

Annex C: Tajikistan Country Findings

Background: Tajikistan is the second most vulnerable country in the USAID E&E region from a health standpoint. It ranks second worst in life expectancy and public health expenditures, and worst in new estimated tuberculosis (TB) incidence. It is a resource poor country, with little to contribute to meeting the health and health care needs of its citizens. Approximately 64% of the population lives below the poverty line, and 36% of the children suffer from chronic malnutrition. It is considered to have a high potential for explosive growth of HIV/AIDS incidence due to the number of injecting drug users.

Reform of the health sector began in 1994 when the President proclaimed a need for general reform, including the health sector. In 1995 a program for transitioning the country to a market economy was adopted, and in 1996 a policy for “Health care reform in the Republic of Tajikistan for 2001” was released. This was followed in 2002 by approval of “Health Sector Reform in Tajikistan,” which stated that primary health care (family medicine) was the top health sector priority. According to the World Bank, the Tajiks vision of reform is to have a health insurance system modeled after Kyrgyzstan.

Until recently, little had been done to move on the reform strategies as understanding of health system reform among policy makers was quite weak. But with the help of ZdravPlusII, the World Bank and the Government of Tajikistan completed a loan agreement. The project, “Community and Basic Health Care,” which is in its second year of implementation, supports primary health care, capitation payments to providers, and co-payments within the context of a formal Basic Benefit Package. Another hopeful sign is that there is now a commitment to increase public allocations to the health sector from 1% to 3% of GDP; however, due to a severe energy crisis, the government may have to use its funds elsewhere.

Donors have been moving to a sector wide approach (SWAp) in Tajikistan, reaching agreement on a comprehensive framework and country strategy that they will support. The concept for the Tajik SWAp does not include budget support because the consensus is that they do not have the fiduciary capacity for management.

Under the ZdravPlusII contract, the country strategy for Tajikistan is to work with other donors/projects to create synergy for linking national level initiatives, such as health financing with facility level activities (top-down, bottom-up). There is very little in place now, and the challenge is to begin building some pride of ownership to create advocates and stakeholders for change as they see differences in outcomes. To do this, the project will focus on using Centers of Excellence as models for how service delivery can be improved under a PHC based system.

Performance Monitoring Plan Analysis: ZdravPlus II is making steady progress in meeting the targets set in the Performance Monitoring Plan (PMP). The implementation indicators are considerably less deep and broad than those set for Kyrgyzstan,

Kazakhstan, and Uzbekistan where the project has supported reforms for over a decade. Nonetheless, the PMP reflects successful acceptance of many of the key reforms implemented in these other countries and early progress is encouraging for this resource-poor country. For 2007, the project is almost reaching, meeting, and in some cases exceeding several of its 2009 end-of-project targets. Noteworthy is the progress towards increasing the percent of total outpatient visits in primary health care practices in Polyclinic 8 Dushanbe (67% actual for 2007 compared to a target of 25% for 2009); the number of entities which serve as mechanisms or channels to empower health action by an individual or community (67 actual for 2007 compared to a target of 30 for 2009); the number of PHC workers receiving CME (6,545 actual as of 2007 compared to a target of 4,000). Progress is tracking more slowly but still above the target for the number of hospitals with standard health information systems (22 compared to a target of 25 for 2007 and 40 for 2009). The project fell short of their 2007 target for retraining PHC workers because the project increased the duration of the course to 7 months (38 retrained compared to 50 targeted in 2007). The PMP sounds no implementation alarms and reflects reasonable and often impressive performance.

Stewardship: ZdravPlusII's efforts to promote good stewardship of the health sector have been well targeted for increasing the potential for primary health care to be a strong foundation of the health care system. With the help of ZdravPlusII, the Ministry of Health has had significant achievements in the development of policies that form the legal base for implementation of primary health care per capita payment. It provided technical experts to help with the development of an implementation plan for the "Strategy of Health Care Financing in the Republic of Tajikistan 2005-2015." The strategy has been approved by three ministries providing a broad base of support within the government. A particularly positive feature of this strategy is that it led to a mandate that the PHC budget be separated from the overall health care budget, creating a political buffer for PHC.

The new system is being implemented in 8 pilot rayons based on regulations that ZdravPlusII developed with the approval of the local khukumats. The rayon pilots are sponsored by other donors, but ZdravPlusII has used them as demonstration sites for informing the Tajiks and donors about the implementation issues for the new system. In addition, they have facilitated the success of the pilots by drafting regulations to govern implementation.

One of ZdravPlusII's greatest achievements has been the reintroduction of the basic benefit package with formal co-payments in 8 categories to be initiated in pilot rayons. As the decree was moving to conclusion, there was an attempt to create 200 categories of co-pays which would have been confusing to patients and difficult to implement. This complication of the concept could have sabotaged the reintroduction of a basic benefit package. However, by its vigilance ZdravPlusII caught the last minute move (by the Vice Minister, now Minister of Health) and was able to have it corrected. Aside from the political maneuvers, the formal co-payments are a strategy to reduce corruption by eliminating under-the-table payments and creating transparency and accountability in the financial transactions between the patient and doctor. In the pilots, receipts are provided

for co-payments; and studies show a reduction in under-the-table payments and increased formal salaries of physicians. However, patient out-of-pocket costs are unchanged.

