3. There is little understanding on the part of the PHC managers of the need to provide support for improving the quality of health care through management initiatives. SINO could focus on this, perhaps providing seed money or co-payments for certain innovations in management and logistics (e.g. taxi service for blood collection from various PHC clinics)</td>
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<td>Thematic Area</td>
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<tr>
<td>Future involvement</td>
<td>Which intervention strategy will be effective in a successive phase to strengthen the stakeholders so that they can better advocate for governmental funds to cover adequately the business plans?</td>
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<td>The PHC managers are using the business plans. The head of health sector reform of the MoH mentioned thoughts of using them countrywide. A successive phase of SINO could aim to work much more closely with the PHC managers to implement quality improvement aspects of the BPs, with some initial co-financing made available for this in order to be &quot;accepted at the managerial table&quot;. Involvement in this process may allow scrutinization of the budgets and support for both efficient use and lobbying by the managers for increased funding. Such lobbying will prove more effective, if the funds are seen to be utilized efficiently and transparently. An apparent complaint of the Ministry of Finance (MoF) is that funds are often returned by the MoH to the MoF at the end of each financial year. Good management of these funds through the understanding and use of the Business Plans will reduce this problem. One idea could be to support a junior MoF official to undertake a study with SINO to find out why the MoH is returning funds at the years end. This will help the MoF to see things from the perspective of the MoH, and ideas may be generated to help the MoH to improve their functioning. Limitations to the business plans include the setting of specific indicators as &quot;targets&quot;. This leads to manipulation of data to avoid punishment, and such numbers should be only held internally by the SINO project and interpreted as &quot;expectations&quot; or simple guidance (see also recommendations).</td>
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| Health financing reform (BBP or Co-payment) | Project inputs: What are the project’s inputs provided in health financing reform in general and in relation to the Basic Benefit Package (BBP) or co-payment program in particular? | | | SINO project is monitoring output at rayon level. They give important evidence to MoH or other donors on details of exemptions and additional income. It was stated by all other donors interviewed, that this function is very helpful. A patient satisfaction survey including a survey of informal payments was conducted by SINO over several years. It is still continuing. SINO produced the forms and books for guidelines for Basic Benefit Package (BBP) supporting MoH. On HC financing policy project SINO (and its project manager) is a contributing partner and is active part of the HC financing workgroup in MoH. Risk: Future changes to BBP and co-payments may indicate even more out-of-pocket payments. There is an inherent risk according to SINO management, that SINO might be associated with these changes. |

| Access for women and children | Are there evidences collected by the Sino project that BBP or co-payment have demonstrated effects on increasing women’s and children’s access to primary care services? | | | We used the definition of Access as: Availability, acceptability, affordability, adequacy, accessibility. The exemptions and co-payment system is not very transparent and far too complex (e.g. 4 ANC visits and a referral letter is necessary for exemption of pregnant women). One of the primary health care managers and hospital directors interviewed could not mention all the details, so how should patients know the system? We could not find evidence that co-payments have replaced or reduced informal payments. Services for pregnant women were officially free of charge before, as now, with exemptions regardless of informal payments. In the Patient satisfaction survey, 45% (2005), 62% (2008), and 50% (2011) of patients reported they have given money to the family doctors in the primary health care facilities. Determinants of these payments were the economic situation of patients (wealthier giving more) and the rayon (more spent in Shavrinaw and Tursunzade). The survey concluded that BBP had little effect as out-of-pocket informal payments are still happening in the pilot rayons although services are legally free of charge. |

