

USAID FY 98 Matching Grant

Promoting Health Reform in Three Countries in Central and South Asia and East Africa through Institutional Capacity Building, Partnership Strengthening and Documenting and Disseminating Best Practices

FINAL EVALUATION

**Matching Grant Projects Implemented by the
Aga Khan Foundation
GORNO BADAKSHAN AUTONOMOUS OBLAST, TAJIKISTAN
October 1998 to September 2004**

(Cooperative Agreement Number: FAO-A-00-98-00078-00)

By

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Submitted November 2004

Acronyms and Meanings

ADB	Asia Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
AKF	Aga Khan Foundation
AK/DN	Aga Khan Development Network
AK/HS	Aga Khan Health Services
ARI	Acute Respiratory Infection
BCRR	Building Capacity through Restructuring and Reform Project
CD	Chief District Doctor
CHP	Community Health Promoter
DIP	Development Implementation Plan
DOH	Department of Health
ECHO	European Commission Humanitarian Office
EDL	Essential Drug List
ELC	Evaluation, Learning and Communications Department/AKF
FP	Family Planning
GBAO	Gorno-Badakshan Autonomous Oblast
GM&P	Growth Monitoring & Promotion
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
HNS	Health Nutrition Survey
HSR	Health Sector Reform
Hukumat	Government
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Disease
Jamoat	Sub-district government
MOF	Ministry of Finance
MOH	Ministry of Health
MSDSP	Mountain Societies Development Support Program
NGO	Nongovernmental Organization
ORS	Oral Rehydration Solution
OTC	Oblast Therapeutic Committee
PHC	Primary Health Care
PHC	Primary Health Care Management Advancement Program
PSF	Pharmaciens Sans Frontiere
PVC	Office of Private Voluntary Cooperation
RPPM	Rationalizing Pharmaceutical Policy and Management Project
RH/CS	Reproductive Health/Child Survival Project
RUD	Rational Use of Drugs
SDC	Swiss Agency for Development and Cooperation
SINO	Swiss Health Reform and Family Medicine Support Project
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VO	Village organizations
WHO	World Health Organization
WB	World Bank

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1.1. Evaluation Profile Sheet

- Aga Khan Foundation USA, C.A. Number: FAO-A-00-98-00078-00
- Gorno Badakshan Autonomous Oblast (GBO) is the site of the projects; The Department of Health (DOH) is the principal partner.
- Duration of Grant: October 1998 to September 2004
- Beneficiary Populations: 120,000 or 60% of the GBO population in 1998
- PVC-AKF match totals: \$ 3,604,100 (Tajikistan projects)
- PVC-AKF match funds disbursed to date: \$\$ 3, 603,934
- Date DIP first approved by PVC (no changes made to original DIP): 1998
- Evaluation Start Date and End Date: October 15 to November 30, 2004

1.2 Summary of conclusions and Recommendations

The goal of MG98 was to achieve a sustained improvement in the status of reproductive women and children under five years of age in Gorno-Badakhshan Autonomous Oblast (GBO), Tajikistan. The grant accomplished its goal in that the status of women and children has significantly improved; however, the program is not yet sustainable in its current stage of development. The oblast-wide PHC delivery system put in place to improve health status is operating effectively throughout the oblast. Yet, institutionalization and sustainability have not yet been achieved due, in part, to the lag in health sector reform.

The MG98 grant, in structuring together the simultaneous development of health sector reform, procurement and supply of essential drugs, and a system of PHC delivery throughout the oblast, has put in place accessible quality services to the rural population of GBO. Survey data and qualitative evaluation data validated significantly greater village level health promotion activity, improved health knowledge and practices of mothers, and decreased disease morbidity among children under five.

More specifically regarding MG98, affordable, quality pharmaceuticals are regularly accessible in six of seven district pharmacies and in all PHC facilities in every district in GBO. By 2004, mothers using modern contraceptives rose from 32% to 45% in six years with another nearly 46% (in 2004) wanting more children or currently breastfeeding. Only about 3.5% stated barriers such as a lack of knowledge about contraceptives, lack of qualified health staff, or expense as a deterrent to use. 98% of pregnant mothers confirmed receiving iron tablets. About 76% of mothers use ORS. Nearly 70% of mothers offered increased fluids during child illness such as diarrhea. Over 90% of children aged 6-59 months received micronutrients. The percent of children underweight for age dropped from 35% in 2001 to nearly 24% in 2004. 90% of children 12 to 23 months were vaccinated against six diseases before their first birthday. About 50% of women knew at least two ways to reduce the risk of HIV infection. There has been a gain in knowledge about the use of condoms to reduce the risk of STIs from 18% to nearly 41%.

A document of the World Bank, *The Republic of Tajikistan Health Sector Note*, June 2004, states, "It is encouraging to note thatGBO, one of the poorest regions in Tajikistan, has one of the lowest prevalence rates of acute child malnutrition and highest awareness levels of HIV/AIDS in comparison to other, better-off, regions. The relative success of GBO in these areas could be attributed in part to the high educational levels of its population as well as to active health promotion and community health activities

conducted in the region, and could serve as a model for other regions.” Not mentioned is that “the active health promotion and community health activities” are, for the most part if not entirely, that of the Aga Khan Foundation through MG98 and the Maternal and Child Nutrition Project.

Rationalizing Pharmaceutical Policy and Reform (RPPM), as stated above, laid the foundation for a regular supply of essential drugs to all PHC facilities in the oblast. Yearly workshops for pharmacists and PHC staff improve and reinforce medical knowledge, appropriate drug treatment practices, and rational use of drugs. Twice yearly monitoring of pharmacies and PHC facilities assures continuous supplies of drugs without shortages, adequacy of drug storage and of pharmaceutical knowledge, and appropriate handling and accountability of drug revenue. The subsidy for drugs has declined from 80% to 50% and will be soon reduced another 15 to 25%.

Key recommendations for RPPM include 1) reducing the subsidy further while monitoring the debt ratio to ensure affordability; 2) eliminating the district private sector pharmacists as monitors and distributors, and establishing a more viable pharmaceutical link to rural PHC facilities; 3) working with the MOH and OTC to streamline the exemption group, 4) working with MSDSP and the hukamat to formalize coverage for vulnerable groups at the village level through VO and jamoat budget support; 5) working more closely with the PSF/ECHO project in the development of the national drug procurement center in Duhambe that will serve the entire country (including Khatlon and Rasht), and 6) considering, in the absence of no DoH interest or infrastructure, the establishment of a non-profit NGO to institutionalize essential drug procurement and supply for the GBAO. (The current plan for the new national drug procurement system does not include a means for distributing drugs beyond the level of the oblast.)

The Reproductive Health and Child Survival (RH/CS) project developed and put in place a network, covering the entire oblast, of trained PHC staff, village health promoters, and their supervision and monitoring. Support included renovating facilities, and supplying equipment, commodities, and education materials. The selection and training of Village Organization (VO) Women’s Leaders to promote the Growth Monitoring and Promotion (GM&P) program and of Community Health Promoters (CHPs) to conduct village health promotion effectively provided the link between PHC service delivery and village ownership and responsibility for health.

Key recommendations for RH/CS include 1) streamlining village health promotion and support by collapsing the GMP and CHP into one position, and reducing quarterly supervision and monitoring visits; 2) consolidating and aggregating monitoring data within the RH/CS program, and adding utilization, morbidity, and mortality data to provide a basis for higher level analyses; 3) in adding Safe Motherhood and Integrated Management of Childhood Illnesses (IMCI) next year, assisting the oblast level “centers” toward better integration of their services to support the PHC program; 4) conducting research on the causes of high infant mortality in Murghab; 5) working with the DoH to institutionalize the RH/CS program by designating an office or position for coordinating the program at the oblast and at each district level; and 6) negotiating with the DoH to begin assuming the costs of the RH/CS program, which is becoming more feasible as the DoH budget increases annually.

The Building Capacity for Restructuring and Reform (BCRR) Project fulfilled its mandate to increase capacity in health sector reform (HSR) from the oblast DoH level through the

district to the village PHC level. Special studies, training courses and study visits served to introduce new concepts and improve awareness of HSR. Working with the DoH, a three year effort involving seven working groups, resulted in a Work Program for HSR 2003-2005 that was approved by the Governor of the GBAO. The project encountered constraints, such as the lack of a Director of the Department of Health for the greater part of a year during project implementation, the inability to obtain long-term technical assistance, and the reluctance of the DoH to appoint a fully staffed planning unit (OPU) with appropriate skills for HSR. In addition, there is pervasive reluctance to implementing HSR in the fear that rationalization of health resources will result in decreases in already under funded budget levels.

Key recommendations for BCRR include: 1) working with the DoH to strengthen the OPU with appropriately skilled and full-time staff; 2) providing hands-on-technical assistance to district HSR teams in the development and implementation of district rationalization plans; 3) facilitating a working relationship between the DoH OPU and the MOH Department of Coordination, Planning, and Implementation of Reform to keep abreast of the active reform efforts at the national level and to pilot or implement them in the GBAO, and 4) working with other international organizations, MoH, and DoH, obtain an understanding and written assurances from the MoF and MoE that budgets will not be reduced as a result of rationalization of resources at oblast and district levels.

Additional recommendations address issues that cut across the three MG98 grant projects:

- The projects need more coordination and integration of activities such as in M&E system development and coordinating village level health programs with Village Organizations (VO) and jamoats;
- Integration into one system aggregated utilization, morbidity, mortality, monitoring, and evaluation data to provide a foundation for higher level analyses, and, if feasible, institutionalize it within the DoH;
- Working with MSDSP, jamoat and VOs, formalize and coordinate RPPM and RH/CS village level activities. Areas needing coordination include 1) clarifying the working relationship between PHC staff, CHP, GMP, VO and VO health committee, 2) rendering transparent funding sources (VO and jamoat), 3) use of village funds for assisting vulnerable groups, and 4) providing oversight to PHC facility financial activities; and
- Institutionalize a means for documenting lessons learned and for sharing information with other organizations and partners.