The World Bank views ZdravPlusII as an important partner to realize a return on their investment in Tajikistan. Zdrav has served as a technical adviser with deep knowledge of the local context of reform as well as a thorough understanding of health systems issues. The WB team leader for the project said that their help was invaluable because their intimate knowledge of the Kyrgyzstan reforms enabled them to advise the Tajiks on what was feasible for their context compared to the Kyrgyz context. For instance, Kyrgyzstan has small oblasts and Tajikistan has very large oblasts, so reforms would be more successful if first tested at the rayon level. This is one example of how they have become known throughout the regional for their ability to “contextualize.”

The key issue in the stewardship component is concern that the new Minister of Health may not be a supporter of efforts to reform and build a stronger primary health care system. Before being appointed minister, he was the deputy minister of health. He and the former minister spent much time debating health reform issues, and the government made slow progress with the reforms. It was not until the government negotiated the recent World Bank health sector loan that the reform movement gained traction. One observer stated that more progress has been made in the last four months than in the past eight years. Other informants the team spoke with believe the new minister will have to support the reforms, noting that the reform process is not dependent on the Ministry of Health alone, citing the Ministry of Finance and Ministry of Economy as other key players. In addition, donor partners will continue to insist that the reforms not be reversed. It is still too early to know; but even if the progress is slowed at the national level, ZdravPlusII has the ability to concentrate more of its attention and resources on strengthening local primary care facilities.

Resource Use: All financing reforms are in early stage of development. The PHC capitated payment is being implemented in 8 pilot rayons (406 facilities, 14% of PHC facilities nationally). ZdravPlusII is providing assistance with the legal/regulatory framework, technical methodology and tools, and implementation of the Basic Benefit Package and co-payments. Monitoring has found that implementation is going well, that the co-pays are understood and are being collected and that accounting systems have improved. Their findings and recommendations for next steps were submitted to the MoH, MOFinance and the Treasury.

The government plans to implement a case-based hospital payment system at the oblast level, and ZdravPlusII is working with the MOH Medical Statistics Department on the development of a health information system that will support this new type of payment. They will be working with the WB PIU to educate people at the rayon and oblast levels about this new information system prior to more extensive implementation.

Service Delivery: The service delivery component is the heart of the ZdravPlusII program in Tajikistan. This is the arena where the most activity is centered, and where ZdravPlusII technical assistance can get the most traction. To strengthen primary care,

physicians and nurses at this level are required to complete training in family medicine. Current estimates are that 4000 family doctors and 8000 family medicine nurses are needed. Thus far, 700 physicians and 700 nurses have been retrained through a 7-month course which includes classroom learning and practical interaction with patients. The team observed a family medicine Center of Excellence which is using evidence-based medicine CPGs and practical training of clinicians. This is the model of practice that ZdravPlusII aims to establish nationwide. Two other donors have already committed to financial support for replication of the model. The process is lengthy and labor intensive, but it will gradually take root as increasing numbers of trainers, medical staff and medical school students are introduced to family medicine EBM and use of clinical practice guidelines. Though there is not yet a national initiative on family medicine, ZdravPlus II's work has the support of members of the medical profession who hold positions at TSMU where they are able to influence the adoption of modern medical practices.

The quality of medical education underpins this component. With strong leadership from the Rector, the Tajikistan State Medical University (TSMU), the only medical school in the country, will begin revising its curriculum to firmly establish family medicine and to teach EBM. He also plans to broaden the curriculum to include biostatistics, clinical epidemiology, computer and internet use for research. All of these disciplines reinforce the methodology of EBM. ZdravPlus II has been helpful to the TSMU in their effort to produce graduates with higher level qualifications. They organized a group of physicians from a prominent US medical school to review the structure of medical education at TSMU. A steering committee has been formed to consider the recommendations.

ZdravPlus II has also supported the Family Medicine Chair of the Postgraduate Medical Institute by providing trainers and materials for programs on evidence-based topics, such as DOTS and drug resistant TB. These programs are incorporated into the 7 and 11 month training, which covers 41 modules for trainers and 23 modules for family medicine.

The first family medicine trainers in Tajikistan were trained in Bishkek and Israel. Then ZdravPlus II provided international trainers to work in Tajikistan. They have also supported an 11 month training of trainers initiative that is both theoretical and practical. Training is conducted in a health center where international doctors mentor the physician trainers. The "students" see their own patients and are trained in evidence-based medicine through patient case studies every morning. These physician trainers are then sent back to their home facilities to conduct retraining programs for doctors interested in becoming family medicine physicians. The 7 month continuing medical education courses are held for physicians and nurses who want to retrain as family doctors. ZdravPlus II gives doctor bags and stipends to trainees and trainers. Graduates of these programs become not only better doctors, but also grassroots advocates for the new medicine. Over the past 4 years, 21 physician trainers have been trained and 11 more are currently in training (some in Bishkek).

