

REVISED ACTION FICHE N° 2 FOR TAJIKISTAN

1. IDENTIFICATION

Title/Number	Health Sector Strategy Support Project DCI-ASIE/2009/020-629		
Total cost	<i>EUR 5 000 000</i> <i>EU contribution: EUR 5 000 000</i> <i>Government of Tajikistan in-kind contribution: EUR 50 000</i>		
Aid method / Method of implementation	Project approach: <i>Joint management with World Health Organisation (WHO) and centralised management</i>		
DAC-code	12110	Sector	Health

2. RATIONALE

2.1. Sector context

In the years following independence in 1991 Tajikistan has embarked on a range of structural adjustments to improve the economic situation. There are signs that economic reforms have resulted in positive economic growth and it is anticipated that this growth will lead to improvements in living standards.

Despite of this, Tajikistan remains the poorest and one of the most fragile of the countries of the Commonwealth of Independent States¹, with 53 % of the population living below the poverty line².

The first years of independence were marked by a substantial deterioration of health status, with a rise in communicable diseases such as tuberculosis, malaria and typhus. Tajikistan has the highest rates of deaths rates of children from diarrhoea diseases and acute respiratory infections, diarrhoea and prenatal conditions are the main registered causes of infant mortality. Per capita incomes remain low, amounting to USD 430 (Atlas method, 2007). There are unacceptable high rates of maternal mortality 170/ 100,000 live births and high rates of neonatal mortality 38/1000 live births and Under 5 mortality 68/ 1000 live births (WHO 2008 Report).

Regarding resources for health, the number of physicians has decreased substantially in the past 15 years due to brain drain to other sectors and migration and stands at a low level compared to other countries in the region. Health professionals are unevenly distributed with higher numbers in urban compared to rural sites and most of the health professionals are still employed by the government with very low wages. Hospitals have been subject to rationalization with a substantial closure of hospital beds and increasing bed occupancy of remaining beds. Hospital admissions have halved and bed capacity substantially reduced during the past decade but the average lengths of stay remains high. There are severe shortages of drugs and medical supply.

¹ Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Uzbekistan and Ukraine

² For 2007 a complete poverty line was derived based on Tajik-specific consumption patters and was estimated at 4.56 somoni/day/person.

In what concerns health financing, Governmental health spending has declined substantially since independence and although there has been economic growth, this has not been reflected in the health budget. Per-capita health expenditure remains low (USD 16), while public sector expenditure on health is estimated at 5% of total government expenditure, much below the CIS average of 9.1% (WHO, 2005). Out-of-pocket payments have grown rapidly as a share of health care funding in Tajikistan, currently accounting for over 70 percent of total health care funding. The main bulk of out-of-pocket expenditures is spent on outpatient drugs.

The pace of reforms has been slow following independence due to the civil war and health needed to be put higher on the governmental priority agenda. In the past 15 years the Ministry of Health has initiated reforms aiming to improve access to basic services, the quality and efficiency of provision, and long-term sustainability.

History of health sector reforms

President Rakhmonov proclaimed the need for reform including reforms to the health sector in 1994. A policy for “Health care reform in Republic of Tajikistan for 2001” was adopted in 1996, with the first stages planned for 1995–2000, outlining the following main directions: reduce hospital beds; strengthen primary health care; train family physicians; update health care technology and procedures; adopt national programmes on immunization, tuberculosis, iodine deficiency, and infectious disease prevention; introduce new health financing methods based on needs based and output based funding; update and upgrade medical education; develop a national policy on pharmaceutical production and distribution; privatize limited services such as pharmacies and medical equipment.

The reforms until 2000 have resulted in: a hospital system down-sized with more than 30% of beds closed; primary care strengthened with better-trained staff but no shift in state funding to primary care which received 20% at most; rationalization of the Sanitary and Epidemiological Service. Also, the Tajik State Medical Institute has changed its curriculum to train general practitioners and the number of medical students entering medical schools has been cut. Training for “middle level” personnel was also reorganized. A pharmaceuticals policy and list of essential drugs have been developed and a regulatory institution established.

A second wave of reforms started in 1999 when the MOH initiated the (Somoni) health care reform project to develop a national plan for health sector reform, intending to consider all aspects of the health care system, particularly in light of the WHO Health 21 strategy.

The main features of the national plan elaborated in 2000 included: strengthening primary health care to be developed as a priority area, reforms in rural and urban health centres to gradually retrain specialists as family physicians; reorganization of the hospital system with reduction of hospitals beds by 50% from the 1992 level. Health care financing reforms have included introduction of per capita financing at PHC, setting up of official patient co-payments for goods and services, and a proposal for health budget to be pooled at the oblast level, rather than being directed by the Republican government separately to oblasts and *rayons*, to be implemented at a later stage when economic conditions will be favourable. A human resources strategy and a health information system were two other important priorities.

In 2006, the Government adopted a national program advocating for strengthening primary health care (PHC), reducing the number of hospital beds and introducing of the family physicians model. In 2005, the Government adopted a Health Financing Strategy to improve equity and efficiency through the (i) establishment of a single-payer; (ii) pooling of sources of public funds; (iii) provider payment reforms; (iv) combating informal payments and introduction of formal co-payments; (v) public sector wage reforms.

Key achievements regarding the implementation of PHC per capita financing reforms in 8 *rayons* since April 1, 2007 (supported by WB, ZdravPlus, ADB and SDC) include: establishment of legal/regulatory framework; consolidation of PHC budgets at the rayon level; separation of hospital

and PHC budgets; nomination of a PHC network manager and role definition; increased autonomy in PHC facilities through participation in the budgeting and resource allocation process; calculation to determine the capitated rate; budget formation for each PHC facility; establishing a separate budget in the Treasury System for each PHC facility and developing funds flow operational procedures.