<p>| Pregnant for free | Are pregnant women indeed getting free services now, or are they still doing informal payments as before? | | | As above: We could not find evidence co-payments have replaced or reduced informal payments. The patient satisfaction survey conducted by SINO concluded that BBP had no effect as out-of-pocket informal payments are still happening in the pilot rayons, although services are legally free of charge. In addition the out-of-pocket expenses for prescribed medicine have doubled over the span of six years with great disparities across rayons. However, it did appear that more women are requesting referral letters for the hospital visits, but there was some discussion that even so staff in facilities were finding reasons why additional payments for extra services were still required. (e.g. Caesarean Section, certain procedures etc) |</p>
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<tr>
<td>Health Sector Strategy</td>
<td>Project contribution: What is the project’s contribution to the development of the Tajik health sector strategy and its current implementation?</td>
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<td>Several sources (in MoH and other donors) stated the strong and active support to the health sector strategy by Project SINO and particular by its project manager. Several policy briefs and written inputs on the health sector strategy were distributed. There is a clear issue for the project, that a new Project Manager will need time to give the same level of input to the health sector strategy as the current one. SINO focuses on the implementation of Family Medicine according the Health Sector Strategy. The whole program is very well aligned with the Health Sector Strategy and has a clear focus. However, there are many variables in the development of the strategy, many of these out of the control of the SINO project, such as the possible future increase in prices for treatment and increase in the number of categories who will have to pay fees for service.</td>
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<td></td>
<td>Influence on policies/ decision/ documents: Have successful experiences emerging from project Sino adequately been translated and fed into the policy- and decision-making process as well as in strategic documents?</td>
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<td></td>
<td>Family Medicine and CME is well integrated in the health sector strategy. Community group involvement is integrated. Business plans are adopted in the phased out in the rayons. Community groups are still kept as well although not as clearly adopted by MoH. SINO provides almost the only evidence on BBP and co-payments, which is feeding into policies and strategies.</td>
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<tr>
<td>Communication and coordination activities for health reforms &amp; FM</td>
<td>Communication local, regional and national: Are project Sino communication strategy and tools effective enough on local, regional and national audience so that project’s experiences and achievements are capitalized within the broader context of health reform in Tajikistan and bring positive changes?</td>
<td></td>
<td></td>
<td>Project’s experiences and achievements are fed into policy discussion in meetings with MoH, MOH work groups, at donor meetings and via policy briefs. Short policy briefs have been recommended in the Mid-Term Review, and these are being considered.</td>
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<td></td>
<td>Coordination with MoH: Has Sino adequately and effectively coordinated its activities with the Ministry of Health in the area of family medicine development and health reform?</td>
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<td>On the basis of many interviews with various stakeholders, SINO is at the table in meetings, active in MoH working groups and has had an impact on Family Medicine issues. This was also confirmed by all MoH authorities interviewed, who explicitly appreciated the input from SINO.</td>
</tr>
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<td></td>
<td>Coordination with donors and other projects: Has Sino adequately and effectively coordinated its activities with other donors and projects in the area of family medicine development and health reform?</td>
<td></td>
<td></td>
<td>SINO is present and active at donor meetings and in the only active working group on Health Financing at MoH. We interviewed the most significant donors (USAID, EC, WHO, KfW) and other actors and all confirmed the positive and strong input from project SINO. The more the individual donors were also present at meetings and involved in the work group, the stronger was their positive feedback on SINO.</td>
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<tr>
<td>Thematic Area</td>
<td>Specific Issues</td>
<td>MEP</td>
<td>SINO</td>
<td>Answers</td>
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<tr>
<td>Future Intervention strategy</td>
<td>Roll out nationally: What is possible future intervention strategy for the project to address/influence positively the challenges related to sustaining and to rolling out the project achievements nationally?</td>
<td></td>
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<td>Roll out to considerably more rayons should be considered, even with likely loss of some quality. Possible obstacles are the capacity of training facilities, finds for renovation and equipment, the availability of sufficient numbers of trainers and SINO staff. It is recommended that consideration be given to identifying local champions who are then sponsored to introduce their ideas and stories to support and encourage new rayons to adopt new practices. Study tours of new rayon staff to experienced rayons should also be an option.</td>
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<td></td>
<td>Integration with govt structures: Is it necessary to change the implementation approach considering a closer integration of Sino into governmental structures?</td>
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<td></td>
<td>We recommend not moving parts of SINO physically into the MOH. A WHO expert who works in MOH reported a lot of political pressure on him and being limited by political issues due to the integration in MoH. He stated he could have more impact while being outside of MoH. However, consideration could be given to involving SINO staff in the Public Health Management Department of the TSMU as further work on Business Plans is undertaken. Closer work with the Healthy Lifestyles Department on Community Group work would also be advisable. Either of these could be for an expert to spend 1-2 days per week at those sites.</td>
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</table>
|                                          | Future strategy: What could be SINO role in the future regarding health sector strategy implementation? |     |      | Currently, SINO has a clear role to play in the development of health care. This should remain the case, with a focus on the strong points of the program and an emphasis on deepening and spreading these initiatives.  
1. There should be further roll out of the model of Family Medicine to more regions with as little loss of quality as possible, and with development of new Family Doctor training centres if necessary  
2. Increased institutional involvement e.g. of the Healthy Lifestyle Centres in the development of the Community Group work, the Public Health management Department of the TSMU for work o the BPs, laboratory training initiatives etc  
3. There could be more feedback from project activities into the processes of management to maximize impact and enhance the quality of care and patient satisfaction, to bring new teaching knowledge and skills from the CME short courses (incl. those carried out with donor support) into the medical education curriculums at undergraduate and graduate levels.  
**SINO should continue to concentrate on integrating medical education and CME with a particular emphasis on Family Medicine**. At PHC level keep the supporting level with rehabilitation, equipment, business plans, peer review groups and community health groups.  
In the highly complicated and politically sensitive world of Health Care Financing, staying within the frame of supporting the evidence on PHC level from the supported facilities at the rayon levels would seem to be appropriate and sufficient to continue to inform the public debate without jeopardizing the trust that has been built up by the project to-date. |
| MEP Key Questions                        | Overall: Is the MEP relevant to population needs, esp in context of urgent need for better service delivery and community health? |     |      | It is clear from discussions with the PGMI and RCFM teachers and participants that the medical doctors they are training as FDs lack very basic clinical skills, which often have to be re-taught during the course. Such a lack of basic skills reduces the effectiveness of the 6-month training program and hinders the development of the finer skills of family practitioners. The MEP is only just reaching the vital stage at which the clear development of the undergraduate course is only just commencing. Without further MEP support, the TSMU course will not produce the quality of medical graduates able to handle family medicine duties, even though in name it may be stated that this is their new qualification.  
While it is clear that Russian teaching allows the graduates to find work in the Russian Federation and therefore leave the Tajik situation, this also has certain advantages. Firstly, the graduates are able to do specialized courses in Russia, and may later bring these new skills back with them when they return. Other options for such postgraduate training are currently limited in Tajikistan. Plenty of good and up to date literature is available in the Russian language, and this could be used to enhance the quality of the course. |
<p>|                                          | Effect on Human Resources of Russian teaching                                    |     |      |                                                                                                                                                                                                                                                                                                                                                                                                  |</p>
<table>
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<th>Thematic Area</th>
<th>Specific Issues</th>
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<th>SINO</th>
<th>Answers</th>
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<tr>
<td><strong>State Standard for Education</strong></td>
<td>Influence on Legislation base: Is the MEP project effective in contributing to develop a legislation base that will allow introducing changes into the State Standard for undergraduate medical education, so that medical education is better aligned with the country health priorities (primary health care and family medicine)?</td>
<td></td>
<td></td>
<td>4 legislative documents have been amended and form the basis of a new draft law that is now awaiting comments from the steering committee. 3 stages of medical education have been identified with clarification of the role of internatura and ordinatura stages and the number of hours to be allocated. Of importance is the provision for a clinical practice year encompassing the 6th year of undergraduate studies, which is considered to be the basis for development of the generalist doctors capable of delivering the basics of family medical care.</td>
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<tr>
<td>Participation of SC staff: How to interpret the low level of participation in project implementation among some members of the SC that was observed?</td>
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<td></td>