In implementing this grant, there were considerable constraints to institutionalizing project activities and achieving sustainability: the economic crisis after the civil war, an entrenched hierarchical and centralized government structure, and very challenging geographical and communication obstacles. Change has been slow, yet progress with results was achieved. The capacity of the GBAO is strengthened and programs are working. Discontinuation of these programs now would abort the progress made. Positive spin-off effects have resulted in the transfer of workable ideas and concepts to other parts of Tajikistan. Development investments made in the GBAO have had positive repercussions not only for GBAO, but also for the rest of the country and can be expected to continue.

1.3 Evaluation Methodology

The evaluation was participatory and included AKF staff, partners, stakeholders, beneficiaries and two external consultants. The consultants conducted a document review that included survey data collected by AKF project staff. In GBAO a questionnaire was developed and translated into Russian. The questionnaire was used by two teams composed of AKF staff and consultants in conducting key informant interviews and focus group discussions with project staff, mothers and CHPs in three districts and in Khorog. Observations were noted and included in the qualitative data collection. From the data collected, the consultants and AKF staff drafted preliminary findings, strengths and challenges (conclusions), and draft recommendations. In a workshop setting, AKF staff, partners, stakeholders and the evaluation consultants collectively reviewed the data presented in the format noted above. Recommendations were finalized and are included in Annex A of this report. In Dushambe the consultants debriefed AKF/Dushambe and invited representatives from other NGOs and international organizations.

1.4 Program Background

The Aga Khan Foundation USA (AKF USA) was awarded by the Matching Grant Program of the Office of Private and Voluntary Cooperation Bureau for Democracy, Conflict and Humanitarian Assistance (DCHA/PVC of the United States Agency for International Development (USAID) a grant entitled, *Promoting Health Reform in Three Countries in Central And South Asia and East Africa through Institutional Capacity Building, Partnership Strengthening and Documenting and Disseminating Best Practices*. The initial grant period was five years (1998-2003). Three projects within the matching grant were implemented in the Gorno Badakshan Autonomous Oblast in the eastern region of Tajikistan. A no cost extension of one year was requested and approved in 2003 for the three Tajikistan projects under MG98, shifting their end-of-project dates to September 30, 2004.

A Brief History of the Projects

A former republic of the Soviet Union, Tajikistan gained its independence in 1991 after being under the Soviet mantle from 1865 to 1991, over 120 years. In 1917, after the Bolshevik revolution, Tajikistan attempted to break away but was defeated, and in 1924 was made an autonomous Soviet socialist republic within Uzbekistan. In 1929 Tajikistan won recognition as one of the independent Soviet socialist republics and maintained this status until it gained full independence from Russia in 1991.

Independence left Tajikistan with political instability and a severe economic crisis that limited its ability to adequately finance the country's social infrastructure, particularly the health sector. Within a year, in 1992, civil war broke out and engulfed the newly independent country until 1995 when there was a fragile cessation of the conflict. A peace agreement was not signed until 1997. Humanitarian assistance was needed and provided by the international donor community, including that of the Aga Khan Foundation beginning in 1993 in the GBAO.

The Gorno Badakshan Autonomous Oblast (GBAO) in the eastern mountainous region of Tajikistan had been historically governed directly from Moscow (bypassing the capital Dushambe). The Oblast included seven districts and the provincial capital Khorog. Vital

supplies for the Oblast, such as food, pharmaceuticals, fuel and fertilizers had been imported from Moscow before independence. At the time of independence, the oblast was entirely cut off and isolated from these vital resources. This isolation continued because of the war and the impassible roads between the Oblast and Tajikistan's capital Dushambe. In 1995, at the end of the major conflict, and no longer able to produce its own food, the survival of the approximately 214,000 population of the Oblast was at stake and in great need of humanitarian assistance

Starting in 1993 AKDN addressed immediate survival needs by delivering and distributing wheat flour and corn-soy blend, along with vital vitamins (A and D), edible oil and iodized salt and oil, largely financed and/or supplied by international donor agencies. During this time AKDN also established the Mountain Societies Development Program (MSDSP) to initiate measures to improve local food supply.

In 1996 AKF/USA received a 15 month grant from USAID's ENI/NIS/EHA for Rationalizing Pharmaceuticals Policy (RPP) in the GBAO. The objective of the grant was to facilitate a sustainable supply of essential drugs in two districts, and create a supportive environment for health sector reform. The grant was successful in introducing and obtaining acceptance of limiting drug procurement and distribution to a WHO approved Essential Drug List with related policies for rational prescribing of drugs.

Rationale for these projects

RPP grant was the precursor to MG98 and provided the foundation to continue efforts in GBAO health sector reform, including rationalizing a pharmaceutical policy and delivery system, and provision of primary health care to improve the status of women of reproductive age and children under five.

The country had essentially inherited an already neglected soviet-style authoritarian, centralized, hierarchical health infrastructure, which deteriorated further after independence. Health care facilities were run down and required rehabilitation; there were severe shortages of pharmaceuticals and medical equipment, and poorly trained health providers. These problems were particularly acute at the rural primary health care (PHC) centers.

The proportion of expenditures for health as a percentage of total government expenditures in the Oblast was about 17% in contrast with the 45% expended on education. DOH management style and resource allocation decisions reflected the focus on and centralization of resources in the more urban, higher cost specialized health care services. For example, in the Oblast hospital service expenditures ranged from about 60% to over 80% of all health care expenditures in most years, and about 35 to 40% of that was expended in Khorog where only a little over 11% of the Oblast population resided. Primary health care generally received only about 15 to 20% of total annual health expenditures. The very low budget levels (about 18%) expended on salaries was a major cause of widespread loss of medical staff from the health sector causing severe shortages of trained staff.

After 1980 mortality and morbidity increased in Tajikistan. For example, the infant mortality rate rose from 45.9 deaths per thousand in 1970 to more than 70 deaths per thousand in 2000. The 1996 and 1998 Health and Nutrition Surveys estimated vaccine coverage of only 60% of children. Neonatal tetanus vaccination was uncommon. Leading causes of child mortality were ARI (57%) and diarrheal diseases (17%), both of

which can be treated successfully and at low cost with adequate basic health care. Of recorded births, 57% took place at home and many unattended by a skilled medical attendant. The surveys showed that 30% of women in the GBAO had birth intervals of less than 18 months. Lack of family planning information and supplies was reflected in an estimated Total Fertility Rate of 4.1, one of the highest of the former Soviet republics.

MG98 was designed to address GBAO health sector reform, continued development of a non-profit pharmaceutical system, and the provision of quality PHC to women of reproductive age and children under five. See "Program Approach," Section 1.4.1, for design details.

Current Implementation Status

Matching Grant 98 was terminated on September 30, 2004, just prior to the final evaluation of this grant. Activities initiated under this grant continue largely due to the largesse of the Aga Khan and some short-term funding available through the Swiss Agency for Development and Cooperation (SDC).

AKF's health development plans after MG98

With the completion of MG98, the Aga Khan Development Network (AKDN) will enter Phase II of its health program. Two of the projects funded by MG98, RPPM and RH/CS, will be folded into Aga Khan Health Service (AKHS) and be continued for the unforeseeable future. The BCRR will remain within AKF. AK/DN plans to consolidate its health program and expand it into two additional areas (Rasht and Khatlon) of Tajikistan.

The focus will be primarily at the district level where it will continue its community health initiatives, including essential drug supply with emphasis on rational use, the successful community health promoter (CHP) program, and the training and monitoring of Department of Health (DOH) primary health care (PHC) staff. Future activities include a particular emphasis on Integrated Management of Childhood Illness (IMCI) and Safe Motherhood. Health Promotion and Training Units (HPTU) will be developed to increase and maintain the competence and confidence of those working to address health needs, e.g., staff in PHC facilities and CHPs. Systematic data collection and analysis will continue and, in addition, a program of research is planned to identify the key constraints to enhancing effectiveness and impact within the health system.

1.5 Program Effectiveness

1.5.1 Program Approach

The goal of the FY 98 matching grant (MG98) was to achieve sustainable improvements in the health status of women and children in South and Central Asia and East Africa. To accomplish this goal, the Tajikistan projects sought to:

- Introduce or refine policies that increase efficiency, effectiveness and sustainability of basic health services;
- Enhance prospects for sustainable financing of basic health services at the local or regional level; and
- Improve the accessibility, quality and equity of basic health services.

The three projects contributed to the above identified overall goals by seeking to achieve the following objectives:

- Through implementation of the Building Capacity for Restructuring and Reforming the Health Sector (BCRR) project, strengthen the capacity of the Department of Health (DOH), the government body responsible for health policy in the Oblast, to coordinate Oblast health sector reform.
- Through implementation of the Rationalizing Pharmaceutical Policies, Practices and Management (RPPM) project, build on previous achievements (with Swiss funding) to ensure involvement of communities in financing and managing their pharmaceutical needs and transform Tajikfarmatsia, a state-owned entity, into a private, not-for-profit organization to manage the procurement of pharmaceuticals.
- Through implementation of the Reproductive Health, Family Planning, and Child Survival (RH/CS) project, builds private sector capability to provide a package of essential services to women and children under 5 and introduce management practices to improve efficiency, effectiveness and responsiveness to the needs of the community.

The projects were designed as the country was coming out of a civil war. It was difficult to take a true pulse of government and health ministry thinking and perspectives at that time. Though the projects did not always progress as planned, the original approach provided a road map. Perhaps underestimated was the resistance to change, the difficulty of moving projects ahead in winter months on impassable roads and no to unreliable communication systems, lack of appropriately skilled local staff, and the difficulty in obtaining expatriate technical assistance.

RS/CS lagged behind initially, in part, for many of the above reasons, and did not really take off until the arrival of the Maternal and Child Nutrition Project (MCN/IC). Combined with the staff and funding provided by the MCN/IC project, the two projects synergistically, in the last three years, made a significant impact on the status of reproductive women and children under five years in the GBAO.