In June 2007 Government of Tajikistan started a second attempt (the first attempt, in 2005, was suspended after a few months), to implement a Basic Benefit Package (BBP) and a simplified formal co-payment structure at the rayon level. The primary goal of the BBP was to reduce informal payments by establishing a predictable and transparent system of patient rights and obligations. It was also expected that the BBP will reduce patient financial burden for certain population groups such as exempt patients and deliveries. Key achievements so far include the approval by the MOH and Ministry of Finance of an instruction on the regulations of the BBP outlining hospital co-payment structure with eight payment categories (30% and 70% of total cost of a service when a patient has a referral from PHC and does not have, respectively). The findings of a survey using data from 2007³ show a mixed picture on the impact of the BBP on patient financial burden. The BBP has been unequivocally successful in reducing the share of patients who make informal payments for all categories of informal payment contributing to an improvement in transparency in the Tajik health financing system. However, the picture is not so clear for assessing the impact of the BBP on overall patient financial burden adding formal and informal payment categories. Adding together all payment categories (co-payment, payment to medical personnel, payment for medicines, supplies, labs, and other items), the BBP has not reduced significantly the share of patients who pay something towards the cost of their care and the BBP has also not reduced patient financial burden in absolute terms with the exception of deliveries and exempt patients. This is because co-payment replaced part but not all of informal payment. The policy implication of these findings is that the BBP alone is not a sufficient policy instrument to reduce patient financial burden, oblast level funds pooling and restructuring are necessary complementary reforms that are currently being considered.

In December 2007 the Government of Tajikistan approved a law for establishing a mandatory health insurance for the citizens. Important legislative actions still need to be taken to allow for implementation, including : to set up a public institution, as the authorized body to finance the health and drug care provided by the medical organizations in the Unified payer system from public budget funds and mandatory health insurance; to define the mandatory health insurance Programme including the scope and conditions for the provisions of medical services and drug supplies; to establish procedures and amount of the contributions. The implementation of the Health Insurance Law has been postponed to 2015.

Political changes, with the appointment of a new Minister of Health at the end of January 2008, have further increased the pressure to speed up health reforms. In 2007, a Health Policy Analysis Unit (HPAU) of the Ministry of Health was established to provide advice on policy development and to monitor and evaluate the reform. The HPAU has delivered a number of outputs including baseline and intermediate surveys to measure the impact of introduction of the BBP in June 2007.

The Government of Tajikistan is showing willingness to increase the health budget and based on Mid-Term Expenditure Framework (MTEF) data in the period 2008- 2011 the health care budget should reach around up to 2.2% of the GDP in 2011 (from 1.56% planned for 2008). However, the expected downward adjustment in the 2009-2011 State Budget due to already felt adverse impact of the global crisis might also affect the MoH resource envelope in the coming years.

Led by the Government with the support of a coordinated donor community, the process to develop a comprehensive Health Strategy for 2010-2020 has kicked off late 2008. Major policy objectives guiding the current Health Sector Strategy Development include:

i) Health financing reform, through the implementation of " Health Financing strategy for 2005-2015" (roll out of implementation of PHC per capita financing, case-based hospital financing and Basic

³ The Basic Benefit Package and Patient Financial Burden at the Hospital Level, An Intermediate Investigation, August 2008 (WHO, UNICEF) funded by SDC

Benefit Package, introduction of mandatory health insurance) and the introduction of the "Medium term expenditure framework" and output based budgeting;

ii) Strengthening the organizational development and management, optimization of the structure and network of health facilities through the implementation of the "Concept note on restructuring the hospital service";

iii) Reform of human resource policy including systematic training programme for human resources based on real needs, ensuring employment opportunities for graduates;

iv) Develop the early warning system to be used for emergency and epidemics situations;

v) Develop services on fighting diseases with social dimensions (study the cause of spread of multi-resistance forms of tuberculosis);

vi) Upgrade and develop technologies and procedures for the provision of medical care, as a result of increased efficiency of the performance of the primary health care facilities;

vii) Reform of the pharmaceutical policy, by allocating soft credits facilities for development of the pharmaceutical industry, strengthen capacity on drug quality control and fighting counterfeit medicines.

After fragmented project interventions in the past and various sub-strategies with very weak relation to the budget, donors and government have agreed to move towards a Sector Wide Approach (SWAp) in the health sector. This shift will require reinforcement of planning and management capacities in critical areas of the health system: comprehensive health strategy, sector budgeting and budget execution, information and monitoring.

It is planned that by end of 2009, the MOH will elaborate (i) the comprehensive health strategy (ii) an Action Plan to implement the strategy, (iii) a Framework for monitoring and evaluation (iv) a Capacity Development Action Plan and (v) Dissemination Plan for implementation of the strategy.

The strategy development Task Force (TF) is driven by a highly competent National Team Leader. Achievements so far include: draft of Conceptual Framework and Methodology for technical working groups (TWGs), agreed composition of the Steering Committee (SC) where the EU is represented among other 27 members, Draft SC statute, Action plan for the SC, the TF and the four TWGs; appointment of MoH representatives for the TWGs and development of ToRs for TWGs international and local experts. The TWGs will become fully operational end March 2009, when the first SC meeting is also planned.