<td>Of the seven members of the steering committee, only 2 have been passive. These are the members from the PGMI, who it appears were junior staff and were not given a strong mandate from the head of that organization. Political relationships are the likely cause of this lack of engagement, beyond the scope of the project to address. All others (MoH, MoE, Director of Nurse Training, Deputy Rector TSMU, MEP Political and Legal Advisers) took a participative role, with the MoE member responding verbally.</td>
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<td>Coordination of stakeholders: Has MEP appropriately coordinated the inputs from all stakeholders including relevant ministries from the beginning of the project while defining their respective roles?</td>
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<td>There have been a number of meetings of the steering group, and this has resulted in significant progress on the legislative and curriculum fronts. However, some stakeholders have not been involved, and these could have included representatives of the student body, family doctors and family doctor trainers.</td>
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<td>Stakeholder commitment: Is there a need to adapt MEP approach in order to increase the commitment of the main stakeholders?</td>
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<td>A signed agreement was made with the MoH to affect the steering committee and this was a great support to carry out the meetings. It is possible more SC meetings could have been held, but it was not always easy to gather everyone together. A regular update newsletter might have helped this, with visits from MEP staff to the SC members on an individual basis to discuss important issues and developments.</td>
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<tr>
<td>Law on Med Education: How to address the challenges ahead in the implementation of the law on Medical Education in Tajikistan?</td>
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<td>The law is still only undergoing review, and it is envisaged that significant support will be needed from the MEP to support the planning and management of the clinical practice year, and in the further development of the curriculum and promotion of adult learning practices among the teaching staff.</td>
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<tr>
<td>Thematic Area</td>
<td>Specific Issues</td>
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<td>SINO</td>
<td>Answers</td>
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<tr>
<td>TSMU curriculum</td>
<td><strong>Int'l standards:</strong> Has MEP properly ensured that the development of the new curriculum is in line with international accreditation systems standards (whether Bologna or WFME)?</td>
<td></td>
<td></td>
<td>With the delay in the development of the curriculum there has been little opportunity to focus deeply on the accreditation standards. However, the members of the working group responsible for the development of the curriculum are aware of the requirements of the WFME and are apparently incorporating those that are relevant not the next draft of the curriculum. In addition, a consultancy was carried out by Farida Noranbetova in October 2011. The WFME process is defined in the draft law in review, and an Accreditation Committee will soon be formed. The MEP political Adviser has the responsibility to ensure that the curriculum topics will include WFME standards and he may in future lay an active role on the MoH curriculum committee</td>
</tr>
<tr>
<td>Working group incentives</td>
<td><strong>Is the performance based incentive system for members of the working group appropriate and effective in developing the new curriculum?</strong></td>
<td></td>
<td></td>
<td>The members of the working group are being paid an amount equivalent to their monthly salary for the extra work involved in developing the new curriculum. This is very helpful and appreciated, but it was clearly stated that even without such support, the group would be working on the task. While this funding was linked initially to performance of certain targets, this has not become uncoupled due to the many constraints to achievement encountered during the process (e.g. shift of deadline from Apr 2011 to Feb 2012 due to changes to Russian Federation curriculum requirements and Tajik Ministry of Education requirements). While it could be argued that this payment is therefore irrelevant, it can also be argued that this work is indeed in addition to the normal duties of all the staff involved, and such remuneration is only fair, and that it contributes to but does not dominate the good working relationship with the TSMU. Future payments could be of lesser amount, and also should not be tied too closely to achievement of certain results. Quality of product is of more importance.</td>
</tr>
<tr>
<td>Challenges of implementing curriculum</td>
<td><strong>After almost 2 years of project implementation, what are the potential challenges in implementing this new curriculum, more particularly related to the reluctance of chairs and teachers in changing their regular working habits and teaching methods? What are the possible coping mechanisms to overcome these challenges?</strong></td>
<td></td>
<td></td>
<td>The curriculum is still a long way from finalization, so this question is really premature. However, a couple of comments: 1. While the decision has been taken for the curriculum committee to work on developing the curriculum before it is reviewed, this may lead to the problem that much rework may be needed after the review. In future it may be preferable that the MEP pays more attention to working with the Curriculum Committee to advise on the content of the curriculum stage by stage, pressing for interaction and offering support. While this may be reluctantly accepted, if done in a non-critical and supportive manner it may lead to faster and better coordinated results, rather than relying on final review of work done when much effort may have gone in the wrong direction and require substantial rework. 2. The impact of the study tours and teaching sessions carried out through the MEP has been of high significance, and appears to have kindled enthusiastic interest among the faculty to improve their teaching techniques and skills. Further such work, if anything more frequently, is highly advisable (so far only 30 have been trained out of 700). Also, interaction with the PGMI and RCFM is also advised, since a number of good (clinical) teaching approaches are employed at these sites. Older teachers are more resistant to change, so the focus is more on the younger faculty, which seems appropriate, but this should be done in a way that allows the older faculty members to be included in introductory sessions that alert them and inform them about the latest techniques in order that they do not oppose that which they do not know.</td>
</tr>
<tr>
<td>Admission and assessment procedures</td>
<td><strong>Is the project approach effective in addressing taboo issues like the admission and assessment processes of students?</strong></td>
<td></td>
<td></td>
<td>This has not been possible to assess in depth. It appears Farida Noranbetova did look at this in a recent visit, and she has pointed out that there is agreement that the procedures are generally transparent, many people are involved in the selection process, and there is an appeal process by which test results can be reviewed. Rumor has it that prices paid to enter the University are very high, and this reflects the danger and difficulty of bypassing the existing official mechanisms: i.e. this is a positive indicator of a fair admissions process. There are increasing numbers of private foreign students entering the University officially, and this is helping significantly to fund the courses.</td>
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<tr>
<td>Thematic Area</td>
<td>Specific Issues</td>
<td>MEP</td>
<td>SINO</td>
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<td>Future options:</td>
<td>What are the potential options in the future to overcome the actual barriers and to strengthening good governance in this field?</td>
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<td></td>
<td>In view of the above, little needs to be done, which is an advantage for the project since involvement in such sensitive areas could be very detrimental to the relationships built up so far. Involvement through support of the review processes and admissions tests could be of some benefit in engaging with this process.</td>
</tr>
<tr>
<td>Large no of undergraduates?</td>
<td>Is the too great number of students an obstacle on the way to increase the country’s capacity to produce graduates with broad range of skills and knowledge required by all physicians? Is it necessary to tackle this critical issue in a successive phase of the MEP?</td>
<td></td>
<td></td>
<td>The number of students is not too many, if the needs of the country are taken into account. 550 graduated last year, in order to provide health care for a population of nearly 7 million. By international standards this is low. The problem is more at the other end: the capacity of the TSMU to cope in terms of organization, teaching skills, materials and equipment availability, and it is with this aspect that the MEP is dealing, correctly so.</td>
</tr>
<tr>
<td>Effectiveness of MEP work:</td>
<td>What are the project’s results in strengthening the teaching capacities of the TSMU staff?</td>
<td></td>
<td></td>
<td>The most important result so far is the establishment of a good rapport with the teachers, and this is reflected in the extra demand by the teachers to participate in the clinical skills teaching courses carried out by the Canadian faculty in March, and by the local trained staff in October 2011. It will be important to build on this work in the future, and this has to be combined with the new curriculum in which teaching techniques are clearly defined. Supportive supervision will be required, perhaps with a regular workshop for the teachers in which different techniques are showcased and discussed.</td>
</tr>
<tr>
<td>Monitor quality:</td>
<td>Is there a mechanism in place to monitor the teaching quality after providing trainings?</td>
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<td></td>
<td>At present no such mechanisms is in place. However, with the development of the curriculum, a number of monitoring options could be considered. Before and after training session tests (knowledge and skills) could be held to demonstrate the short-term results of the training workshops. Over the longer term, development of student satisfaction surveys linked to a database that could help identify exceptional performers, information which could be used to encourage those who are best to support with ideas those who are less good.</td>
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<tr>
<td>Gender sensitive approach:</td>
<td>What was project’s contribution in applying a gender sensitive approach in medical education teaching methods, in fostering a gender perspective in the relationship between a doctor and his/her patient? How to improve this effort in the future?</td>
<td></td>
<td></td>
<td>Numbers of male and female students are roughly equal in each year. Effect of impact of clinical skills training by Canadian University to instil an attitude that promotes a fair gender perspective is not yet evident due to the early phase of the project.</td>
</tr>
<tr>
<td>Results of clinical training:</td>
<td>What are the MEP results related to clinical skills training approaches?</td>
<td></td>
<td></td>
<td>So far this is unknown. Those 30 staff, who undertook the training were keen to implement their new knowledge and skills, but no mechanism is in place to observe any changes. A survey of the teachers could be developed, but there was insufficient time during the review period to carry this out. Development and implementation of the new curriculum should be the catalyst that enables the teachers to really put into practice what they have learned, and this will need to be combined with good planning for the classes and class sizes relative to the teachers.</td>
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</table>
Evaluation report SINO and MEP projects Tajikistan