1.5.2 Achievement of Objectives

The evaluation teams made field visits into three of seven districts in GBAO and within Khorog town. Interviews and focus groups were conducted at all levels of the districts. The observed strengths and weaknesses of project activities were noted and organized into the tables found in Annex A. These tables show the findings, conclusions (strengths and weaknesses), and recommendations made by the evaluation teams and other project staff. They were finalized at the workshop attended by AKF project staff and partners.

Summary of DIP Results Status

See Annex B

Impact of projects on the target population

Putting aside statistics (contained in Annex B), one can only be impressed, from visiting and interviewing people and DoH staff in villages and towns, by the impact of MG98 projects and the MCN/IC project as they worked in tandem. With the exception of one

district central pharmacy, central pharmacies and PHC facilities visited were all supplied with low cost, high quality essential drugs. Pharmacy drug debts were at a minimum suggesting financial and geographical access to pharmaceuticals (with a 50% subsidy).

The evaluation teams conducted interviews and focus groups with mothers, community health promoters (CHPs), VO head of women leaders (who do growth monitoring and nutrition education -- GM&P), and village organization leaders. There was enthusiasm and appreciation for the health promotion activities in their respective town or village. Mothers responded accurately when asked about what they learned and how they behave differently as a result of health promotion activities in their communities. CHPs and GMPs were clearly enthusiastic and well trained. This was evident by their responses to interview questions and the responses given by mothers when asked what they had learned from the CHPs and GMPs.

When asked about change in their communities, those interviewed repeatedly commented on a cleaner environment, construction of toilets, fewer cases of diarrhea, and healthier children. There is clearly a value on education in the GBAO where the population is literate. The investment in health education and promotion has been rewarded by their deep appreciation for learning and the capacity of the Pamiri people to absorb and use it.

The Health and Nutrition Surveys (HNS) and the annual LQAS surveys show health behavior improvements and high target population access to micronutrients, FP services and contraceptives, STI services (and more recently HIV/AIDS services), ORS, and immunization. Refer to DIP Results Status, Annex B.

Impact of projects on strengthening DOH capacity to deliver sustainable services

a. RH/CS

The DoH has primary responsibility for PHC. Also, there are other key players involved in implementing and supporting health promotion activities at the community level. This project has demonstrated the important role of the CHP and GMP. Without their involvement, health knowledge and practices, i.e. behavior change, would not have been as effective. In addition, it appears, from site visits and interviews, that the Village Organization (VO) health committees could potentially be playing a larger role in supporting the PHC worker, CHP and GMP, as well as vulnerable groups in the community. All contribute to the delivery of sustainable health care and promotion activities in the community.

Selected Oblast DoH staff received Training of Trainers (TOT) training and worked with RH/CS staff in the training of District Monitors, DMs, CHPs, and GMPs. The evaluation teams interviewed DMs who are DoH district doctors, nurses and midwives. Trained by the project in supervision and monitoring, they visit the PHC facilities and village CHPs and GMPs to provide professional support needed to ensure continuous quality care and health promotion. With their involvement, the DoH is able to reach and engage in the rural areas and provide support to PHC facilities that was not previously available after the soviets left. Other district DoH physicians often ride with the DMs to provide medical care to remote villages, as was the practice in the Russian era. PHC workers are no longer isolated and left on their own without equipment, drugs and up-dated primary health care skills and knowledge. It was clear that the PHC staff knew their DoH/DM and project RH/CS staff/trainers well.

At the oblast level, staffs from the specialty centers (reproductive health, childhood diarrhea, nutrition, acute respiratory infection, and healthy life-styles) are involved in a vertical fashion and need to be more integrated. As the RH/CS program, working with these DoH centers, moves into strengthening its Safe Motherhood program and developing an Integrated Management of Childhood Illness (IMCI) program, there will also be an effort to more closely integrate these vertical programs. In addition, free supplies from these centers provided by UNFPA, UNICEF and others are not always regularly available. RH/CS is working closely with these centers and international organizations to resolve the problem of irregular supplies to PHC facilities.

The evaluation teams interviewed district chief doctors, hukumat (district government) officials, jamoat (sub-district government) officials, and village leaders who are appointed by the jamoat. For the most part, the chief doctors were supportive and work cooperatively with the MG98 projects. One newly appointed chief doctor tracked training and monitoring in his district, but was not supportive of the CHP concept. In contrast, another chief doctor who had worked with the project since its inception was implementing many of the initiatives introduced by the project, and very actively supporting GMPs, CHPs and DMs in her district.

Government officials appeared to be less knowledgeable about the project at higher district levels and more knowledgeable closer to the villages. All showed interest in wanting to know more and some wanted more involvement. As one jamoat official put it, "I have authority and I could help if asked." At the village level, the local jamoat budget contains the health budget for PHC facility salaries, some drugs, fuel, soap supplies and stationary. With the exception of their salaries, many PHC staffs do not know about the other budget line items and do not seek out this budget support for their facility.

Informally most village organizations (VOs) support health activities in the village, particularly by paying for vulnerable groups who cannot pay for their drugs and paying for transport for those needing higher levels of care. Each VO has a health committee comprised of the PHC worker and one or two others, including at times the CHP. The potential of these health committees to mobilize the village or town in support of health promotion has not been uniformly tapped. The VO health committee, including the VO accountant and not including the PHC worker, could provide oversight of the drug supplies received, revenues collected, and revenues returned to the oblast level. In addition the VO health committee could be responsible for ensuring maintenance of the PHC facility. The facility needs to be "owned" by the community to ensure its maintenance over time.

While the DoH has the primary responsibility to deliver sustainable PHC services, it is also the community's responsibility to support its PHC facility and the health promotion activities of the village CHP, GMP, and PHC worker. The VO and jamoat could potentially be supporting players if each of the above understood its respective role and responsibilities and all are supported in developing a working relationship to improve the health environment and status of the community.

b. RPPM

There is currently no DoH capacity in the procurement and supply of essential drugs. The DoH no longer has the pharmacists or infrastructure for supply and distribution of pharmaceuticals since the privatization of the oblast central pharmacy (TajikFarmatsia) and district pharmacies several years ago. The only provision of essential drugs for

PHC is provided by the RPPM project for the entire oblast. The DoH is said to prefer a for-profit pharmaceutical system, which would create a problem of financial inaccessibility to a significant proportion of the population. The Director of the DoH stated in an interview that he does not want the AKF pharmaceutical model in the DoH. He prefers to have the AKF pharmaceutical system in competition with the increasingly available low quality private source drugs. Currently, there is no quality control of these low quality private source drugs.

At the district level, PRRM uses the privatized district pharmacies to sell RPPM essential drugs. These pharmacies are also selling private source drugs that are of low quality and high cost. The incentive is to sell the private source drugs because they sell at higher prices. As a result there has developed, with the growing availability of private source drugs, an inherent conflict-of-interest situation at the district private pharmacies.

Though the subsidy continues to decline and people are increasingly able to pay for essential drugs, the structure for drug distribution needs to be redesigned out of the hands of the private, for-profit pharmacists who are also currently the district monitors. The drug market is, indeed, operating in a competitive environment. With increasing availability of private source drugs, physician prescription of private source drugs, and a tendency to self-medicate, it is becoming increasingly harder to encourage sole use and rational use of generic essential drugs. To be financially sustainable there has to be an appreciable demand for essential drugs. It may now be time for RPPM to explore social marketing concepts to more aggressively sell essential drugs and for maintaining rational use practices. In addition, it may be necessary to train oblast physicians in hospitals about essential drugs and rational use concepts to mitigate the backward sliding in rational use and offset the sale of low quality private source drugs.

The MOH in Dushambe and ADB/PSF/ECHO are developing a national non-profit essential drug procurement center. GBAO is designated to have one of only three oblast drug warehouses to be developed under that project. Once delivered to the GBAO, districts, including PHC facilities, are expected to pick up their supply of pharmaceuticals from the oblast warehouse twice a year, i.e., there is currently no plan for a MoH organized distribution system once delivered to the oblast level. If and until this project is successfully implemented and if and until the DoH health budget is augmented, it is unlikely the DoH will develop its own capacity for managing an oblast pharmaceutical distribution system, particularly a non-profit, corrupt-free system.

At the same time, SDC and the World Bank, working with the MOH, are designing a “benefit package” for the delivery of health care that will be piloted in two districts. The design includes the provision of free services and drugs at the primary health care level. To-date the MoH financial system is not in place to implement this package. It will be important for AKF to follow these pilots closely to determine the implications of this project on its own pharmaceutical model. (It should be noted that the PSF technical advisor to the national drug procurement center project thinks the law will change and allow payment for essential drugs within the next two to three years.)

c. BCRR

The focus of the Building Capacity for Restructuring and Reform project was to build DoH capacity for health sector reform. Trainings, study visits, and special studies were provided to DoH staff at the oblast and district levels. A three-year effort resulted in the development of a “Health Sector Reform Programme of Work 2003-2005. This involved

at least seven working groups. Three-day planning and management workshops were conducted for PHC workers in rural areas. In April 2004 a planning unit was opened within the DoH with a three-person staff.

Capacity building was successfully addressed given the inability to attract long-term technical assistance through out the life of the project. The capacity to implement HSR has yet to be developed, partly as a result of the need for additional technical assistance, and partly from a perceived lack of political will.

The newly created planning unit in April 2004 is not complying with the stipulations of the grant letter between the oblast hukumat and AKF. One room was devoted to the new unit, rather than three. Justifications for funds expended and required reports are not forthcoming or on time.