The mechanisms for strategy development proposed by the Government with the support of donors allows for extensive participation of key national stakeholders at an early phase in the process which builds local ownership. The budget for strategy development amounts to almost 1 million USD and apart from donors' contributions (EU, SIDA, DFID, WHO, UNICEF, World Bank), the Government is also participating with financial and in-kind resources.

The Ministry Of Health recognizes that there is a vast need to improve capacities to effectively implement the comprehensive health strategy as of 2010 The MOH recognizes the importance of having a fully costed strategy that will allow reconciling the priorities with the available financial resources. There is a consensus among donors and government on the fact that without a proper costing, the strategy for health risks to become just another policy document with vague perspective for actual implementation. Donors and government see the benefits of the costing as it will allow allocating resources according to priorities and funding a financial gap by fully aligning to government priorities.

In order to conduct the costing of the strategy the MOH has requested the EU to support the Economic and Budget planning Division in performing this exercise. There is strong commitment of Division staff to shift from input-based budgeting to output-based budgeting operations. Capacity limitations have started to be addressed with the support of the EU MTEF project since mid 2008. Results achieved until now under his project include the development and endorsement of a training plan in areas of MTEF, budget preparation, budget setting, budget monitoring and control, health financing and strategic management. Also, the project supported the establishment and effective functioning of an MTEF Working Group since October 2008. This group is gradually acquiring the understanding of

MTEF philosophy, process and expected outcomes through on-the-job learning and participation in study tours and training activities. In January 2009, the Ministry of Finance (MoF) has requested EC support in conducting a mini-functional review of the departments in MOF and MOH dealing with budgeting operations. This is a positive step and the results of this assessment expected in March 2009 will allow developing a comprehensive plan to strengthen capacities in dealing with policy-based budget planning, implementation and monitoring. The costing of the strategy will be instrumental for the preparation of the MTEF for the 2011-2013 cycle and of annual budgets which will reflect the priorities identified in the health sector.

A proper costing and high quality MTEF depend on reliability, accuracy and timely data provided.

The Soviet system, on which the Tajik data-collection system is based, was primarily build to support the planning and control functions of the central Government in Moscow. The situation has improved with the new MOH leadership putting Health Management Information System (HMIS) on the reform agenda, reflected in a HMIS Strategy adopted for 2006-2010. The strategy with a strong focus on information and computer technology has been only partially implemented, mainly with the support of ADB Health Reform Support Project. The MOH is strongly committed to reform the current HMIS and recognizes that it is essential for the future definition and implementation of the performance framework in the sector, as well as for evidence-based policy making.

There has been no common methodology among stakeholders to conduct the HMIS strengthening. Several past HMIS reviews conducted mainly by WHO and ADB produced valuable results yet only with a narrow focus. The ongoing EU project (SSTA 2008) supports the Republican Centre of Medical Statistics and Information (RCMSI) of the MOH in conducting a comprehensive assessment by applying the WHO Health Metrics Network (HMN) and Standards. Main achievements of this project until now include clarified arrangements regarding lines of decision making for HMIS at the MOH, the establishment of the HMIS Task Force fully integrated in the mechanism for health strategy development and the endorsement and official MOH launching of HIS Assessment.

The joint MOH-EC-WHO workshop marking the start of the HIS Assessment conducted in March 2009 revealed a number of technical, institutional, data related and coordination issues that need to be addressed to improve the HMIS in the country. The needs identified by stakeholders include a better communication and coordination of activities among the main institutions involved in HIS, particularly State Statistical Committee (GosKomStat), RCMSI, the Sanitary and Epidemiological Service (SES) and the Office for vital registration (UAGS) under the Ministry of Justice. These institutions have worked until recently with the philosophy of a system which is driven by data and not by indicators but are now recognising the need to improving capacities to collect and comprehensively analyse the data to produce relevant information and to create a culture for evidence-based health related decision making. The HIS Assessment will contribute to strengthening country leadership and ownership of the system, and its results expected in June 2009 will allow redefining priorities and medium and long term directions in the HMIS.

In addition, the HIS local partners have expressed the urgent need to revise the routine data and rationalize the existing 834 indicators. The 37 reporting forms corresponding to more than 20.000 data elements and the 248 recording forms make the system highly inefficient. The system is mainly data led and not action led, implying that the focus is primarily on reporting for meeting the needs of the bureaucracy rather than on analysis and use of information for action.

Vital statistics (live births, deaths, fetal deaths) are a key input for policy making and planning of human development. UAGS considers important to improve the data collection system and recognizes that one of the biggest challenges is the weak level of public awareness as population is not aware about the obligation to declaring births and deaths.

At the moment there are 7 different HMIS software applications developed by RCMSI (1), ADB (1), World Bank (4) and USAID –funded ZdravPlus project (1), each of them with their own strengths and

weaknesses. ADB software has computerized the current 37 reporting paper forms but as the forms were not revised before computerization, the information produced does not effectively serve the real needs of the health care system. ADB project team explicitly acknowledged the flaws of this approach. Nevertheless, the results of the ADB project include high quality and flexible adaptation and localisation of DHIS2 software piloted in five *rayons*, provision of hardware and capacity development activities including study tours and training the health staff in operating the system.

The World Bank-SDC-SIDA funded Community and Basic Health Project (CBHP) has produced four software applications in the area of financing reforms, piloted in Sugd and Kathlon oblasts where hardware was as well procured, software installed to track the number of patient visits under the copayment reform (BBP) and health staff trained. ZdravPlus also has developed friendly-user software application for hospital payment with good results. Finally, RCMSI operates its own software developed by local consultant, however with low efficiency.

