

2/3/2008					
Response to Tina's Questions -- Tajikistan					
Not start work in Tajikistan until ZdravPlus					
Most activities done in collaboration with other donors/projects, documented elsewhere, not included due to space constraints					
Same situation at independence for all countries although level of health financing collapse varied					
See ZdravPlus II Project Regional Conceptual/Technical Overview Paper Distributed to USAID Evaluation Team for General Definition of Project Components					Tina's
Just intended to provide a general picture, not fully specified, activities not always fit precisely across projects, generally allocated to time where most accomplished					Scale
				ZdravPlus II Remainder	For Z+II
				and Beyond	+R for
Project Component	At Independence	ZdravPlus	ZdravPlus II To Date		Roll-out
Stewardship					
Legal and Policy	No comprehensive policies, patchwork of laws/regulations, governing done by decree	Supported by WHO created Somoni Master Plan, generally good plan but created a semi-parallel MOH and a lot of conflict. Broad policy dialogue difficult. Started productive health financing reform dialogue with a multi-sectoral working group. Dialogue about family medicine also contentious.	President. Approval of regulations to start PHC per capita payment. Significant conflict over nature of BBP and copayments but ultimately approval of good policy. General service delivery and family medicine dialogue more productive although issues with approval of international consultants for SM. Surprisingly good openings for dialogue in EBM and ME.	Continue to strengthen policy dialogue processes and legal/regulatory base. Is talk of SWAp or at least development of Health Sector Strategy.	O
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	Substantial conflict over who has the leading role in introducing family medicine and retraining (PGI or new Republican Family Medicine Center) demonstrates problems with duplicative roles. Clear that building capacity in MOH will be long-term and difficult challenge.	Initiate productive dialogue on establishing a oblast-level health purchaser. Family medicine institutional conflict somewhat mitigated. It appears DIC and EBM Center in good institutional home in TSMU. Creation of Family Medicine Association. Center of Excellence (COE) model established.	Establish and solidify health purchaser and define health provider autonomy and public/private relationships. In service delivery, continue separating and decentralizing functions and establishing and clarifying roles and relationships	O
Policy Marketing	Command and control, little dialogue	Very controlled and politicized environment and not broad dialogue	Dialogue broadening but still very politicized. Try to support MOH in advocating and showing results to the Government to obtain more time and space for reform implementation	Priority to enhance dialogue and broaden participation.	O
Monitoring and Evaluation	Politically driven	Minimal	WB project and WHO working with Tajik partners to establish a Health Policy Analysis Unit similar to Kyrgyzstan	Objective data and analysis of reform implementation needed to depoliticize environment and move toward evidence-based policy-making	O
Donor/Project Coordination	None	Contentious at times. Possible some underlying tension due to who there during the war vs. who not and relationship humanitarian assistance and development. ZdravPlus contributed to donor coordination process.	Still difficult at times. Nature of Tajikistan does contribute to a divide and conquer mentality.	A major issue requiring a lot of effort. Unpredictable whether moving toward SWAp will improve or worsen in the short-term although likely good for the long-term.	O
Resource Use					

Project Component	At Independence	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Health Delivery System Structure	Inverted pyramid	Loss of time during war years really hampered development of bottom-up pilots and restructuring which was generally happening in other CAR countries.	Decision on rural PHC model -- Rural Health Centers reporting to PHC Network Manager under the CRH, working on establishing specific roles and relationships now. Cities mixed polyclinics which enables COE development. Minimal hospital level restructuring and given low level of funding the system continues to collapse under its own weight.	Expand PHC reorganization and restructuring. Hospital level restructuring needs to start and critical to long-term sustainability of health sector.	O
Human Resources Planning	None	None	None	Definitely a future priority	
Health Financing	See writing on fragmented financing, no separation of purchaser/provider, wrong incentives in provider payment systems (PPS), etc.	Initiated productive, multi-sectoral dialogue	Hard to agree upon first implementation step after National Health Financing Strategy approved. After long dialogue and development of multiple implementation strategies and plans, implementation of pilot PHC per capita payment started in 2007. Approval and pilot implementation of BBP with formal copayments. Most CAR countries generally improved pooling and purchasing arrangements first and then solidified BBP after payments could be matched to benefits. Tajikistan is introducing BBP and then will need to back down the chain to improve pooling and purchasing arrangements to realize the BBP, dialogue in process.	Just starting health financing implementation, substantial support needed in the future to continue to develop and implement TJ health financing model.	P, O
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	Initiated automated hospital database and HIS	Expand automated hospital database and HIS. Currently working on module to attach to hospital HIS to enable better planning and management of formal copayments	Continue implementation and expansion linked to health financing implementation	P, O
Health Management	Command and control, politics equated with management	Provided training to health providers on general health management principles and communicating the objectives of the health reforms.	Health financing and management training provided in pilot PHC per capita payment system sites. Dialogue on coordinating with health management training under WB project	Short-term -- capacity building training linked to health financing implementation Long-term -- health management education needed	P, O
Service Delivery					
General Health System Functions					
Postgraduate Medical Education	Old system collapsed	With expatriate doctors, started FM TOT, collaborated on formation of oblast FMTCs and starting PHC retraining process	Expatriate doctors continued FM TOT, ongoing faculty development, strengthened FMTCs/COE, supported retraining, and initiated short CME conferences very popular with doctors	Continue support faculty development, PHC retraining, and CME	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	Minimal	FM trainers graduating from FM TOT go to polyclinic affiliated with TSMU to start FM residency, mixed results in short-term largely due to personalities but structure in place and we expect it to progress	Continue development of FM residency, link graduate medical education improvement to general medical education reform	O