Two model Centers of Excellence (COE) have been established by Zdrav as sites for demonstrating how vertical programs are integrated into a family medicine practice.

Arterial hypertension (AH), reproductive health and DOTS, an evidence-based treatment protocol for TB, are the first examples. Quality improvement teams have been organized at the COEs. They are learning how QI programs are implemented and how to make use of the data that is generated about patient care. With ZdravPlus II's help, the hypertension CPG for PHC providers was approved by prikaz in December 2007 and is already being implemented in the two centers. The COE initiative has attracted other donors who intend to introduce similar programs.

The team visited two of the 7 maternities serving as pilots for the implementation of Promoting Effective Perinatal Care (PEPC) program. These programs call for the use of WHOI-EURO standards of EBM to achieve reductions in maternal and neonatal morbidity and mortality. Baseline data is collected for these facilities to determine the impact of the program. Results thus far show a decreasing rate of postpartum hemorrhages, as well as home deliveries. In discussions with the medical staff and patients we found that the new methods for treating maternity patients have been well received. There have been impressive changes in the hospitals that have improved outcomes and satisfaction of both the patients and the medical staff. Constrained resources exacerbated by the power shortage revealed the extent to which the staff goes to extraordinary efforts to protect the mothers and babies from complications. There was some question as to how much attention the staff gave to the monitoring reports, and more attention will have to be devoted to using the QI reports effectively.

The Drug Information Center (DIC) was established to provide independent, objective, evidence-based information to promote rational drug use. ZdravPlus II provided assistance to the DIC and informed development of the essential medicine list (EML). Subsequently the DIC developed the first Tajik National Medicine Formulary (detailed information on the EML). A lot of information about these resources has been disseminated to medical professionals. The legal status of the DIC has not been formalized.

In the 28 countries of the USAID E&E region, Tajikistan ranks as having the worst rate of TB incidence, but efforts to improve and strengthen the capacity of PHC physicians to diagnose and treat TB have moved very slowly. ZdravPlus II researched the level of DOTS institutionalization into the retraining programs for PHC doctors at the post-graduate level. They followed up with a training seminar for TB faculty at TSMU in order to improve the DOTS component for family medicine retraining and residents at the graduate level. At the COE in Dushanbe, they have sponsored CME seminars to improve implementation of DOTS at the PHC level. While these appear to be ad hoc efforts, they have identified the few good opportunities to reach medical professionals and offer organized programs, which are the necessary first steps for raising awareness.

Population and Community Health: ZdravPlus II has worked with the MoH press center to develop strategies for publicizing the new reforms of family medicine and the BBP with co-pays. They have also helped the COEs to develop marketing skills for their facilities and their concept – preventive and family centered care. In addition, ZdravPlusII has developed material for the public on breastfeeding, IMCI and TB.

To assure that patients can perceive a difference in the new medicine of family practice and the old style medicine, providers have been given training on listening and interpersonal communication skills.

The Family Medical Association has applied to register as an NGO. They now have 600 members and represent family doctors and nurses, providing them with advocacy, CME and membership activities. One of their priorities is to have a new law on family medicine and CME approved.

Patient clubs have been established for hypertension, diabetes and lung conditions at the Family Medical Center #1, which the team visited. The Mahallas are helping to raise awareness in their communities about family medicine, the need to take responsibility for their health and to encourage people to get to know their physicians. They are credited with helping to reduce the rate of home deliveries over recent years from 4.8% of births to 2.2%. Mahalla leaders are also providing feedback to the Family Medical Center on the satisfaction of their population with the Center's services.

Conclusion

ZdravPlus II, as elsewhere in CAR, is playing a critical health reform role in Tajikistan, providing much of the technical analysis underpinning the reforms undertaken to date. In all four component areas of the project, Tajikistan is moving very slowly. It remains uncertain the extent to which the new Minister of Health will support the reforms. However, the reform movement and loan support from the World Bank are sufficiently established that his actions may delay progress, but will not reverse it.

ZdravPlus II should continue its top-down, bottom-up implementation strategy. Only a small part of the complete policy framework for restructuring the health care system is in place. ZdravPlus II's assistance is essential for Tajikistan to develop the policies and laws needed to create a foundation for health sector restructuring. Beyond that, the practical demands of restructuring call for experts in implementation, a role ZdravPlus II is uniquely positioned to fill. Active ZdravPlus II involvement in Tajik health reform is advised until there is a solid cadre of local professionals who have learned their skills from ZdravPlus II and other reform experiences in Central Asia.

USAID, its donor partners, and ZdravPlus II should continue to explore establishing a sector wide approach (SWAp) in Tajikistan patterned on the one in Kyrgyzstan. The SWAp may provide an opportunity to gain more buy-in from the Minister of Health, while at the same time introducing more transparency and accountability into the management of health sector funds.