With several software applications currently operating in the country, the MOH recognizes the need to change towards either partial or full integration of current applications. Also, the MOH is willing to follow the recommendations from ADB report which calls, among others, for progressively moving from a "maximum" to "minimum" to "essential" data set and adapt the software application in line with data revision. It also calls for future investment in Information and Communication Technologies (ICT).

This project aims at supporting capacity development for further strengthening of the HMIS in accordance with HMN Framework and Standards in close collaboration with the existing health projects, targeting the four main institutions involved in data management: GosKomStat, RCMSI, SES and UAGS. There will be close coordination with the existing projects in line with the Paris Declaration on Aid Effectiveness and Accra Agenda.

2.2. Lessons learnt

The long term involvement of ADB in HMIS sector (2004-2009) has produced some important lessons to be taken on board when designing new operations: the need to fully revise the routine data before computerization of HMIS ; the need to share information and disseminate project results in a more effective way in order to avoid parallel system (in this case parallel software applications), the need to put health managers/workers in driving seat, but not IT; the need to build incentives which are linked to institutional changes in order to not only produce data but also meaningful information which can help shaping better decision making in health; the need to support HMIS with technology adapted to the local environment, by developing tools that can be easily learned and that are flexible enough to allow for adaptation to changes in coverage and output over time.

In particular, the ADB Review (January 2008) recommends a set of actions including: progressively moving from a maximum to a minimum and then essential data sets, build capacity including trainings for effectively strengthen the HMIS and hardware procurement and piloting of adapted software applications. These recommendations have been extensively discussed with the national stakeholders and will be supported by the EU project, ensuring close coordinating with other donors.

Also, scarcity of evidence based decision making is both a result of technical issues related to data generation and of institutional and behavioural barriers that impede the effective use of information. Both these aspects will be addressed by the EU project.

The World Bank will conduct an evaluation of the HMIS support for financing health strategy in May 2009 and results from this evaluation will be used when drafting the TOR.

Important lessons learned from the EU support to the costing of education strategy conducted in 2008 reveal: (i) the need to ensure that the strategy action plan is government-owned and (ii) the need to institutionalize the elaboration of the strategy and action plan by MoH. These lessons have been considered during the early phases of the health strategy development process.

The Review and Follow up of experiences (November 2007 - May 2008) conducted by the SDC funded SINO project shows that the low capabilities and capacity at local level to implement reforms requires an incremental approach to roll them out. Also there is a need for long term donor support in the sector to institutionalize behaviours and attitudes.

Previous experiences in supporting MTEF show that all too often external technical assistance projects have resulted in Ministries gaining various templates, models for forecasting and handbooks for costing but without the practical knowledge and experience of how to combine and apply these instruments effectively. Successful results are essentially about changing the way people think about public expenditure, how they do their day-to-day work tasks and the process through which decisions are made and implemented. As such, whilst it is important that the outputs are delivered to the highest possible quality, the Project team should spend considerable time in working with counterparts and stakeholders – the people who will conduct the costing and operate the MTEF and will ultimately be responsible for their effective and sustainable implementation.

2.3. Complementary actions

There is clear sequencing of EU activities planned in HMIS area. The ongoing project (SSTA 2008) supports the HIS assessment by applying the WHO HMN tool. The results expected by June 2009 will allow defining the long-term vision of HMIS. Another EU project starting fourth quarter of 2009 will support (i) the improvement of quality of routine data and rationalization of indicators, (ii) development of HMIS strategic plan for 2010-2020, and (iii) the development of a monitoring and evaluation framework for HMIS. By maintaining close contact with the other international agencies involved in HMIS, the project will ensure coordination to avoid duplication of activities and to build on already existing results.

Regarding the costing the health strategy, the EU is the only donor supporting the elaboration of a MTEF, which is closely linked to the exercise. Valuable inputs into the costing are expected to be derived from the World Bank funded National Health Accounts starting in May 2009 and the cost benefit analysis for youth friendly health services conducted by UNICEF in 2008.

Past, ongoing and pipe-line EU interventions complement this Support to the Health Sector Strategy .

EU ongoing Complementary actions		
Action Programme	Nature of assistance	Links to this Proposal
AAP 2006	<ul style="list-style-type: none"> • Support to PRSP monitoring focused on health and education 	<ul style="list-style-type: none"> • Development of performance monitoring framework for the sector, revision of health indicators included in PRS 2
AAP 2006	<ul style="list-style-type: none"> • Medium Term Expenditure Framework for Social Sectors 	<ul style="list-style-type: none"> • Strengthening the links between policies and budget allocations in health • Mini – functional review of budget departments at MOH and MOF • Coordinates for the costing exercise of the Action plan of the strategy
AAP 2006	<ul style="list-style-type: none"> • Public internal financial control and audit 	<ul style="list-style-type: none"> • Institutional Capacity development of the MOH – Financial control and internal audit
SSTA 2008 and AAP 2008	<ul style="list-style-type: none"> • Support to the Health Management Information System in Tajikistan 	<ul style="list-style-type: none"> • Development of phase 1 and 2 of the comprehensive plan to modernize the HMIS (based on Health Metrics Network methodology)
SSTA 2008	<ul style="list-style-type: none"> • TA support to the development of a comprehensive strategy in health sector 	<ul style="list-style-type: none"> • Development of the National Health strategy 2010-2020 and action plan 2010-2015

AAP 2007	• TA for SPSPS SP	• Introduction of new administrative classification of the budget
EU pipe line of complementary actions		
AAP 2009	• Strengthening the PFM and institutional capacities of the SPSP Social Protection	• Strengthening capacities of the MOH through the implementation of a comprehensive training plan (budgeting, strategic planning and management, human resources)