Thematic Area | Specific Issues                                                                 | MEP | SINO | Answers                                                                                                                                                                                                 |
---------------|---------------------------------------------------------------------------------|-----|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
**Barriers & future** | What are the potential barriers in further implementation them and what intervention strategy need to be developing to address these challenges? |     |      | Barriers include:                                                                                                                                                                                       |
                                           | 1. Lack of day-to-day support for the teachers and weekly training sessions/workshops (strategy: full time expert in-country); |     |      | 1. Lack of day-to-day support for the teachers and weekly training sessions/workshops (strategy: full time expert in-country);                                                                      |
                                           | 2. Lack of a system of monitoring of the teachers in their lessons (strategy: student satisfaction forms); |     |      | 2. Lack of a system of monitoring of the teachers in their lessons (strategy: student satisfaction forms);                                                                                             |
                                           | 3. Lack of updated and detailed curriculum (strategy: full time expert in-country, possibly a Family Doctor trainer with sufficient teaching skills and competency to provide ongoing support to the curriculum development staff). |     |      | 3. Lack of updated and detailed curriculum (strategy: full time expert in-country, possibly a Family Doctor trainer with sufficient teaching skills and competency to provide ongoing support to the curriculum development staff). |

**Chosen Definition of Access:**
Access is an important concept in health policy and health services research, yet it is one which has not been defined or employed precisely. To some authors "access" refers to entry into or use of the health care system, while to others it characterizes factors influencing entry or use. The purpose of this article is to propose a taxonomic definition of "access." Access is presented here as a general concept that summarizes a set of more specific dimensions describing the fit between the patient and the health care system. The specific dimensions are **availability, accessibility, accommodation, affordability and acceptability**.

ANNEX 6 Outline of Steps to Enhance Internatura for Family Medicine

The Table below gives an outline of the steps that might be necessary in order to strengthen the format and management of the Internatura Graduate Year for Family Medicine candidates. SINO/MEP staff would coordinate and manage this process, working closely with Family Medicine teachers perhaps on a temporary contract basis.

It is envisaged that this work would run alongside other SINO/MEP activities.

<table>
<thead>
<tr>
<th>Action</th>
<th>Involved personnel</th>
<th>Method</th>
<th>Timeframe: person/weeks over first year</th>
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<tbody>
<tr>
<td>Establish a Working Group</td>
<td>RCFM, the TSMU, the PGMI, MoH</td>
<td>Meetings with relevant leaders</td>
<td>1 person/week intermittent meetings</td>
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<tr>
<td>Develop a survey of needs and expectations for enhanced Internatura</td>
<td>SINO, MEP staff, FM Teachers</td>
<td>Deskwork and discussions</td>
<td>2 person/weeks</td>
</tr>
<tr>
<td>Carry out survey and collate results</td>
<td>Graduates, Family Doctors and FM Teachers, RCFM, PGMI, MoH</td>
<td>Site visits, interviews</td>
<td>6 person/weeks</td>
</tr>
<tr>
<td>Based on survey findings, develop suitable objectives, protocols, and learning expectations for Internatura year</td>
<td>SINO, MEP staff, FM Teachers of RCFM, PGMI</td>
<td>Deskwork and discussions</td>
<td>12 person/weeks</td>
</tr>
<tr>
<td>Agree roles and responsibilities</td>
<td>RCFM, the TSMU, the PGMI, MoH</td>
<td>Meetings with relevant leaders</td>
<td>1 person/week intermittent meetings</td>
</tr>
<tr>
<td>Begin implementation</td>
<td>RCFM, the TSMU, the PGMI, MoH</td>
<td>Printing &amp; dissemination of guidelines, conference to inform relevant stakeholders, organise workshops as necessary</td>
<td>4 person/weeks intermittent work</td>
</tr>
<tr>
<td>Ongoing follow-up/supervision and monitoring</td>
<td>RCFM, the TSMU, the PGMI, MoH</td>
<td>Site visits, annual survey of Internatura candidates and mentors</td>
<td>2 person/weeks intermittent work</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>28 person/weeks</strong></td>
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ANNEX 7  Terms of Reference

Contract no. 81013520 (Mandate type B)

External Reviews of the Tajik - Swiss Health Care Reform and Family Medicine Support Project (SINO) and of the undergraduate Medical Education Reform Project (MEP) in Tajikistan

1. General context in Tajikistan and context patterns related to the health care sector

 Shortly after the collapse of the Soviet Union, a fierce civil war broke out in Tajikistan which lasted until 1997. Much of today’s political situation originated during this time including an authoritarian presidency relying on and supported by clans as well as an endemic corruption system and a lack of rule of law and respect for human rights. Infrastructure (health facilities, water, communication, etc.) has mostly collapsed due to civil war and funds for proper maintenance are lacking; public services - where still existing - are of appalling standard. Access to resources is limited; the economy is marked by monopolistic structures.

Since its independence, Tajikistan has seen a dramatic decline in living standards till around 2000. Indicators have improved since but are still below their 1990-level. Poverty has declined slightly in the last few years with 47.2% of the population living in poverty in 2009 (WB); the percentage living in extreme poverty however has remained at 17.5%. The polio outbreak in summer 2010 is a stark reminder of the difficulties in the service delivery system. Food security is also jeopardized, with 28% of households being food insecure (WFP). As a consequence, malnutrition is rising. As regards the MDGs, the picture is mixed with some progresses though the goals are unlikely to be reached. The last 20 years have further seen a massive brain drain. Moreover, around 1-1.5 million Tajik people work as labour migrants abroad, their remittances (estimated by ADB to contribute around 40% of GDP in 2010) being the major reason for the decline in poverty. Since its independence, a process of de-secularization has been taking place in Tajikistan resulting in an increased return to traditional values and gender roles, in particular in rural areas. Limited investment is made in girls and women who are first in line to suffer the deterioration of social and other public services.

In general, the country is marked by the following elements of fragility: concentration of power in the hands of a narrow group of top-level politicians, increasing influence of the global economy, weak institutions and an "accountability gap" between the State and its people, and rise of radical movements and Islamic organisations.

Tajikistan’s health system has evolved from the Soviet model of health care, an expensive specialized, curative and hospital-based system, with so far few structural changes. The state allocation for health care in Tajikistan amounts to 1.6% of GDP or US$6 per capita, the 2nd lowest worldwide. Management of these limited resources is inefficient and professional training is outdated, resulting in health services too often of low quality and provided unequally between regions. The overwhelming
majority (70%) of health care funds comes from private, out-of-pocket payments, making health care services less and less accessible for the poorest.

Following the Health Care Reform Concept of 2002, the Government of Tajikistan (GoT) has been attempting to strengthen Primary Health Care (PHC) system and to introduce quality family medicine services for more than a decade, as a means to make health care services more accessible, affordable, effective and efficient\(^4\). Family medicine, introduction of adequate financing, monitoring and management mechanisms, further development of the health workforce and involvement of communities to take responsibility for their health as main issues for reforming primary health care in Tajikistan are clearly outlined in the comprehensive *National Health Strategy of the Republic of Tajikistan, 2010-2020*. This key reform document has been elaborated through a broad stakeholder consultation process in 2009 and 2010\(^5\) and endorsed by Presidential decree in July 2010.