An interview with the planning unit staff indicated 1) the staff were all employed 100% in other jobs within the DoH system, 2) only one of the three has some analytical skills, 3) there was no real understanding about the function and role of the planning unit, and 4) a general belief that HSR required a higher budget level and “we can’t do anything until the MOH tells us to.” Also, unspoken but present, was the concern that implementing rationalization of health resources meant losing budget levels, and, if there are cost savings, losing those savings from the oblast or district level at which they accrued. Also operating in the background is concern that rationalization would disturb the current hierarchical structure and all the formal and informal relationships associated with it.

The impression is that, because of the above, there is a pervasive inertia against moving HSR forward in the oblast. At this time the DoH does not appear to have the political will or vision to initiate HSR and the newly staffed OPU does not have the capacity to implement it. Project inputs are readily accepted by the DoH, but outputs and results are not likely to occur in a timely fashion unless some of the above identified concerns are addressed.

At the district level one newly appointed chief doctor interviewed was not as “on board” as those who had worked with the project over the LOP. The new chief doctor was not focusing on district level health sector reform activities, such as developing a plan for rationalizing health resources in the district. In contrast, another chief doctor, who had worked with the project since its inception, was implementing many of the HSR initiatives introduced by the project, and had developed and was implementing a plan for rationalizing health resources within the district. The range of involvement varied and suggests that BCRR initiatives needs to be more actively involved at the district level with chief and deputy chief doctors and other district staff involved in HSR.

AKF, via the BCRR project, has made HSR concepts known throughout the GBAO at every level down to the PHC worker. A foundation has been laid for change. Eventual institutionalization and sustainability of grant funded PHC activities will depend, to some extent, on reform. Until there is change, there will continue to be an irrational distribution of health resources in the GBAO. Funds permitting, it is recommended that AKF continue its HSR efforts with a focus on 1) addressing the operating beliefs that impede HSR, and 2) directing technical assistance to the district level for development and implementation of rationalization plans.

It is recommended that, working with WHO, ADB, World Bank, SDC and other partners involved in HSR at the national level, AKF encourage and facilitate a process of obtaining an agreement with the MOH, MOF, and MOE that oblast and district budget levels will not be decreased as a result of rationalizing health resources or from any cost savings that may result from rationalization.

At the district level, funds permitting, AKF support hands-on technical assistance for the development of rationalization plans and their implementation. A case study of a successful district to show that rationalization does not require higher budget levels could be developed and shared with other districts and at the national level.

It is questionable that the DoH planning unit, as currently staffed, will have the capacity to lead HSR in the oblast. If its composition can be changed, its new staff may need training in analytical and planning skills and knowledge, as well as a good understanding of its role and function within the DoH.

At present there is no working relationship between the MOH Department of Coordination, Planning and Implementation of Reform and the GBAO DoH planning unit. AKF could facilitate such a relationship by conducting a workshop between the two departments to 1) clarify roles, responsibilities, and functions, 2) develop channels of communication, 3) identify and resolve the roadblocks to HSR, 4) involve the DoH planning unit in national level HSR, and encourage the DoH to move forward in its HSR initiatives. See Annex A, BCRR table, for additional recommendations.

Unintended impacts to date, positive or negative

- CHPs, GMPs and PHC workers were encouraged to work together, but were not given training in how to do that. In some villages and towns, the evaluation teams observed what appeared to be genuine team work among these workers. In one district town the DM worked closely with the CHPs and GMPs in conducting health promotion activities. In addition, some VOs were supporting the CHP, GMP and PHC worker by helping to mobilize the community for health promotion activities.
- There has been some return to the old soviet system of doctors visiting rural areas to provide care. With the availability of vehicles and fuel supported by the project for DMs to conduct monitoring visits, district doctors are able to accompany them and, once again, to travel to rural areas to treat the ill.
- The focus on improving the status of reproductive women and children, is having a positive impact on improving the health of the community as a whole, including members of all ages and of both sexes.
- Unfortunately the MOH often neglects or discriminates against the GBAO because there is a prevailing assumption that the Aga Khan programs can be counted on to take care of the GBAO health problems and needs.
- Initially it was the intention of the RPPM project to transform the DoH TajikFarmatsia into a non-profit entity for pharmaceutical procurement and distribution for the oblast. Unforeseen was the privatization of TajikFarmatsia, which, now in private hands, only operates in Khorog and has one branch in another district. As a result, the distribution of essential drugs to all PHC facilities in every district is now totally dependent on the RPPM project.
- Ministry and Department of Health staff salaries are so low that one can not survive on salary alone. As a result there is low motivation and productivity. AKF has had to provide increments to salaries and *per diems* to encourage DoH staff to take on additional responsibilities and participate in project health promotion and support

activities. This practice had resulted in DoH staff expectations that additional work, particularly working with AKF projects, means one should receive a financial incentive. The incentives are necessary now; however, are they setting a negative precedent for the future when salaries are higher and there will be no Aga Khan programs?

Summary of mid-term evaluation results

BCRR:

Findings: AKF has done an excellent job in making the reform effort in GBAO transparent and participatory. Publication of the *Bulletin* kept health professionals informed on what is happening in the health sector.

Recommendations	AKF Staff Response	Evaluator's Response
(1) Address the extremely low salaries paid health workers through discussions with the DOH to reallocate a higher proportion of the health budget to salaries.	Discussions were held and GB/AO DoH cannot make salary reallocations as this is done at the central level.	At the MoH and DoH levels, a decision has been made to raise PHC worker salaries slightly next year.
(2) Develop ways for community members to pay for a portion of their health services.	VO health committees could collect funds to pay for health services. This discussion is in process.	Currently, the law stipulates that health care is free. Informally patients already pay a fee or in-kind for hospital services and for care received from a provider.
3) Study the experience in two districts given greater authority with their health budgets to determine what lessons were learned, to ascertain if performance improved, what is needed to improve the situation in the future and how it can be replicated in other districts of the oblast.	The Evaluation, Learning, and Communications Department conducted the study, which showed that the initiative had advantages and disadvantages. The report is available.	The report is inconclusive and did not clearly define or summarize what was learned. It is not ready to be shared with others.
(4) AKF can do more to document lessons learned and best practices in the area of health reform.	No response	This has not been accomplished and is still needed.

RPPM:

Findings: AKF successfully changed the way DOH health workers prescribe medicines by reducing the number of drugs prescribed, reducing the number of antibiotics prescribed and inappropriate treatment. Almost 90% of drugs prescribed are now from the EDL, and the AKF subsidy for drugs had been reduced from 80% to 65%. IV Fluid production was making a profit.

Recommendations	AKF Staff Response	Evaluator's Response
1) Provide technical assistance to determine the cost-effectiveness of bringing the laboratory's quality assurance up to WHO standards so its market can be expanded.	The IV fluids lab has been privatized and is currently seeking external funding.	The lab was brought up to WHO standards, but is now privately owned.
(2) AKF and DOH determine as soon as possible how the pharmaceutical fund (recovered cost of drugs) is going to be used.	A proportion of the revolving fund was used to purchase drugs but only received a 25% payback.	The fund is slowly accumulating and will be used to purchase drugs when the revolving fund is covering costs and there is no longer donor support.
(3) AKF develop a plan on how to institutionalize access to pharmaceuticals.	It is believed the HHCES study did not access the real capability of people to pay for pharmaceuticals.	The subsidy continues to be reduced and will likely reach 25% (from 50%) in the near future.
(4) AKF select one person from RPPM program to be sent and trained in forecasting, procurement and inventory control of pharmaceuticals.	Did not take place due to a lack of funding.	Better English language ability is needed to successfully complete such training.

RHCS

Findings: The Growth and Monitoring Program (GM&P) was successfully launched in one district. The 2001 HNS identified positive trends directly related to AKF interventions, such as increased contraceptive use, ante-natal care, exclusive breastfeeding, and immunization coverage; decreased prevalence of low birth weight, iron deficiency anemia among women and children, iodine deficiency and Vitamin D deficiency. Also noted was the growing percentage of deliveries made at home, a more than 50% increase in the infant mortality rate, and increases in the prevalence of acute malnutrition (moderate and severe wasting and underweight). Almost half of infants die in the first month of life.

Recommendations	AKF Staff Response	Evaluator's Response
(1) Verify the accuracy of the data, and if found accurate, the causes of infant death be determined and addressed.	No response	Almost half of infant deaths occur in one district (Murghab).
(2) Take more action to improve the water and sanitation situation in the Oblast, such as	The CHP program provides health education regarding water and sanitation to the communities.	Communities have worked with MSDSP and other donors to build wells and latrines.

collaborating with MSDSP in developing and implementing a water and sanitation component.		
(3) As a priority, recruit a replacement nutritionist to lead the GM&P into the other districts.	An expatriate nutrition consultant was recruited to work with local Community Nutrition Officer for a short period.	The GM&P has moved into all the districts and currently has a strong nutrition component.
(4) Continue to place special emphasis on behavior change communications in the health, water and sanitation and nutrition.	This is currently being done with the CHPs and the IEC materials are being delivered. The project has also begun an anti-helminthe campaign in the communities.	There was evidence that this occurred from the interviews conducted by the evaluation teams.
(5) Take special efforts to empower communities by using proven methodologies as Participatory Learning for Action, Participatory Rapid Appraisal or the Triple A approach.	No response.	Community empowerment per se has not been the focus of the project. It has been on mobilizing for health promotion only and involved participatory learning techniques such as role playing, etc.
(6) AKF consider adding a community empowerment specialist to the staff to oversee development and capacity building of health committees in the VOs.	CHPs will be the community empowerment specialists.	CHPs have proven to be successful in mobilizing for health promotion, but have not been involved in developing the VO health committees.
(7) A senior AKF health manager together with local Community Organization specialist visit several countries where AKDN has successfully utilized community empowerment techniques.	AKF project managers visited Pakistan for a study visit in the AKDN working area.	
(8) Add a question to the HHCES to determine if non-contracepting women would use a modern method of contraception if it were available at no cost. The findings should be a basis for a review of the contraceptive pricing policy.	No response	The 2004 HNS showed 1.4% of reproductive age women citing expense as a deterrent to using contraceptives. The household expenditure survey had problems and was to be conducted again, but this has not occurred to-date.