Other complementary actions funded by donors

Donor	PROJECT - Nature of assistance	Links to this Proposal
ADB	• HRSP – support to HMIS	<ul style="list-style-type: none"> • Development of software with good parameters that could be scaled up in other <i>rayons</i> • Capacity development for RCMSI and training for software users at rayon levels • Provision of ICT at rayon levels
World Bank SIDA SDC	<ul style="list-style-type: none"> • CBHP project – Implementing organizational and financing reforms in health sector – strengthening PHC management and financing (until March 2010) • CBHP project 	<ul style="list-style-type: none"> • Development of software in supporting health financing reforms and piloting it in Sughd and Khatlon <i>rayons</i> • Provision of ICT at rayon levels and MOH • Training activities and local consultant for RCMSI • Distribution of mini-ICD10 at oblast level (translation in Russian and tajik) • Support to National Health Accounts • Support to Health Policy Analysis Unit of MOH
USAID	• ZdravPlus	• Development of software for hospital management
UNICEF	• Cost and benefit analysis of youth friendly health services in Tajikistan	• Assess cost and benefits of operating YFHS sites that can be used as inputs into the costing exercise
SDC	• SINO Project	• Introduction of family medicine, BPP at rayon level

2.4. Donor coordination

Taking into account the number of donors involved in the health sector (about 30 donors funding 88 projects in 2007) and the scope and number of issues at stake, the MOH recognizes that reforms could not be implemented effectively without a consistent, integrated and sustainable government led coordination mechanism with the development partners.

On the ground there is currently a certain level of coordination and there is a growing consensus shared by the government and donors that the ongoing process for development of a national health strategy becomes a rally force for sector coordination. Lessons learned presented in recent study carried out by WHO in Tajikistan⁴ as part of the JCSS has revealed that it is much easier to coordinate

4 Improving Aid and Development cooperation in Tajikistan, a preliminary discussion to contribute to the JCSS, Javier Martinez, January 2009

around a strategy which is government –owned, as it is nowadays the case in the education sector. The recent actions carried out in the inception phase of health strategy development process have indeed confirmed this statement.

The Swiss Development Cooperation (SDC), leader of the Health Cluster group under the Donor Coordination Council and then the World Bank have supported the MOH in taking the lead in the early phase of the SWAp in health since 2008, with mixed results. The role of WHO in leading sector policy dialogue with the MOH and the Government has strengthened in the past months, being partly driven by the JCSS process. Regarding sector coordination, there are encouraging signs showing that the MOH is increasingly assuming the leading role. Since 2009, it leads monthly coordination meetings with donors which prove to be a good platform to discuss current challenges in the sector.

A Letter of Intent setting out the shared principle under the SWAp in health will be jointly signed in March 2009. Donors and MOH are in the process of discussing the most suitable mechanism for health sector coordination which will take into account the recommendation formulated under the WHO study.

With a number of donors pulling out of the sector (ADB, SIDA) and the continuous need to support the reforms, the EU role will become instrumental in supporting the government in implementing reforms in a more programmatic way.

In the HMIS area, the HMIS Working Group although formally established under the ADB project was revived at the start of the EU SSTA 2008 project, its work being fully integrated in the mechanisms for development of the health strategy.

There is a clear division of labour among donors (mainly ADB, USAID, World Bank) both in terms of geographical coverage and specific area of HMIS support. There are ongoing discussions about the future leading donor of the HMIS working group and the European Commission is ready to assume this role. The EU approach in HMIS is to offer support by applying the WHO Health Metrics Network and Standards, building on results and defining activities where complementarities and synergies with past and ongoing projects can be found. Considering that the country is drafting the next PRSP (2010-2012), this project will be instrumental in supporting definition of indicators that will allow a proper monitoring of reforms in the health sector. The ongoing PRSP Monitoring project will feed also into this process.

3. DESCRIPTION

3.1. Objectives

The **overall objective** of the project is to contribute to the improvement of the health status of the Tajik population, mainly the poor, through equitable utilisation of quality health services, particularly Primary Health Care.

The **purpose** of this project is to contribute to the development and implementation of the Health Strategy in Tajikistan.

A comprehensive Strategy will provide the basis for the Development of a Sector Programme and donor/ EU SPSP.

3.2. Expected results and main activities

This project has the following **expected results**:

Result 1: Based on the Health Metrics Network Framework and Standards, the HMIS will enable the Tajik authorities to follow up the objectives, outputs and outcomes as defined in the Health Strategy.

Result 2: Enhanced management and technical capacities of the MOH to complete and implement the health strategy including the costing of the strategy and development of various guidance documents.

The project should be seen as contributing to the foundations of Sector Wide Approach (SWAp) in health.

To reach the above results the project will have two components.

COMPONENT 1 (corresponding to Result 1): HMIS strengthening

The implementation of an HMIS aims to improve the ability to collect, store and analyse accurate health data. Implementation HMIS also aims to increase data accuracy and effectiveness of intervention, increase accountability, and improve tracking of health trends in the country.

HMN Framework identifies three phases: (1) Leadership and coordination strengthening, assessment of the HMIS; (2) Priority setting, planning and costing and (3) Implementation of health information strengthening activities. This project will strengthen capacities at the MoH in the implementation of phase 3, the first two phases being expected to be accomplished under the ongoing TA bridging contract (STTA 2008) and the project decided under AAP 2008.