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Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	Early on it appeared that productive dialogue with TSMU on medical education improvement could be established earlier in the process than other CAR countries, dialogue through Regional Council of Rectors	Assessment of TSMU by international consultants, ongoing technical assistance to TSMU to develop Medical Education Reform concept and implement some early steps, work on medical education accreditation and adapting WFME standards	Expand medical education reform and improvement	O
EBM/CPGs	Nature of clinical practice not based on evidence	Minimal	EBM Center established in TSMU, productive dialogue and capacity building in EBM, started developing new CPGs.	Continue to expand activities	O
Quality Assurance	Punishment	Minimal	Some dialogue about facility accreditation	Possibly initiate facility accreditation and maybe QA linked to health purchasing	
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	A strength of initial donor inputs due to strong WHO pharmaceutical team and humanitarian assistance focused on drugs. Relatively strong MOH capacity. Drug Information Center (DIC) established in TSMU and provided objective evidence-based information to health providers and population	National Drug Policy developed and approved. DIC continue substantial activities on rational drug use. Broad picture confusing as working to reestablish central procurement of drugs. Donor commitment to provide drugs more uncertain. Should link to health financing reform but how not yet clear.	A broad strategy on financing mechanisms for drugs needed and ongoing rational drug use activities	O
Infrastructure	All owned by state, massive and deteriorating	Major issue as system substantially decayed. Hasn't been major investments in infrastructure especially for PHC as in other CAR countries.	Z+ limited investment in COEs. Some investment under WB and ADB projects but still major issue.	Infrastructure needs more upgrading to realize health system improvement	O
Service Delivery Priority Programs					
General Practice/Hypertension	Problems inherent in system including weak PHC	General family medicine introduction	Initiated pilots in COEs	More investment in pilots and eventual roll-out	P
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based	Minimal	Initiated pilots in COEs and working to solidify and start roll-out	Continue to solidify pilots and roll-out	P
Child Health	Problems inherent in system including weak PHC and not evidence-based	Incorporated into general family medicine introduction	Incorporated into general family medicine introduction	Continue to solidify in general family medicine introduction	O
TB	Excess capacity in vertical system, not evidence-based treatment, reach of vertical system no longer able to control all TB-related issues	Minimal	See other writing -- generally, policy dialogue, integrate TB DOTS into ME, integrate TB DOTS into PHC, link civilian and prison TB systems, health promotion. All activities in collaboration with Project HOPE.	Continue integrating into medical education and PHC. Gradually create more health system linkages including financing and vertical system restructuring	P, O
HIV/AIDS	Not yet emerge	Minimal	Incorporate into Safe Motherhood, some links to PHC training and health promotion	General strategy needed including addressing role of vertical system	O
Population and Community Health					
Marketing the Reforms	Population role not seen as important	Minimal	Established MOH Press Center but not yet mature and seems part of country environment is increasing desire to control information	Should be expanded if country environment allows	O
Health Promotion -- Government	Not yet emerge	Supported Somoni Team and Republican Center in health promotion	Limited support for Republican Center	Continue limited support....	O
Health Promotion -- Providers Linked to Service Delivery	Not yet emerge	Minimal	More intense and focused health promotion at health provider level for service delivery priority programs	Enhance and expand in concert with COEs and service delivery priority programs	P, O
Health Promotion -- Community-Based Entities	Not yet emerge	Minimal	Initial linkages with mahallas and other community-based entities	Should be expanded if country environment allows	O