(9) Improve quality of home deliveries by working with the DOH to review TBA training and explore ways to strengthen it.	The project would like to introduce the Life Savings Skills program developed by the American College of Nurses and Midwives. (ACNM), which includes Safe Motherhood.	The project will focus more intently on safe motherhood in the coming year.
(10) Give a high dose vitamin A supplement to every post-partum mother.	Vitamin A is currently being given to mothers after delivery.	In the 2004 HNS, 39.8% of mothers received Vitamin A within 40 days of delivery.

Cross-cutting/Management Issues

Findings: In capacity building, AKF has upgraded pedagogical methodologies and techniques, such as introducing participatory training techniques. AKF also worked with counterparts in developing a management course for chief doctors and their managers at the Public Health Institute, and also strengthening nurse training at the nursing school.

Recommendations	AKF Staff Response	Evaluator's Response
(1) The Health Program director hold biweekly meetings of the project heads to discuss what has taken place, problems and plans for the next two weeks.	The program has weekly meetings with all project managers. They include discussions of work plans for the next year, and sharing info regarding meetings with DoH .	The Health Program Director is located in Dushambe; however, with the end of the project, these activities will be folded into AK/HS under a new director.
(2) Make greater effort to document lessons learned and best practices so that they can be shared within the AKF network and other regions of Tajikistan.	The ELC Unit of AKF will help the project in this process. The project does not feel that a local person needs to be hired to do this.	This continues to be a problem and was not adequately addressed during the life of the project.
(3) AKF apply for a one year no cost extension.	AKF applied for the one year no cost extension. It was approved by USAID.	

1.5.3 Cross-cutting Issues

Partnerships

AKF has worked collaboratively and closely with the DoH in health sector reform, pharmaceutical supply and distribution, and in developing a strong RH/CS program at the PHC level. For example:

- A three-year effort with the DoH, involving eight working groups, resulted in an approved Work Program for Health Sector Reform 2003-2005.
- The establishment of the Oblast Therapeutic Committee (OTC), chaired by the Deputy Director of the DoH, has resulted in a close working relationship between the RPPM project and the DoH. All RPPM project activities are known to the DoH through this committee.

- RH/CS project staff work with district chief doctors in coordinating its training programs for all DoH staff at the district level, and ensures chief doctor receipt of all data collected within the district.
- As part of BCRR, a joint annual exercise has been carried out in the last two years to bring all stakeholders in the oblast together to plan PHC health topic-specific activities and define roles and responsibilities.

With the assignment of the Health Program Director to Dushambe, AKF is better able to collaborate and coordinate with other NGOs and international organizations represented at the national level. Such collaboration is going on, for example, with Project Hope regarding tuberculosis, with the SINO/World Bank project regarding HSR, and UNICEF regarding the CHP and GM&P programs. Because so much is occurring now with the entry of ADB into HSR and ADB/ECHO/PSF into pharmaceutical systems development, it will be a challenge for the Health Program Director to keep abreast of all of these and other new initiatives.

New national level policies are being formulated, tested and even legislated in HSR and pharmaceutical systems development. These areas are very important to the future direction of the Aga Khan health program in Tajikistan, especially in the area of financing health care. It is suggested that in addition to the Health Program Director's presence in Dushambe, the HSR and RPPM project managers make a greater effort to keep abreast of national level initiatives by visiting and engaging more often with their work-relevant partners in Dushambe. While the GBAO has been a leader in HSR and pharmaceutical procurement and supply, national level initiatives are quickly over taking the GBAO.

Both MOH and DoH planning units are relatively new as of this year and are just beginning to define their roles and responsibilities. With so much taking place in HSR with the involvement of the World Bank, ADB, WHO, and SDC (Agency for Swiss Development and Cooperation), the GBAO DoH planning unit will need to work closely with the MOH planning unit to stay abreast and current. In addition some pressure from the MOH on the DOH planning unit to implement HSR would be of assistance. This working relationship does not currently exist and could be facilitated by AKF to guide and inform future HSR in the GBAO.

As stated above, RH/CS has worked closely with the DoH in linking the oblast, district, sub-district and village levels in support of PHC. The system is in place and working; however, there is need for progress in institutionalizing the program within the DoH. What is missing is 1) a designated DoH position at the oblast level and in each district to coordinate this program as the RH/CS project expands into Khatlon and Rasht, and 2) DoH financial support of the program. Institutionalization and sustainability will require that these two issues be successfully addressed.

To be able to partner with the DoH, the RPPM project and the DoH, created the Oblast Therapeutic Committee. It is chaired by the Deputy of the Director of the DoH, and comprised of DoH staff, project staff, private sector pharmacists, and a narcotic drug control representative. The committee jointly provides oversight of essential drug procurement and distribution, reviews issues raised by the project, and is able to resolve most of them. Unresolved issues go to a higher level in the DoH.

RPPM has partnered with the district central private pharmacists who monitor essential drug delivery, use and the collection of revenues. This relationship is tenuous due to

increasing conflict-of-interest between selling essential drugs and private source drugs. To-date the PHC facilities continue to reliably receive their drug supplies from the central pharmacies. Partnering has involved training in essential drugs, rational use, appropriate treatment, and drug management. Continued use of private pharmacy pharmacists, who are organized and monitored by RPPM staff and are not under the management of the DoH, is not likely to lead sustainable institutionalization of drug distribution to and monitoring of the PHC facilities.

As well as AKF has collaborated with partners, it has also been said that it has not always collaborated as well with its other partners in the international community. In recent years this has improved, but others from the international community have said that AKF does not document and share information readily. AKF...” needs to develop more alliances with other partners.” If AKF continues to go it alone it may find itself cut off from traditional funding sources. Rather than funding little projects to NGOs, the larger donors are more interested in funding larger amounts to consortia made up of multiple NGOs working in partnership.

New Tools, Guidance, Standards

Within the BCRR project, training was provided to 119 DoH staff in PHC-MAP (Management Advancement Program). They received the planning and budgeting training component of PHC-MAP. In addition, the DoH Department of Statistics was given a CD custom tailored with GBAO specific PHC-MAP information as a basis for conducting HSR.

A new automated system for stock cards and invoices was designed and installed for the RPPM project. It is expected that the six days required to do monthly reports may be reduced by as much as 50% once the system is fully in place.

Basically, the MG98 projects were implemented, where relevant, according to WHO approved guidelines and protocols.

Advocacy

Through BCRR much was undertaken in the area of planning for HSR. The process in developing the *Work Program for Health Sector Reform* involved planning and developing strategies for reform, such as decentralizing authority, restructuring, reallocating resources from hospital-based services to primary health care services, and increasing health worker salaries. The Work Program was completed and there is now increased awareness of the need for reform; however, implementation of reform is not progressing. There is resistance to change, and, in addition, the DoH is not empowered to change or alter its budget as forwarded from the MOH and MOF. Advocacy for policy change at the MOH level would require letting go of old beliefs and practices, the political will and leadership for change, and creating a different, more pro-active, working relationship with the MOH. A stronger planning unit capability could potentially support DoH advocacy for policy change with the DOF, MOH, and MOF.

Sustainability and Coverage

Coverage was nearly, if not, 100% in the RH/CS and RPPM projects. All 193 PHC facilities in the oblast had been renovated, equipped, and staff trained in PHC and drug management. Pharmaceuticals are available in every PHC facility in the oblast. CHPs and GMPs provide health promotion information and assistance in every district and in

many villages. The project continues to train CHPs in order to cover the entire oblast, particularly where there are PHC facilities. PHC service coverage in the oblast by PHC facilities is good. Unfortunately the project did not collect and analyze utilization data, which might have given some indication of greater accessibility to and use of PHC.

As observed in one village visited, gaps in service may occur when new staff are assigned to PHC facilities and have not yet been trained by the project and DoH trainers. One district central pharmacy was not functioning due to stolen revenues by the pharmacist, which left an essential drug availability gap in one district town. The RPPM project and OTC are now seeking a way to return access to essential drugs to this district town. PHC facilities in that district continue to regularly receive quarterly drug supplies from Khorog.

While coverage is excellent, sustainability is not yet within the reach of these three projects. Sustainability has been the objective of AKF throughout the project. Unfortunately, sustainability can only occur where there is a political will and sufficient DoH resources. The difficulty in achieving sustainability is largely a result of working in an environment plagued by two key problems:

- 1) A severely under funded health delivery system, and
- 2) A corrupt environment.

In **BCRR** sustainability in HSR capacity is not feasible given current beliefs and corrupt practices that inhibit implementation of HSR. Policy changes at the national level to ensure no decreases in budget levels due to rationalization may need to occur as well as strong leadership in the DoH in support of HSR. Neither exists at this time. In addition, there is a need for expatriate assistance to:

- 1) build analytical capacity in the DoH at oblast and district levels, and facilitate implementation of HSR plans; and
- 2) build linkages with the Department of Finance at the oblast and district levels to participate in the health budgeting process and to obtain greater flexibility in moving expenditures between budget line items.

RPPM

The main criteria for determining the sustainability of drug procurement and distribution would be that revenues cover cost, including the replacement value of the pharmaceuticals. The continual need for a subsidy to cover costs indicates that the pharmaceutical system developed within RPPM is not sustainable at this time. There is reason to believe it may yet achieve sustainability.