The **main activities** will consist in supporting capacity development including through technical assistance:

- a) Support to compiling and reviewing of the legislation pertaining to health statistics;
- b) Develop and deliver training modules in data collection and analysis at republican, oblast, rayon and facility level;
- c) Training in computer and HIS software application use;
- d) Adapt the software application in line with the revised recording and reporting forms and rationalization of indicators;
- e) Install software applications at republican, oblast rayon, and facility level;
- f) Organise study tours and seminars to ensure that local partners have adequate skills and understanding of HMIS;
- g) Carry out actions to raise awareness about the need to disseminate and effectively use health related information;
- h) Support to development of incentives schemes for evidence based decision making in health;
- i) Procure, deliver, and install necessary network equipment and computers at republican, oblast and rayon level.

Specifications and locations for delivery of equipment will be agreed with the national counterparts based on needs and priorities and will be identified during the TOR formulation.

The TA will support the main beneficiaries Republican Centre of Medical Statistics and Information (RCMSI), State Statistical Committee (GosKomStat), Sanitary and Epidemiological Service (SES) and General Office of Civil Registration (UAGS) on a daily basis in their work so that transfer of knowledge is ensured.

COMPONENT 2 (corresponding to Result 2) with WHO: Capacity Development for finalization and implementation of health Strategy including support to health policy analysis and costing of strategy

This component aims at providing policy and institutional capacity support for the definition of health policies and implementation of the health strategy.

The **main activities** will consist in enhancing institutional capacity to implement the strategy:

- a) To build the institutional capacity of the Ministry of Health through technical assistance to finalise the strategy and assist in its implementation;
- b) To support the Drafting and finalization of the costed strategy;

c) To support the Ministry of Health in policy development and analysis and in preparation of implementing reforms

The consultants will be based in the MoH and will work closely with the staff of Economic planning and budget division, as well as with other sector policy departments at the MOH.

The costing methodology will be reviewed by the MTEF working group. The consultants will update the projections of fiscal space made available for health by basing themselves on the latest available macroeconomic and fiscal projections underpinning the PRSP, in order to determine (i) the part of expenditure health that can be supported out of domestic resources; (ii) the part that can be supported by mobilizing foreign resources in compliance with macroeconomic and financial constraints; (iii) foreign resources already earmarked, projects/ programmes in the pipeline of the donor community and residual financing gap. The mapping of health projects by donors compiled under the JCSS will provide valuable inputs. The costing exercise will identify resource gaps, and these may help in advocating for and identifying donor support in particular areas and will allow for a better division of labour among donors supporting the sector.

This Support to Health Sector Strategy will identify key counterparts, and will work with them on a day-to-day basis so that they are actively involved in all phases of the project. This enhances mutual learning and facilitates on-the-job training and knowledge transfer, building the capacity and understanding of the counterparts. For the project team this relationship will allow learning what is appropriate and works in Tajikistan, will help understanding background information or issues, as well as accessing the necessary people and data. The experts will explain and support new processes, concepts and techniques to relevant individual counterparts and stakeholders, using a range of techniques such as coaching, mentoring, on-the-job knowledge transfer, workshops, seminars and formal training.

3.3. Risks and assumptions

Assumptions

- The development of the National Health Strategy and Capacity Development Action plan will remain on track
- The other ministries (MoF, MoJ...) and agencies will support the process

Risks	Risk Mitigation Measures H: High, S: Substantial, M: Moderate, N: negligible or low	Risk Rating with Mitigation
<i>To Project's overall objective</i>		
Decreased level of commitment to the project development objective.	Strengthen and coordinate policy dialogue (shared action Government of Tajikistan-EU, other donors)	M
Public Administration Reform Strategy (2006) not implemented so far (limited capacities of institutions)	Strengthen and coordinate policy dialogue under the JCSS and provide all the necessary technical support	S
<i>To Component results</i>		
Delay in development and adoption of national health strategy	The European Commission has recruited TA for a key position in supporting the development of the health strategy; other donors speed up recruitments of remaining staff needed Donors keep the same level of commitment to supporting the development of the health strategy and the future SWAp	M

Risks	Risk Mitigation Measures H: High, S: Substantial, M: Moderate, N: negligible or low	Risk Rating with Mitigation
Delays in implementation of phase 1 and 2 under the HMIS development plan	Regular monitoring of ongoing HMIS project to ensure progress on track Contracting in time by the EU Delegation of new project under AAP2008 Donors support the government in the development of the health strategy which is crucial for formulating priorities, including HMIS	M
Sustaining skill levels in HMIS	A comprehensive training component is planned, including: courses and certifications in operating systems, databases, and networks; staff training on future system specifics; end-users training on future system; and seminars and study tours to ensure that staff have adequate skills and understanding of HMIS	M

Regarding sustainability, the project supports key health reforms which form an integral parts of the Government policy.

The technology to support the development of the HMIS will be adapted to the local environment, by developing tools that can be easily learned and that are flexible enough to allow for adaptation to changes in coverage and output over time. Implementation of the project components is institutionalized in the health departments and agencies that represent important players in within the Health sector (RCMSI, GosKomStat, SES, and UAGS). Such arrangements will provide for strengthening and maintaining adequate organizational capacity necessary to sustain immediate project outputs and to proceed with further developments in the sector as the national policies evolve.

3.4. Crosscutting Issues

This Project will contribute to the strengthening of good governance of the health sector. Governance rests on four pillars: (1) accountability: managers in the health sector will be accountable for public money used in the sector and for the results of spending it; (2) transparency: entails the low-cost access to relevant information, (3) predictability: results from laws and regulations that are clear, known and uniformly and effectively enforced and (4) participation: needed to supply information and to provide a reality check for the ministry's action.