The family medicine practitioners are currently prepared by internationally supported projects through the retraining of specialists at postgraduate level. The training capacity of this post-graduate approach is very low as it covers only around 70 doctors per year while the need for general practitioners in the country amounts at 5'300\(^6\) (today 2.700 (50%) family doctors were prepared). Without a strong involvement of the Tajik State Medical University (TSMU) at under graduate level, it would still take decades to roll out the primary health care system and up-keep family medicine services and their related needed staff nation-wide. In 2007, the Ministry of Health (MoH) and the management of TSMU developed a **Concept to reform medical education** in order to provide a legal frame for adapting the teaching program to the new health system requirements. This Concept has been approved in October 2008 by Decree (#512) by the Government.

Regarding the **national stakeholders**, the MoH directly manages most health facilities at the national level and is responsible for national health policy, but has no control over the overall health budget. Local authorities at district level are responsible for most social services, including health and education. The oblast health departments (GBAO, Khatlon and Sogd) are responsible for health care provision of oblast-owned health care facilities and for the activities of city and rayon health facilities within the respective oblasts, together with the executive local authorities (khukumats) of cities and rayons. The TSMU being the only University institution in Tajikistan entitled to prepare and train medical doctors at under graduate level (appr.600 diploma/year) is a key actor in the roll-out of the family medicine and its related training schemes in Tajikistan. Professional associations have no major role in health policy making; physicians influence national health policy on an informal basis. Although growing, the number of private health care providers is still low.

\(^4\) Health houses are the first point of contact in rural areas. They are affiliated to rural health centres, the second level of the PHC. Rural health centres (formerly rural physician clinics or rural hospitals) are staffed by physicians, in addition to nurses and junior health staff. In urban areas, the policlinic remains the first point of contact.

\(^5\) The elaboration of the strategy was organized along 4 working groups based on the WHO health systems performance framework and coordinated by a secretariat within the MoH financed by the European Commission, and other development partners including SDC.

\(^6\) According to the currently approved standard that 1 family doctor serves for 1 350 people (as stated by the Republican Family Medicine Centre of the MoH at the Health Summit on “Family Medicine in Republic of Tajikistan” held on May 13. 2009)
2. History and latest developments of SDC portfolio in the health care sector

The Health Care Reform is recognized to be a long-term challenge related to social development. Therefore, the Swiss Agency for Development and Cooperation (SDC) has been supporting the health sector in Tajikistan since 1999. In the current Cooperation Strategy for the Central Asia Region (2007-2011) and in the next cooperation strategy (2012-2015), Health Care Reform is and will remain a priority domain of intervention of the cooperation programme in Tajikistan.

SDC focuses its efforts on the support to health sector reforms in Tajikistan in order to improve access to and quality of health services delivered at the primary level. In line with the national strategy and with the other donors active in the sector, SDC is making recognized inputs in selected pilot districts to the development of models of family medicine, including health financing mechanisms, training of medical staff and involvement of the communities for promoting healthy lifestyles.

As of today, within its health portfolio, SDC supports the "Swiss - Tajik Health Care Reform and Family Medicine Support Project" (known as “Sino” Project), which is presently in its 3rd phase (2009 - 2012), as well as finances the AKHS implemented Community Based Family Medicine Project in GBAO and three districts in Khatlon (phase 1). From 2006 to 2010, SDC co-funded the World Bank led Community Basic Health Project, with a focus on the Family Medicine Training component. In 2010, Switzerland launched the Medical Education Reform Project (MEP), which introduces new curricula at the TSMU to align the Tajik medical undergraduate studies to the ongoing health reforms. Furthermore, in 2007-2008 Switzerland provided a total of 13’140 books and equipment worth CHF 496’000 to the TSMU, thereby addressing the issue of availability of reliable, state-of-the-art medical literature for future practitioners. On a policy dialogue level, Switzerland has been a major donor in financing the development of the Comprehensive Health Strategy. SDC and the implementing partners are currently participating in the Health Coordination Council and its working groups, the newly established platform for policy dialogue in the sector.

Both, Sino and MEP projects are being implemented by the Swiss Centre for International Health (SCIH) of the Swiss Tropical and Public Health Institute (Swiss TPH).

The overall goal of the Sino Project is to improve the health status and access to health services for the population of Tajikistan, especially for poor groups. The main objective of the project is to further test, develop and support the implementation of accessible and sustainable Primary Health Care (PHC) models and family medicine services.

The expected outcomes of project Sino are:

1. Access to good quality Primary Health Care (PHC) services is improved through testing models for family medicine provision that are then available for roll-out.
2. The design, planning and management of Primary Care Services at Pilot Rayon level is improved, and a mechanism exists for monitoring the sustainability of PHC services and rolling-out tested models to other Rayons.
3. The capitalization by MoH and Donors of the experience gained in the Pilot districts is supported and the integration of these experiences into strategic documents is promoted thereby close coordination with the ongoing design of the Health Sector Strategy is assured.

7 The Project’s first phase was in 2003- 2006
Activities concentrate on four pilot rayons: Dangara; Varzob; Shahrinaw and Toursunzade, thereby the project has operated a gradual withdrawal in Dangara and Varzob and has initiated activities in Vose and Khamadoni during phase 3.

The midterm review of Sino Project carried out in the beginning of 2011 emphasises on two main project’s achievements:

- High recognition of the value of experiences emerging within project Sino pilot rayons and their transfer to other regions/project in Tajikistan.
- The collaboration with Government departments and other development partners continues to be sound. This indicates the substantial efforts made by project staff.

According to the Sino Project’s retrospective investigation, only 12% of the trained family medicine specialists have left their workplaces since 2005 in the project’s areas. Low state financing of the health care sector significantly impedes the process of scaling up the project achievements nationally.

The midterm review came to the conclusion that phase 3 was overall well in track. Some recommendations were issued to provide a solid background for the Sino project:

- Create a better harmonized approach towards the location and number of "clinical training basis" across Tajikistan;
- Strengthen links between Family Medicine and community activities so to underline the credibility of family medicine services;
- Further strengthen the mentoring activities of the project Sino office of rayons and rural health centres (RHC), for example through routine analysis and monitoring of the business plan execution;
- Strengthen the use of Business Plans as a management tool at rayon level as well as to explore further ways to improve the quality of the monitoring and use of information (e.g. maps available through the geographical information system);
- Support SDC and the other stakeholders engaged in primary care development in Tajikistan in a more proactive role and formal coordinated assembly of the "family medicine steering group";
- Explore options for the project Sino office to get physically closer to MoH;
- [...]

The overall goal of the MEP project is to reform medical education of doctors in Tajikistan and to align and harmonize the reforms with broader health reforms and family medicine strengthening.