The project is at a crossroads as the grant funding comes to an end. It can, as has been suggested, retrench in 2005 and only provide essential drugs to PHC facilities. This would decrease current procurement levels by about 50%. RPPM would cost less to sustain by lowering drug costs and reducing the subsidy, perhaps entirely. The trade-off is the almost certain backslide in essential drug use and rational use by physicians and patients, and an increase in the use of low quality drugs. PSF, currently providing only 15 to 30% of hospital drugs, is also withdrawing its free essential drug supplies from the hospitals. Without access to PSF and RPPM supplied essential drugs, physicians will be forced to prescribe low quality private source drugs. There are several alternatives to consider:

- 1) Withdraw essential drugs from the hospitals and only supply PHC facilities.
- 2) Meet the growing demand in hospitals and PHC facilities oblast-wide for essential drugs while decreasing the subsidy until the debt ratio begins to climb appreciably (indicating that financial access is decreasing).
- 3) Meet the demand for essential drugs and continue to provide them to hospitals with an agreement with the DoH that it will cover the subsidized portion of drug costs for hospitals (more likely when the subsidy decreases appreciably in the near future).

Health expenditure data at the national level show that people are currently paying about 70% of all health expenditures from out-of-pocket. (What proportion is in-kind or for drugs was not indicated.) The economy is growing. It is within reason to expect essential drug prices to cover costs within the next several years with little to no subsidy. Sustainability may be feasible and further analysis is recommended before a decision is made to narrow the provision of essential drugs to only PHC facilities in the oblast. It is also recommended that a sound household expenditure study be conducted in GBAO to support a sustainability analysis of the pharmaceutical system.

Given the current position of the DoH regarding a state-supported non-profit pharmaceutical system, there is no opportunity at this time or in the near future for integration of RPPM into the DoH. It may be in the interest of AKF or AK/HS to turn the RPPM project into a legally established NGO. It could, with MOH and/or DoH approval, establish non-profit district level drug outlets for the sale and distribution of essential drugs, thus eliminating the conflict-of-interest situation with the private pharmacies. The major obstacles are the lack of available pharmacists, the added cost of pharmacist salaries, and the cost of procuring its own warehouse facility or a more affordable storage facility. Purchasing or renting another facility may prove less costly than paying the current high rent on the warehouse. It is recommended that this option be explored, and, if feasible, be piloted in one or several districts.

RH/CS

Sustainability of reproductive health and child survival is not now possible, but could be feasible in the next few years. Refinements are needed, such as collapsing the CHP and GMP into one volunteer, adjusting the training to reflect this, and expanding the CHP into more villages within the GBAO. There is need to reduce the frequency of monitoring as the programs stabilize, and to improve the capacity to analyze and use the data collected. The biggest challenge and most outstanding issue, before sustainability can be achieved, is the need to institutionalize the RH/CS program. This would require that the DoH to designate an office or position in the DOH and at each district level responsible for coordinating and managing the training, supervision and monitoring of PHC.

Programmatic integration with the DoH is occurring and will continue during Phase II to strengthen the likelihood of sustainability. To-date, financial assumption of RH/CS program costs by the DoH has not occurred. As stated previously, the DoH budget is severely under funded and mismanaged, the latter due, in part, to corruption. The DoH budget has increased incrementally in recent years. This is expected to continue due, in part, to the influence of international donors at the MOH level. As health budget levels increase, AKF could negotiate with the DoH for it to assume program costs on the basis of a time table established by AKF and the DoH. For example, the DoH could begin to assume the more minor cost items, such as fuel and per diem costs for monitoring. With

time, education materials and training costs would be added. The BCRR-supported health expenditure study made the oblast health budget more transparent. These studies should continue on an annual basis and provide the leverage needed to negotiate with the DoH.

BCRR is not currently sustainable in that:

- 1) entrenched beliefs prohibit forward movement in HSR (as discussed above),
- 2) staff of the DoH planning unit, created only six months ago, is not assigned 100% to the unit or qualified to perform the mandate of a planning unit, and
- 3) the ability to get sufficient external expatriate technical assistance to build analytical capacity for HSR in the DoH has been limited.

Though not sustainable at this time, the project fulfilled its mandate to build HSR capacity. Unfortunately the barriers to implementation of HSR remain to be addressed.

1.5.4 Program Lessons Learned and Recommendations

Lessons Learned

- Study visits in health sector reform were conducted early in the implementation of BCRR to Latvia and the Ukraine and again later to the SINO/World Bank pilots being implemented in two districts outside the GBAO, but in Tajikistan. The observation of one AKF staff was that visits outside the country lead to comments such as, “It is different in Tajikistan and it won’t work in our country”. In contrast to these visits, those conducted within Tajikistan were found to be more helpful and considered more feasible by the participants.
- The life of a grant or project needs to take into consideration the environment and the reality of where projects are to be implemented and to calculate that in determining time lines and expectations.
Discussion:
Difficulties in starting up these projects were underestimated by the project designers as reflected in expectations regarding accomplishments and expenditures in the first few years of implementation. First, and perhaps not recognized, was the growth required of local professional staff to reorient themselves to a) US mentality, b) implementing development activities as opposed to humanitarian activities, and c) health-related skills and knowledge to do the job as required by USAID. Secondly, the projects were funded just before the long winter season when access to the rural areas was almost impossible. Third, geographical and communication access to AKF/Dushambe, from where the projects were initially heavily managed, was difficult. Finally, long-term expatriate technical assistance was not available. An expatriate program manager was hired two years into the matching grant implementation. All of the above circumstances improved with time and the projects did well in spite of the constraints. Except for RPPM, which started 15 months prior to grant approval, it took a good two years of a five year grant to gather momentum and begin to make a difference. The one-year no cost extension was needed and provided for further gains and accomplishments.
- For the above stated reasons and because the RS/CS project strategy was not as well thought out, the project made slow progress in the first two years. It would not have been as successful if it had not been for the infusion of resources from the well developed MCN/IC project approved in late 2000. The resources of both projects together provided for added staff and funds to expand the RH/CS program activities

and to expand it throughout the oblast. It appears that earlier under funding and subsequent under staffing limited what the project was able to do in the time provided.

- Institutionalization of a quality PHC system is, in part, dependent on sector reform, e.g., the reallocation of resources, restructuring, and decentralized delegation of authority. Unless institutionalization can be achieved informally within the DoH, sector reform in the GBAO will be required to institutionalize and maintain the newly developed PHC delivery system put in place by RPPM and RH/CS.
- The provision of technical assistance to the RH/CS project in its last year in a support role, rather than as an expert with managerial authority, has proven to work well and served to reinforce the capacity of the local staff in managing and implementing the project.

Discussion:

Building local staff capacity (“localization”) was an integral part of the matching grant. While there has been a great deal of local capacity development, there are gaps in that capacity such as the ability to better analyze data collected, knowing when and how to institutionalize project activities, and in some skill areas such as in HSR. The decision to entirely “localize” and no longer use long and short-term expatriate technical assistance appears to have been premature in the implementation of these projects. It would have been expected by the end of the grant, but not at the time it occurred during implementation of the grant.

- Sustainability is generally expected by the end of project activities. These projects under the grant have, in many respects, been highly successful and have most certainly made an impact on the health status of reproductive women and children in the GBAO. In the face of corrupted institutions and a severe lack of state and private health resources, it has not been feasible to reach institutional and financial sustainability within the life of these projects. That has become more of a possibility in a relatively short period of time as the country moves out of economic destitution into a growing economy. To maintain the successes achieved, these activities will need continued support for an additional limited period of time. Projects cannot always control environments to ensure sustainability, which should not be the only criteria for determining future funding decisions.
- Development funds are often provided for a limited time for humanitarian reasons, though they may only serve a small target group. There are situations when continued support, beyond the initial allotment of funds, provides benefits that go beyond serving only the small target group.

Discussion:

After an initial five-year investment, donors are quick to withdraw, in part, because the GBAO contains only 4% of the population of Tajikistan. It is often overlooked that this oblast contains 46% of the geographical area of Tajikistan, is very literate, and, through these projects, has developed successful approaches that have been shared and have informed the development of the health sector throughout the country—a very positive externality. Without the value placed on learning, and perhaps on serving a “higher purpose”, these successes may not have been as possible if first initiated in other areas of Tajikistan.

Recommendations

- Study visits to places with very similar government policy environments, economies, and cultures may prove to be of more utility than to places with dissimilar characteristics.

- Start up requirements, when initiating new projects in new environments and cultures, need to be considered when establishing expectations, objectives, and project time lines.
- Grant and project proposals and DIPs need to contain well developed strategies with realistic levels of resources.
- Health sector reform is essential to institutionalization and sustainability of PHC services and needs to be continued as a vital part of the Aga Khan Health program.
- Though local capacity building is important, expatriate assistance needs to be withdrawn in a timely fashion so as not to prematurely thwart local capacity building. Use of short-term assistance or support assistance (rather than “take charge” assistance) can be used judiciously to further local capacity building as a grant or projects come to a close.
- Though sustainability is not always feasible during the life of a grant or project, extending funding may prove to reap sustainable benefits within a limited extended period. This possibility should be considered when terminating further assistance.
- Development investments in small groups may appear to limit the impact or payoff of the investment; however, positive spin-offs may extend impact beyond the small group and should be considered in future funding decisions made by donors.

1.6 Program Management

1.6.1 Management Approach

It is a challenge to evaluate development programs and their management concurrently in the time allotted. Some observations about management were made and should be considered as areas for further study.

- The transfer of the Health Program Director to Dushambe appeared to have left a management void at the top in Khorog. Most decisions, particularly budget decisions had to be made by communicating with Dushambe, which was very difficult. (The communication infrastructure was only improved with the availability of internet a year ago and the availability of mobile phones by satellite only months ago.)
- Though there are monthly visits to Khorog, it appeared that it might become increasingly difficult for the Health Program Director to manage from Dushambe and keep abreast of what was happening in the GBAO.
- There was a top management vacuum in Khorog leaving, at the top, three project managers in charge if their respective project and resulting in more vertical programming and less cross-project coordination. More coordination was needed, for example, to coordinate and integrate project information systems, and for the projects to work together at the village level with MSDSP, VOs and jamoats. The integration of RH/CS and RPPM into AK/HS may eliminate this problem.
- Financial management, to be discussed below, served to 1) keep an exceedingly tight reign on expenditures, 2) overly centralize the program budget decision making (and indirectly program decision making), and 3) be a constant source of staff dissatisfaction that consumed much of staff time and energy.
- Low salaries and long hours led to high staff turn over, loss of technical expertise, and program disruptions.
- Some staff needs go unmet, such as long periods of time without vacation due to workloads, working without electricity in adverse weather conditions, not receiving training to do the training required in one’s job, and so forth. One person commented that the funds for training were not “rationalized.”