This project will also support gender equity. Through the provision of reliable, gender sensitive and timely health data and statistics, health authorities will be able to adjust policies, make more effective financial allocations and take appropriate measures to address women and child health needs

3.5. Stakeholders

Despite substantial involvement of bilateral and multilateral donors, achieving sustainable progress in health is hindered by weak institutional capacity in key government institutions, including the health sector. Well qualified professionals in health area are scarce and low public sector salaries (head of department's monthly salary at MOH around 150 USD) provide little incentives for trained capacities to stay and new talents to join and develop careers in the civil service. This is a national problem and although a Reform of Public Administration has been initiated, with a Public Administration Strategy adopted in 2006, there have been delays in implementing it. Attraction and retention of qualified staff in both civil and public services is a significant obstacle to the implementation of system-wide reforms. In the process of JCSS, donors and government agree that civil service wages is an issue that needs to be addressed over a medium-to-long term. Already there have been some upward adjustments in salaries and some reforms of pay structures; however, further improving pay conditions will likely have lower priority in light of limited fiscal space in the coming years. Consequently, capacity to implement reforms will continue to be a challenge for Government and donors.

The **Target Groups** are: for component 1, the four national main institutions in the HIS involved in data management GosKomStat, RCMSI, SES and UAGS. They have limited capacities for planning, analysis data, data monitoring and coordination but show strong commitment to reforms. The same applies at the sub-national level (rayon and oblast levels); for component 2: the MOH Economic and Budget planning Division and the HPAU, responsible for drafting policy notes and budgeting sector priorities for submission to the Ministry of Finance; sector policy Departments of the MOH. Key representatives from these institutions will be involved from the early stages in project design in order to ensure ownership of project and later on sustainability of results.

Final beneficiaries are the Tajik population as a whole. The final users of the HMIS and beneficiaries of the national health strategy are the people of Tajikistan that will be able to rely on sound policy and strategic decisions taken by the National Health authorities that should prevent them to face the consequences of inefficient and ineffective health services.

Stakeholders at Republican level	Main role in the project	Interests in the project	Commitment to change	Capacity to change
Ministry of Health	Main producer but also the main user of health statistics to support policy formulation and execution. Main responsible for formulation of health strategy Main responsible for drafting policy notes and sector priorities and submission to the Ministry of Finance	High	Medium/ high	Low/Medium
The Republican Centre of Medical Health Statistics and Information (part of the MOH)	Responsible for collection, processing and transferring of information on population health status and health facility activities, and also for presenting state statistic reports on health care to State Statistics Committee of the Republic of Tajikistan.	High	High	Low
The State Statistical Committee of Tajik Republic (GosKomStat)	Central statistical office of the country. The statistics collected and disseminated by the GosKomStat are governed by the Law of the Tajik Republic on State Statistics • 431, dated May 15, 1997). GKS received administrative data on health care and illness, and provided by the Ministry of Health. GSK is directly involved in monitoring implementation of the PRSP and MDGs.	Medium	High	Medium
The Sanitary and Epidemiological Service (SES)	Important public health responsibilities that include monitoring of the quality of water and air, occupational health and safety, infectious disease prevention and outbreak control including communicable diseases surveillance and response at national level	High	High	Low/medium

The General Office of Civil Registration (Min of Justice) UAGS	Independent entity for civil registration activities, assisting with normative acts, responsible for collection of information on Birth, Death, Marriage, Divorce, Affiliation, Adoption, Changing of family first and patronymic name	High	High	Low/medium
--	--	------	------	------------

4. IMPLEMENTATION ISSUES

4.1. Method of implementation

Joint Management with an international organization through the signature of a Standard Contribution Agreement with WHO for component 2, as this renders the EU aid more effective and strengthens the EU policy dialogue in the sector.

A Standard Contribution Agreement with WHO will be signed by the European Commission.

For component 1, direct centralised management through the signature of a Financing Agreement with the Republic of Tajikistan. A Financing Agreement will be signed with the beneficiary government.

Technical assistance, supply of equipment, and evaluation and visibility contracts will be managed by the EU Delegation through the signature of contracts following calls for tenders and Framework contracts.

Technical Assistance (TA) will be located in the Ministry of Health to coordinate and implement the activities. The technical assistance team will work closely with the Budget and planning Division, sector policy departments, RCMSI, SES, UAGS, GosKomStat and the current EU health related projects and other donors.

4.2. Procurement procedures

Joint management with an international organization: All contracts implementing the action must be awarded and implemented in accordance with the procedures and standards documents laid down and published by the International Organization concerned.

Centralised management: All contracts implementing the action must be awarded and implemented in accordance with the procedures and standard documents laid down and published by the Commission for the implementation of external operations, in force at the time of the launch of the procedure in question.

Participation in the award of contracts for the present action shall be open to all natural and legal persons covered by the Regulation (EC) No 1905/2006 of the European Parliament and of the Council of 18 December 2006 on establishing a financing instrument for development co-operation (“DCI”). Further extensions of this participation to other natural or legal persons by the concerned authorising officer shall be subject to the conditions provided for in *articles 31(7) and (8) DCI*.

4.3. Budget and calendar

The total cost of the project is 5 000 000 EUR of which EU contribution is 5 000 000 EUR. The operational duration of this project will be 36 months as of the signature of the contract.