The expected outcomes of MEP are:

1. The State Standard for undergraduate medical education is adapted
2. A new curriculum for the medical faculty of TSMU is developed and approved taking into account gender sensitive health needs and good governance principles when applicable
3. Admission and assessment processes of students are reviewed and adapted considering gender sensitiveness and good governance
4. Teaching capacities of the staff of the medical faculty are strengthened
5. The material basis of the teaching/learning process is improved
6. Different approaches to the clinical skills training using clinical training bases for TSMU taking into account gender sensitive training needs are outlined and piloted
Activities materialise and focus on the TSMU in Dushanbe. Some lessons learnt were highlighted in the last operational report (August 2011):

- Some of the faculty members do not agree with the changes proposed to be introduced to the new curriculum. Faculty members showed their disagreement mainly because of lack of involvement in the process of curriculum development or because of their lack of knowledge about weaknesses of the old curriculum and strengths of a new one. The lesson learnt is that there should be a stronger participatory approach and communication shall be improved between the working group of TSMU and the faculty members.

- The baseline assessment mentioned that some students perceive admission examination as unfair and inequitable although the WG has a quite different opinion. The procedure can in fact be said to be fair and equitable. However, theory and practice can be quite different. To that extend, to avoid any disagreement regarding fairness of the admission procedure, it would be better if an independent commission reviews the procedure, identify potential weaknesses while providing recommendations if necessary.

- Good cooperation and coordination is generally observed between the key project’s partners, including TSMU, MoH, MoE, etc... represented in the Steering Committee (SC) of the WG. However, it should be mentioned that the project is behind schedule for some of the activities and expected results. It seems that the members of the WG, who are also employees of TSMU, are very much overloaded by their duties at TSMU and do not have enough time to actively participate in the project implementation. Moreover, among some members of the SC, passive participation in project implementation was observed.

3. Purpose and overall objectives of the review mandate

The third phase of the SINO will end in June 2012 and the first phase of the MEP will be concluded by April 2012. It was foreseen for both projects to undergo an external review.

Two external reviews, one for each project, will be conducted simultaneously. This choice is motivated by efficiency reasons, by the fact that the two projects are distinct, but share a medical education component and by giving the opportunity to the evaluation teams to get a broader understanding on SDC portfolio in the health sector beyond the project to be evaluated.

This review occurs in an important strategic moment for the Swiss interventions in Central Asia. The actual Cooperation Strategy (2007-2011) comes to an end and a new Swiss Cooperation Strategy for Central Asia (2012-2015) is currently under elaboration. The regional part of the new cooperation strategy will further focus on water management and Kirghizstan and Tajikistan will remain the two priority countries for the Swiss cooperation, with context adapted programmes and domains of intervention. Health care is an essential survival good for the population, especially for the poorest segments, and strong basic services are extremely important in a fragile context to prevent political unrest and instability. This explains why health will remain a priority in the Tajik programme with the Rule of Law/Access to justice, private sector development and water supply & sanitation sectors. Some important changes in the approach are foreseen in Tajikistan by integrating ways to address fragility in a context of very weak governance. The Swiss cooperation will also contribute to improve the structural stability of the country by promoting partnerships between the Tajik government and the civil society for changes of legislation and reforms implementation; special endeavours will be directed towards reinforcement of the nascent civil society so that it can become a credible interlocutor of the government, be it at national or at local level.
A strategic orientation (results framework) has been drafted for the health care sector and is given in the review documentation. The programme will focus on the provision of Primary Health Care (PHC) services and community health, at local level in 2 oblasts (GBAO and Khatlon). Accordingly, the domain goal is: **Men and women enjoy better health thanks to improved primary care services and health promotion.** The current family medicine models will be extended from 11 to 22 districts, benefiting a total of approx. 1 mio people. These Swiss interventions are expected to lead to an increased access to quality Family Medicine (FM) based PHC services for the rural population; these services are better resourced and managed in an efficient and transparent way at rayon level to increase their sustainability. As a third outcome, the population is mobilized and plays an active role in health promotion.

The **main objectives** that should guide the external review are:

- **To assess if the two projects were effective** (and in some extend cost-effective) in terms of achieving the set objectives, thereby emphasizing results achieved by the two projects (outcome mapping) and pointing out possible shortfalls;
- **To assess the relevance** of the two projects in terms of needs and identified priorities in the health sector in Tajikistan, as well as with regard to SDC planned strategic framework in the health sector within its new cooperation strategy;
- **To assess if the Sino project is sustainable**, especially in those areas where Sino support has come to an end over phase 3 (Varzob and Dangara),
- **Establish recommendations** for possible upcoming projects phases, in particular with regard to:
  - Coherence with and relevant contribution of the projects (outcomes, approaches and lines of intervention) to SDC strategic orientation in the health sector (from 2012 onward) as well as to the Tajik national health strategy 2011-2020 and investments of other actors in the health sector in Tajikistan; give feedback on the results framework of the new country strategy in the light of the findings and recommendations.
  - Synergies and complementarities across the two projects and within the SDC programme in the health sector development in Tajikistan;
  - Possible implementation changes or extension of project activities to improve the systemic functioning of the health sector;
  - Recommended main areas/approaches to focus in order to reduce fragility of the country (thematic and geographic considering conflict sensitiveness)

### 3.1. Key questions for Project Sino

The following specific questions in relation to project Sino may enrich the review and can be used for providing answers to the overall objectives of the review.

**Objective 1: Access to good quality PHC services is improved through testing models for family medicine provision that are then available for roll-out.**

- What are the evidences of better access and improved quality of PHC services (including referral patterns) in pilot districts? Is the MoH sufficiently involved to overcome obstacles in improving the access and quality of the PHC services in pilot districts?
- Is the project adequate in responding to the re-training needs of doctors and nurses in project’s pilot districts? What can be said about the Clinical Training Basis, the quality of their teaching and the harmonization and sustainability of their operations within the broader health workforce development? Is the mentoring system of family doctors appropriate and sufficient to improve the quality of care? How the sustainability of quality circles at family medicine level has to be judged?
- How effective are continuous medical education measures initiated and sustained by project Sino, especially the peer review groups? Are the project’s activities effective enough in
advocating for a Continuous Medical Education (CME) conception and monitoring to be approved by the MoH?

• How effectively concerns of community groups have been taken up? Have these activities been related to family medicine strengthening? Is the Sino’s approach to community participation adequate to empower effectively citizens, and in particular young women, so that they take more responsibility for their health and work in partnership with local health authorities? Is the SINO health community model sustainable?

**Objective 2: The design, planning and management of Primary Care Services at Pilot Rayon level is improved, and a mechanism exists for monitoring the sustainability of PHC services and rolling-out tested models to other Rayons**

• What is the project’s impact on changing maintenance practices of PHC infrastructures? Are the project’s mechanisms adequate to keep appropriate and sustainable maintenance practices at district and national levels?
• What are the evidences for and who benefit from better planning and management of PHC services at pilot rayon level? Which interventions or tools of the project are models for this positive development and for enhanced accountability and transparency regarding health expenses?
• What is the degree of implication of different stakeholder groups, in particular the rayon management team, in the development of evidence based business plans? Is this commitment sufficient to ensure sustainability after project phase-out in a district? Which intervention strategy will be effective in a successive phase to strengthen the stakeholders so that they can better advocate for governmental fund to cover adequately the business plans?
• What are the project’s inputs provided in health financing reform in general and in relation to the Basic Benefit Package (BBP) or co-payment program in particular? Are they evidences collected by the Sino project that BBP or co-payment have demonstrated effects on increasing women’s and children’s access to primary care services? Are pregnant women indeed getting free services now, or are they still doing informal payments as before?