- Some project activities in the field, such as training, are accessed by using poorly maintained rented vehicles, implying that there are not enough vehicles to support safe program implementation.
- AKF/USA and AK/DN/Geneva were invited by AKF/Dushambe about three years ago not to be involved in project oversight or in provision of technical assistance as stipulated in the matching grant. This may or may not have affected the availability of technical assistance and other support for the grant projects, which was a continuous problem almost throughout the life of the grant.
- Not necessarily a reflection on management, staff cited problems as listed above, but seemed passive in making any attempt to raise issues to management, propose solutions, or share in the problem solving.

In the area of staff training, building technical capacity within AKF has been slowed by language barriers. At times AKF sends staff to Russia for technical training, however, it has been said that the courses were not as useful. Nearly every AKF staff interviewed expressed a desire to learn more English. Secondly, staff and DoH partners have learned to collect data and do surveys; however, analytical skills are needed to facilitate improved use of the data collected.

It is always easy to point out what could be improved. It should also be noted, on the positive side, that all staff interviewed by the consultant received technical training, and that salaries are increased annually. Management has created what appears to be a good *esprit de corps* among the staff, and an ability to work well and cooperatively together. The staff, in general, appeared to be dedicated to their work and worked hard and long hours (both a positive and a negative).

Staffs (AKF and DoH) work under very difficult conditions with all the traveling they do to supply pharmacies, and conduct training and monitoring in the districts throughout the GBAO. The roads are hazardous, and in very poor condition. Riding on them is not only bad for the body, but also can be life threatening. The vehicles appear to be kept in good repair and the drivers are excellent.

1.6.2 Quality and Status of the Detailed Implementation Plan (DIP)

The DIP gave an adequate background to the three project initiatives under the grant. It was realistic in stating that, under the circumstances of a post-conflict society, sustainability was a remote possibility. That proved to be true.

The DIP objectives and indicators were adequate, particularly for the RH/CS component. RPPM objectives were too quickly achieved or determined not feasible early in the project, and did not go far enough in laying down expectations for establishing an enduring pharmaceutical system. Though easy to judge in hind sight, BCRR objectives were too ambitious given the circumstances in the DoH, which do not appear to have changed since the inception of the grant.

The DIP did not have a clearly developed and realistic strategy for achieving the objectives of the three projects. For example, most of the strategy appeared to depend on the success of the BCRR component in changing DoH attitudes and behaviors, reallocating resources, restructuring, and decentralizing authority, all of which did not happen. The DIP assumed that there would be the means for costs to be assumed either by the DoH or people receiving services. Cost-recovery for PHC was not realistic in the context of a post-conflict society undergoing a severe economic crisis with more

than 80% of the population below the poverty line (now reduced to 57% in 2004). The fee-for-service concept may be more feasible in Phase II of the Aga Khan strategy for health, particularly now that PHC service quality has improved, fees-for-drugs have paved the way, and individual purchasing power is improving.

The DIP strategy included creating a local NGO to interface with the DoH in the provision of PHC. The infrastructure in place and used by the RH/CS project is that of the DoH. The capacity of the DoH has been strengthened. The cost to maintain the quality of the PHC services, now in place, should not be beyond the means of the DoH if there is a reallocation of resources to PHC. What is now required is the political will to reallocate resources to support this program. Creating an NGO might have been redundant and more costly, given the nature of the activities involved and traditionally assumed by a DoH.

The MG98 RH/CS program lacked a clearly defined strategy, but when combined with the MCN/IC project, which had a clearly defined strategy, did well. Together, the two projects did exceptionally well in making an impact on the status of reproductive women and children.

Though the DIP was weak in strategy, the projects implemented on a learning curve, progressed well, and achieved many of the objectives outlined in the DIP.

1.6.3 Financial Management

Until recently, and this will change with the creation of an Aga Khan bank in Tajikistan, the financial management system has been a cash-based system. Funds move, via various use of carriers, from the United States to Geneva, Switzerland to Dushambe, Tajikistan to Khorog, Tajikistan. There is a quarterly cash request from Dushambe to Geneva and a monthly transfer from Geneva to Dushambe.

Khorog makes in advance a monthly request for funds. To receive funds for project implementation, project managers propose and estimate a budget. Spending project funds need approval and the process of approval for disbursements is the following (as told to the consultant):

- Project staff in Khorog must first seek approval from the project manager.
- With project manager approval, staff take the request for disbursement to the designated Khorog person, over all the matching grant health projects (in the absence of the Health Program Director in Dushambe), who is authorized to approve up to \$500.
- If the amount is more, the project manager must seek approval from the Program Director in Dushambe who can approve up to \$1000.
- If the amount exceeds \$1000 (and many training workshops do) approval must also be obtained from the Program Operations Director who is authorized to approve up to \$3000.
- If the amount is over \$3000 the request goes to the CEO.
- The request is then returned to the requesting staff person in Khorog.
- It then goes to Khorog finance for approval and then back to Dushambe finance by fax for approval, and then back to Khorog for disbursement.

If the authorizing person is not present, staff stated that they must wait until that person returns, thus holding up the disbursement further. The Director of Finance stated that

the approval could be simply moved up to the next level of approval if someone was unavailable to approve the disbursement of funds.

The approval limit of the finance department in Khorog for petty cash is only \$200. When the consultant asked for the grant project pipelines in Khorog she was not given them, and had to obtain them in Dushambe. It appears that the financial management system is tightly controlled and centralized in Dushambe with little authority delegated to the Khorog finance department.

It was only in recent years that project managers were permitted to see their project budgets and pipelines and be involved in the budgeting process. It has been said that project managers often were not informed when funds were taken out of their project budgets for expenditures such as for vehicles. Initially, in the first years of implementation of the matching grant projects, the yearly budgeted amount was very small in proportion to the amount budgeted over the entire five years of the three projects. Generally project expenditures are highest in the first few years of a project. The Dushambe finance department was heavily involved in funding decisions of a programmatic nature. All of this has improved over the life of the grant. The reason for pointing out these former practices that occurred during implementation of the grant is to demonstrate the highly centralized financial management system. This is still evident in the approval process for disbursements.

Staff frustration with this approval system was evident (in a focus group setting), is a major source of unhappiness, and consumes a lot of time. Examples were given that if staffs use their own resources when travel advances prove to be insufficient, reimbursement is often at the end of the year or even a year later. For most people living on monthly income this can be a hardship. These are staff perceptions, which may or may not reflect the entire story; however, the frustration levels associated with AKF financial procedures are significant. It is recommended that disbursement procedures be reviewed, particularly to raising approval levels and to decentralizing additional authority to the Khorog finance department.

The Director of Finance is new as of this year, and has already taken steps to train project managers in how to read their project pipelines and make expenditure requests based on what is budgeted quarterly and annually. The director expects the project managers to instruct their respective staff in how to do the same. It is hoped that the project managers are also involved in computing the quarterly and annual budget levels for their respective project budgets. See recommendations in section 1.6.8 below.

1.6.4 Monitoring and Evaluation (M&E) System

RPPM and RH/CS projects, independently, have put in place a system for monitoring the activities of the projects. Data is collected by AKF staff and by four types of district monitors (DM) who supervise and monitor PHC services. There is one DM for each program to supervise and monitor 1) pharmaceutical supply and use twice per year, 2) CHP activities quarterly, 3) GM&P activities quarterly, and 4) PHC workers twice per year. AKF staff monitor with the DMs about 50% of the time to supervise and monitor the DMs.

Each monitor uses a checklist that ensures thorough coverage and uniform data collection and reporting. The data is given by the DM to both AKF and the chief doctor of the district, who, in turn, passes the information to the DoH at the oblast level. The

system has been very effective in maintaining quality services, and the skills and knowledge of PHC staff, GMPs and CHPs. They are well supported and being held accountable. Their performance is reflected in the results of the HNS and LQAS. In addition, the system is effective in detecting problems or weak areas and DMs are trained to raise problematic issues with AKF staff and district chief doctors.

The evaluation aspect is completed with the annual LQAS and the Health and Nutrition Survey conducted every two years. The LQAS is a “quick and dirty” sampling of mothers of children aged 0-23 months. It is carried out by AKF staff and DMs, and tests access to IEC materials, and health knowledge and practices. The HNS carried out since 1994, is more thorough and collects information regarding demography, household economy, morbidity trends, and maternal and child health throughout the GBAO. The HNS has improved in the last ten years and has become an increasingly reliable instrument.

While the M&E system is working and in place it could be improved in the following ways:

- Monitoring for CHPs and GMPs, whose functions will be rolled into one position, could be consolidated and conducted twice per year rather than quarterly. Their reports, however, should be collected quarterly.
- Bring together the data from RPPM and RH/CS (and AK/HS) into a single automated information system,
- Collect and add utilization, morbidity and mortality data to the system,
- Develop the capacity to aggregate the data and conduct analyses to support continued program improvement and planning,
- Accomplish this with the assistance of the Education, Learning and Communication Department (ELC), and, if feasible, locate this in the DoH in the Department of Statistics through an HMIS II type initiative, and
- Make note of and record lessons learned and disseminate this information to other stakeholders.

AKF staff expressed interest in developing a stronger analytical capacity, but stated the need for training to carry this out.

1.6.5 Information Systems

The DoH access to information has improved considerably as a result of the MG98 grant. RPPM shares all pharmaceutical-relevant data collected through monitoring with the Oblast Therapeutic Committee, and all district chiefs and the DoH Department of Statistics now have data, on a quarterly basis, on all PHC facilities and village health promotion activities in every district in the oblast. Through BCRR, PHC-MAP is automated and part of the DoH information system.