The indicative budget breakdown for this project is foreseen as follows (all amounts in EUR)

Category	EU funds	Government	Total	Contracting
----------	----------	------------	-------	-------------

Breakdown		Contribution (in-kind)*		/ Paying Authority
1. Services	3 750 000	38 000	3 750 000	European Commission
1.1 Technical assistance - component 1 (HMIS)	3 600 000	38 000	3 600 000	-
1.2 Monitoring and Evaluation	70 000	-	70 000	European Commission
1.3 Information and visibility	80 000		80 000	European Commission
2. Supplies (for component 1)	350 000	-	350 000	European Commission
2.1 Computers and network equipment	350 000		350 000	
3. Joint management – component 2	900 000	12 000	900 000	European Commission European Commission
3.1 Contribution Agreement with WHO	900 000	12 000	900 000	
TOTAL	5 000 000	50 000	5 000 000	

* Estimate of local contribution in terms of office spaces, running cost and payment of staff that will be participating in the project (UAGS, RMCSI, UAGS, GSK, MOH) both at national and sub-national level.

The Beneficiary will cover all salaries related to the participation of its staff during project implementation and will provide office space for the technical assistance provided by the EU.

Technical Assistance for component 1 will be financed through service contracts following call for tenders.

Component 2 will be financed through signature of a Contribution Agreement with WHO. Monitoring and Evaluation, as well as Information and Visibility activities will be contracted through framework contracts.

Supply of equipment under component 1 will be financed through supply contracts following call for tender.

4.4. Performance monitoring

For each component, the project will have a Steering Committee that will meet regularly to review progress and to ensure that project activities and results are on track and reflect the priorities of the

institutions concerned. It is recommended that the project makes use and involve already existing platforms (Steering Committees or Task Forces already established under ongoing EU interventions).

Regular monitoring will be a continuous process as part of the Commission's responsibilities. External monitoring (ROM) might be also carried out by independent consultants recruited directly by the Commission in accordance with EU rules and procedures on specifically established terms of reference. WHO has its own internal monitoring arrangements and the proposed arrangement is complementary to these arrangements.

A series of qualitative and quantitative performance indicators will be developed and included in the terms of reference.

4.5. Evaluation and audit

External evaluation as foreseen in the budget will, and audit may, be also carried out by independent consultants recruited directly by the Commission according to EU rules and procedures on specifically established terms of reference, as follows: a mid-term evaluation mission; a final evaluation, at the beginning of the closing phase, and possibly an ex-post evaluation.

External experts will be recruited by the European Commission through contracting of services using the framework contract procedures for evaluation.

4.6. Communication and visibility

A communication plan supporting the project objectives and activities will be developed by the contactor where the visibility of EU contribution to the programme will be ensured by the contactor according to the Commission visibility guidelines. The Guidelines cover the written and visual identity of the EU and are to be used in briefings, newsletters, press conferences, presentations, invitations, signs, commemorative plaques, etc.

An appropriate allocation is made in the project budget for visibility and awareness activities. Communication activities may include for instance events, publications, awareness raising campaigns, etc.

Logical Framework (OVIs to be refined during the formulation of the TORs)

Project description	Indicators	Source of verification	Assumptions
<p>Overall objective:</p> <p>To contribute to the improvement of the health status of the Tajik population, mainly the poor, through equitable utilisation of quality health services, particularly Primary Health Care.</p>	<p>Health related MDGs indicators</p> <p>MDGs 4, 5 and 6 (Targets set by the Tajik Authorities)</p>	<p>United Nations (WHO and UNDP 's reports)</p> <p>PRSP Monitoring report (Health Sector)</p> <p>National Statistics Committee's reports</p>	
<p>Specific objective:</p> <p>To contribute to the development and implementation of the Health Strategy in Tajikistan</p>	<p>National health strategy for 2010 – 2020 and Action Plan developed and approved by the Government of Tajukistan</p> <p>% of government and donors expenditure in line with priorities as defined in the national health strategy</p> <p>There is a national set of indicators with targets and annual reporting to inform annual health sector reviews and other planning cycles</p>	<p>Ministry of Health</p> <p>Republican Centre of Health Statistics and Information</p> <p>Sanitary and Epidemiological Services</p> <p>State Statistical Committee</p> <p>Monitoring and evaluation reports</p> <p>Review of annual health statistics report</p>	<p>The MoH is committed to change the health services delivery system</p> <p>The main stakeholders ensure an effective coordination both at the donors but also at the sector level (republican and local)</p>
<p>Expected result 1:</p> <p>Based on the Health Metrics Network Framework and Standards, the HMIS will enable the Tajik authorities to follow up the objectives, outputs and outcomes as defined in the Health Strategy</p>	<p>Health policy makers use complete, timely, accurate, relevant and validated HIS information for policy making</p> <p>Guidelines and tools for health data collection , analysis and diffusion of information are developed and implemented</p> <p>Number of new/revised legislative/normative acts related to HMIS</p> <p>Health information (population health status, health system, risk factors) is used in the planning and resources allocation processes (MTEF, health annual development plans)</p> <p>Health statistics published every 3-6 months following the reference period and</p>	<p>Ministry of Health</p> <p>Republican Centre of Health Statistics and Information</p> <p>Sanitary and Epidemiological Services</p> <p>State Statistical Committee</p> <p>Monitoring and evaluation reports</p>	<p>The MoH and the main stakeholders are effectively cooperating</p>

finalization of the costed strategy; c) To support the Ministry of Health in policy development and analysis and in preparation of implementing reforms.			
Evaluations		70,000 EUR	
Dissemination of project results and visibility		80,000 EUR	