**Objective 3: The capitalization by MoH and Donors of the experience gained in the Pilot districts is supported and the integration of these experiences into strategic documents is promoted thereby close coordination with the ongoing design of the Health Sector Strategy is assured.**

• What is the project’s contribution to the development of the Tajik health sector strategy and its current implementation? Have successful experiences emerging from project Sino adequately been translated and fed into the policy- and decision-making process as well as in strategic documents?
• Are project Sino communication strategy and tools effective enough on local, regional and national audience so that project’s experiences and achievements are capitalized within the broader context of health reform in Tajikistan and bring positive changes?
• Has Sino adequately and effectively coordinated its activities with the Ministry of Health, other donors and projects in the area of family medicine development and health reform?
• What is possible future intervention strategy for the project to address/influence positively the challenges related to sustaining and to rolling out the project achievements nationally? Is it necessary to change the implementation approach considering a closer integration of Sino into governmental structures? What could be Sino role in the future regarding health sector strategy implementation?

### 3.2. Key questions for Medical Education Project (MEP)

The following specific questions in relation to project MEP may enrich the review and can be used for providing answers to the overall objectives of the review.

• Is the project **relevant** with regard to the health care needs faced by the Tajik population? The results and impact of the curricula reform to improve quality and accessible primary care services so that men and women enjoy better health may be seen in a mid-term to a long term
perspective. However, is such project appropriate in the fragile context of Tajikistan which speaks in favour of focusing the general orientation of the SDC health programme on service delivery and community health?

- As the Russian medical education continues to be a reference for the development of a new curriculum for the TSMU and as Russian Federation (RF) represents a significant source of job opportunities for medical profession, does the project sufficiently mitigate the risks that investments made in the medical education reform will not benefit Tajikistan and its citizens?

**Objective 1: The State Standard for undergraduate medical education is adapted.**

- Is the MEP project effective in contributing to develop a legislation base that will allow introducing changes into the State Standard for undergraduate medical education, so that medical education is better aligned with the country health priorities (primary health care and family medicine)?
- How to interpret the low level of participation in project implementation among some members of the SC that was observed? Has MEP appropriately coordinated the inputs from all stakeholders including relevant ministries from the beginning of the project while defining their respective roles?
- Is there a need to adapt MEP approach in order to increase the commitment of the main stakeholders? How to address the challenges ahead in the implementation of the law on Medical Education in Tajikistan?

**Objective 2: A new curriculum for the medical faculty of TSMU is developed and approved.**

- Has MEP properly ensured that the development of the new curriculum is in line with international accreditation systems standards (whether Bologna or WFME)?
- Is the performance based incentive system for members of the working group appropriate and effective in developing the new curriculum?
- After almost 2 years of project implementation, what are the potential challenges in implementing this new curriculum, more particularly related to the reluctance of chairs and teachers in changing their regular working habits and teaching methods? What are the possible coping mechanisms to overcome these challenges?

**Objective 3: Admission and assessment processes of students are reviewed and adapted, if necessary.**

- Is the project approach effective in addressing taboo issues like the admission and assessment processes of students? What are the potential options in the future to overcome the actual barriers and to strengthening good governance in this field?
- Is the too great number of students an obstacle on the way to increase the country’s capacity to produce graduates with broad range of skills and knowledge required by all physicians? Is it necessary to tackle this critical issue in a successive phase of the MEP?

**Objective 4: Teaching capacities of the staff of the medical faculty are strengthened**

- What are the project’s results in strengthening the teaching capacities of the TSMU staff?
- Is there a mechanism in place to monitor the teaching quality after providing trainings?
- What was project’s contribution in applying a gender sensitive approach in medical education teaching methods, in fostering a gender perspective in the relationship between a doctor and his/her patient? How to improve this effort in the future?

**Objective 6: Different approaches to the clinical skills training using clinical training bases for TSMU are outlined and piloted**
• What are the MEP results related to clinical skills training approaches? What are the potential barriers in further implementation them and what intervention strategy need to be developing to address these challenges?

4. Composition of Review Team and requested qualifications

There will be two review teams, one for the Sino Project, one for the MEP project.

One of the international experts will be in charge of the Sino Project review. His/her profile should be as follows and areas of expertise may include:

• Professional skills and working experience in evaluation methodologies;
• Excellent knowledge of sustainable development and cooperation in transition context (being familiar with Tajikistan is an asset), in particular as regard to project management and capitalization of experiences;
• Excellent oral and written knowledge of English
• Expertise and working experience in the sphere of health reform and/or family medicine:
  o Role and function of family medicine services
  o Planning and management of primary care services

The other international expert will be responsible for the review of the MEP Project. His/her profile should be as follows and areas of expertise may include:

• Professional skills and working experience in evaluation methodologies;
• Excellent knowledge of sustainable development and cooperation in transition context (being familiar with Tajikistan is an asset), in particular as regard to project management and capitalization of experiences;
• Excellent oral and written knowledge of English
• Expertise and working experience in the sphere of medical education and/or curricula reform:
  o Curriculum development
  o Teaching and pedagogic approaches
  o Clinical skill training

The two reviews will be conducted simultaneously; they will have common and independent programme parts. Among common elements are briefings, debriefings, interviews with stakeholders involved in the two projects, medical education components (undergraduate, postgraduate, continuous). One of the international experts will be tasked as a team leader to coordinate the preparation of such a programme and to consolidate in one single report review report the two reviews under the perspective of SDC’s current and future investments into family medicine development in Tajikistan.

Dr. Peter Campbell has been selected as Team Leader for the review and will be primarily responsible for the MEP component of the review.

Heinz Henghuber is the second consultant and his main area of work will be to evaluate the SINO project. He will work in close cooperation with Debora Kern, SDC Health Policy Advisor and co-focal point for Health, as well with Tobias Schüth, Project Coordinator of the Community Action for Health (CAH) Project, Swiss Red Cross Country Delegate Kyrgyzstan.

CIS Division is interested to have SDC co-focal point improving her knowledge on the operations in the heath sector in CIS countries so that this work will be better represented in the future in SDC health policy and strategic documents. SDC as a learning institution shall also use the expertises available in house and strengthen them. A review is a unique opportunity to learn about projects.

The role of the SDC co-focal point in the review process can be summarized as follows:

• Contribution to the preparation of the review;
• Active participation in the reviews mission (due to previous experiences, focus will be set on the SINO review);
• Comments on the draft review report.

The role of Tobias Schüth is to be involved in the review as a peer reviewer assessing in particular the community health component of the SINO project. CIS Division is in fact interested in capitalizing on the CAH’s good practices in Kyrgyzstan for its projects in Tajikistan and the present review offers an excellent opportunity to do so.

The review team will be supported by one local expert and two translators.

5. Methodology and reporting

During the preparatory stage, the experts will review all the relevant documents.

A briefing at SDC Head Office will be held in Berne with the two international experts and the SDC Health Policy Advisor to clarify the ToRs. Similar briefing will take place in Basel with the two project leaders of the Swiss TPH.

The ToRs will be reviewed during the briefing meeting and any deviations/modifications will be reflected in the "Review Framework" issued by the consultants.

Upon arrival in Tajikistan, the two review teams will have a briefing with SCO Dushanbe (SCO Country Director, NPO in charge of Health) and with the long-term technical expert of Sino project as well as the project coordinator of MEP.

Interviews with key stakeholders of the two projects will be conducted, such as:

• Ministry of Health (MoH) and its institutions (Republican Centres - Family Medicine; Institute of Post Diploma Preparation of Medical staff, Clinical Training Centres, Oblast and Rayon health authorities)
• Ministry of Education (MoE)
• Tajik State Medical University (TSMU)
• International organisations active in the health care reform domain (World Bank, USAID, EC, GiZ-KfW, UNICEF) and projects and programmes partners.

Field visits are also planned to selected districts, including interviews with beneficiaries of the projects (community groups, family medicine health staff, and clinical training bases).

At the end of the mission, a debriefing will be organized in Dushanbe. The two review teams will present the preliminary findings, conclusions and recommendations to SCO Dushanbe, implementing partners and key stakeholders and collect first general impressions and feedbacks. The minutes of the debriefing are handed over to SCO before departure.

In consultation with SDC, the two consultants will take overall responsibility for developing further, in an innovative way, the methodology and main instruments of the review (questionnaire before the mission, stakeholders' workshop, etc.). The team leader will be in charge of editing and consolidating in one review report the two assessments on the Sino and MEP projects.

The Review Report should be submitted in English and cover all the elements mentioned under the objectives in a maximum of 30 pages (excluding annexes). The report is introduced by an executive summary. Its main body starts with a description of the method used and is structured in accordance with the present ToRs. Based on the review assessment and findings, the review team shall draw
conclusions and lessons learnt, as well as make recommendations and present them in order of priority. The two review teams are also tasked with the elaboration of stakeholder assessments as an initial step in the preparation of successive project phases.

The first draft of the Review Report should be submitted not later than 15 days (mid-December 2011) after the end of the Review Mission. The consultants will receive consolidated comments from SDC and project partners, which will be used to finalize the Review Report final version to be submitted not later than 40 days (end of January 2012) following the end of the Review Mission.

The Team Leader will present the results of the review and the recommendations during a debriefing meeting that will be held at SDC Head Office in Bern around mid January.

6. Review Timetable

The mission in Tajikistan is scheduled during weeks 46, 47 and 48 (from 17th November to 1st/2nd December 2012).

Working days for the international experts

<table>
<thead>
<tr>
<th>Days</th>
<th>Activity</th>
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<tbody>
<tr>
<td>1 day</td>
<td>Briefing at SDC HQ</td>
</tr>
<tr>
<td>3 days</td>
<td>Preparation / desk study</td>
</tr>
<tr>
<td>2 days</td>
<td>Travel Switzerland-Tajikistan-Switzerland</td>
</tr>
<tr>
<td>up to max. 13 days</td>
<td>Field mission</td>
</tr>
<tr>
<td>3 days</td>
<td>Elaboration of report</td>
</tr>
<tr>
<td>1 day</td>
<td>Debriefing at SDC HQ (only Team Leader)</td>
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TOTAL working days: 23 (+ 3 additional days for the international expert in the position of team leader)

(Note: The mission’s working week will counts 6 working days if the mission is more than 10 days in total.)

7. Logistics

SDC HQ shall support the international consultants in their travel arrangements, if required (visa, flight tickets, travel advance, information for SDC consultants travelling to CA/TJ, etc.). SCO Dushanbe shall organize the field mission of the review team and provide logistic support.

Translation into Russian both during the mission and of the report will be arranged by SCO Dushanbe.

8. Available Documentation

The experts will be provided with all the documentation on the project implementation necessary for the proper evaluation:

- Concept Note for the Swiss Cooperation Strategy for Central Asia (2012-2015)
- Drafted strategic orientation (results framework) for the health care sector in Tajikistan
- Central Asia and Tajikistan context analysis (2010)
- Sector analysis for the SDC Health care programme in TJ (2011)
- Tajik National health strategy, Action plan and other related documents
- Concept to reform medical education
• Relevant SINO and MEP projects documents (Credit Proposals, project documents, and annual progress reports)
• SINO internal mid-term review from January 2011
• SINO policy briefs
• Consultant reports of project Sino on areas such Continuous Medical Education, Community Participation, Retention of health workers, etc and of MEP in relation to the curriculum reform or accreditation
• Poverty Reduction Strategy 2010-2012
• National Development Strategy 2006-2015

Bern, ..................................................  Heidelberg, ..................................................
For the Swiss Agency for Development ........................................... For the Consultant  
and Cooperation ........................................ EVAPLAN

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Sophie Delessert  Siegrid Tautz
Programme Manager for Tajikistan  Executive Director

Tentative draft programme

Timing, placing and duration (to be further developed with the review team leader)
The following schedule is tentative:
November 2011 (Wedn.)  Departure
November 2011 (Thursday)  Arrival Dushanbe
November 2011 (Thursday)  Briefing SCO Country Director, Health NPO  
Briefing meeting long-term technical adviser (Sino)
November 2011  Meeting with MEP coordinator and MEP Technical expert  
Meetings with Minister of Health and possibly Minister of Education;  
Meeting project Sino project staff  
Meeting CME national expert group team
November 2011  Meeting with the Rector of the Tajik State Medical University  
Meeting with the Working Group of the TSMU  
Meeting with the Political Advisor of MEP at MoH  
Meeting with staff of Post Graduate Medical Institute  
Meeting with staff of Republican Centre of Family Medicine
Meeting Health Policy Analysis Unit MoH
Meeting USAID health quality project

November 2011
Field visit to Shakrinau and Turszunsade
Visit Clinical Training Basis

November 2011
Field visit Vose, Khamadoni, Dangara

November 2011
Field visit to Varzob

November 2011
Meeting health reform department MoH
Meeting Legal Advisor of MEP
Meeting WHO and UNICEF
Meeting with AKF/AKHS
Meeting with KfW/GiZ
Meeting EC
Meeting with the WB
Meeting with Human Resource Department of the MoH

November 2011
Debriefing SDC coordination office Dushanbe
Debriefing TSMU
Debriefing MoH and MoE, as well as project Sino staff

November 2011
Preparation of the Workshop

November 2011
Workshop with stakeholders

November 2011 (Thursday)
Departure Dushanbe and arrival home destination