The M & E system is structured so that the data generated, including survey data results, is regularly and routinely shared with the DoH. When the data indicate problems, the information is discussed with relevant DoH person or committee and action is taken. In the process of sharing information and identifying problems, staff of AKF and the DoH are learning to use the data as a management and planning tool.

1.6.6 Staffing and Supervision

Almost all local program staff hired by AKF was on a learning curve in order to successfully implement MG 98, a western project with western concepts and ideas in an eastern context. Local staff capacity building was part of the mandate and implementation of MG98. Fortunately, staff hired for MG98 had medical backgrounds, and included educated, capable people who valued learning. During the course of this participatory evaluation, staff was open and very involved in all the new challenges of how to participate, collect data, organize and analyze it, and make recommendations. Though staff analytical skills still need further development, there appears to have been good appropriateness and competence of the staff who implemented MG98.

Given the short duration of the evaluation, there was insufficient time to ascertain whether the staff was sufficient in number. If long working hours is one indication, perhaps there was not enough staff. Other factors such as lack of good use of time and job dedication may result in overtime, and not necessarily indicate a need for more staff.

As mentioned in section 1.5.1., supervision could have been stronger with the designation of a health program manager in Khorog to coordinate the MG 98 projects at the time the Health Program Director was moved to Dushambe. Her role in Dushambe was important, but being able to do both jobs from Dushambe may not have been workable in the long run. The plan to move RPPM and RH/CS under AK/HS may solve this problem.

1.6.7 PVC Program Management

The USAID PVC program is smaller and changing its focus. In this *milieu*, there may not have been enough attention and oversight given to MG98, particularly when the backstop officer left in the last year and there was no replacement. In the earlier years of the project there was chronic under spending. At that time there was a need to investigate further as to its cause. The problems of a highly centralized and controlled AKF finance system might have been detected and addressed earlier in the life of the grant. On a positive note, the one-year no-cost extension for MG98 was granted by PVC. Significant additional progress was made in the last year of grant implementation, such as expanding the CHP program and giving it a sounder foundation, and reducing the pharmaceutical subsidy successfully to 50%.

1.6.8 Program Management Lessons Learned and Recommendations

- Staff may have a commitment to the work that they do for reasons that go beyond just making a salary; however, it should not be taken for granted by expecting long work hours.
- Program management and decision making needs to be more decentralized to Khorog.
- As stated in the mid-term evaluation and continues to be a problem, there needs to be more coordination between health project activities whether under AKF or AK/HS.
- Assertiveness training appropriate to the work place is recommended for all local staff to encourage raising issues and proposing solutions, i.e., in speaking up about problems, being pro-active, and working with management to solve problems.
- It is recommended that AKF/Dushambe, AKF/USA, and AK/DN/Geneva physically sit down together with a facilitator and clarify roles, responsibilities and expectations to improve communication and mutual support in the implementation of its programs.

- The 1999 DIP strategy for the matching grant was not well developed or very realistic; however, the DIP for the Aga Khan Maternal and Child nutrition project was well developed. The only recommendation is for AKF to more consistently produce quality, well thought out DIPs.
- The AKF financial system is highly centralized and needs to delegate more approval authority at higher budget levels to program directors and managers, and to the finance department in Khorog.
- The financial disbursement approval process needs to be streamlined, which would be feasible with more delegation of authority to Khorog.
- The recommendations for improving the M&E system are listed above in section 1.6.4.

Grants, programs and projects can always be improved, but taking a step back and reviewing the accomplishments of MG98, including local capacity building and partnering, it must be stressed that much was accomplished. The grant has successfully served as a bridge between the period immediate after a civil war and now when the country is getting back on its feet. Only recently has it been possible to begin to consider institutionalization and sustainability. In the interim the status of reproductive women and children under five years has significantly improved in the GBAO.

Strengths, Challenges and Recommendations

Matching Grant 98 Building Capacity for Restructuring and Reform (BCRR) Project

Theme/Findings	Conclusions		Recommendations
	Strengths	Challenges	
<p>Health Sector Reform</p> <p><u>HSR training/capacity building</u></p> <ul style="list-style-type: none"> New DOH planning unit is not staffed with full-time analysts to do HSR. 	<ul style="list-style-type: none"> BCRR project conducted capacity building in HSR at the national, oblast and district levels from 1999 to 2004. <ol style="list-style-type: none"> In 1999 and 2000 study visits were made to Ukraine and Latvia respectively for MOH and DOH staff to learn about the HSR process. Six doctors from GBAO trained in Dushambe on PHC-MAP by AKU Pakistan. PHC-MAP course on planning and budgeting conducted for 119 oblast health care staff. In 2003 one-day workshops conducted in each district for chief doctors, Deputy <i>Hukumat</i>, PHC facility chiefs (nurses and doctors) and MSDSP in which GBAO Program of Work for HSR and concept of district level HSR planning (rationalization) was introduced. In 2002/2003 16 PHC staff from most districts in GBAO trained in family medicine. In Aug/Sept. 2004 senior and 	<ul style="list-style-type: none"> DOH planning unit is <u>not</u> staffed with full-time analysts to plan and implement HSR. 	<ul style="list-style-type: none"> Support DOH planning unit staff analytical capacity development when grant letter requirements are met. Build district planning teams and Khorog General Hospital capacity in planning and budgeting to support district and Oblast HSR. Develop clear terms of reference for DoH planning unit, including its relationship with the DoH.

<p><u>HSR Rationalization (Planning and Budgeting)</u></p> <ul style="list-style-type: none"> • Undertaking decentralization, one district chief doctor able to reallocate facilities, beds, and staff according to need • Same district CD has prepared a district rationalization plan and is implementing it. • In one district new chief doctor aware of HSR, but is not taking action or staying current. • Hukumat has control over district DOH budget, which is fixed and cannot be changed. • Current system of budgeting is not flexible enough to be in sync with the district rationalization plans if implemented. • <i>One Hukumat</i> Chairman supports transfer of health budget to district chief doctor for health budget allocation 	<p>mid-level visit to SINO/WB pilot districts in Tajikistan to exchange experiences and ideas regarding HSR.</p> <p>7. Three-day training of 202 PHC staff and <i>Jamoat</i> accountants on planning and budgeting. Oblast now has the capacity to do this training without national level trainers from the Post-graduate Medical Institute.</p> <ul style="list-style-type: none"> • The oblast strategic plan for health sector reform (HSR) developed, approved, and consistent with MOH directives • National level presentation by DOH on program of work for HSR in the GBAO. • Primary health care facility staff awareness of HSR planning and budgeting improved. • Full participation of district level DOH in GBAO HSR plan of work facilitates district level rationalization. • Health Expenditure Survey made DOH budget more transparent. • PHC-Map (Management Advancement Program) developed for oblast and given to DOH for planning use of health resources by area. 	<ul style="list-style-type: none"> • Resistance to rationalization may be fear of losing budget funds. • Appears that the process of rationalization of health resources has slowed/stalled. • DOH/DOF joint budget planning may be possible with strong supporting analysis. • District level DOH budget is not flexible and does not accommodate or support rationalization. • Belief of some Hukumat officials and DOH staff that the reform process can only occur if DOH budget is increased. • Some PHC staff are not aware of <i>Jamoat</i> health budget and do not request it. • Additional resources for DoH budget may include alternative financing such as charging minimal fees for use of hot 	<ul style="list-style-type: none"> • AKF, with other donors in HSR, discuss and achieve agreement with DoH/MoH, DoF/MoF and MoE to ensure 1) oblast and district health budgets will not be reduced due to rationalization, and 2) cost savings resulting from rationalization will remain in the budget and be allocated at the level at which the savings accrued. • Conduct a workshop for MoH and DoH planning units to identify roadblocks to HSR, and improve communication and coordination of HSR implementation. • Provide technical assistance to each district health planning team on how to prepare and implement a rationalization plan. • Each district rationalization
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<p>according to need.</p> <ul style="list-style-type: none"> • CD believes HSR requires additional funding. • PHC staff do not know <i>Jamoat</i> budget for drugs and do not request it. • DM makes own business plan for district, which may include use of hot springs for income generation and fee for service, e.g. surgery. <p><u>Partnerships/stakeholders</u></p> <ul style="list-style-type: none"> • DoH planning unit compliance with components of the BCRR project agreement is not complete or timely • DOH resistance to activating HSR in the GBAO. • GBAO DoH seems to believe change is not possible unless directives come from the MoH 	<ul style="list-style-type: none"> • For two years AKF organized annual joint planning exercise with DOH, specialty centers, and other international organizations and NGOs to plan and coordinate topic-specific health initiatives for the oblast. As a result, joint strategy plans were developed for iodized salt, HIV/AIDs, CHLS, immunization. • One room has been set aside and rehabilitated in the DoH for a planning unit and computer equipment provided. 	<p>springs and health services.</p> <ul style="list-style-type: none"> • Need to ensure DOH planning unit compliance with grant letter, including provision of three rooms for a proposed five-person planning unit staff (3 DoH and 2 AKF). • MOH does not pay enough attention to HSR in the GBAO. • BCRR project needs to more effectively address DOH planning unit resistance and low motivation for HSR. • Need to continue partner relationships at the national level and remain in the 	<p>plan be discussed, revised as needed, and approved by communities and local <i>hukumats</i> before submission to DOH.</p> <ul style="list-style-type: none"> • Highlight most successful district rationalization process by developing a case study to share with other districts, the DoH and MoH to counteract belief that rationalization requires higher budget levels. • In district planning process make <i>jamoat</i> health budget transparent by sharing it with PHC facility staff. • PHC staff training on mgt., planning and budgeting should continue until training series is completed. • While keeping the door open, there should be no further support to DOH planning unit until grant letter requirements are met, e.g. three rooms are set aside for the planning unit, appropriate/qualified staffing assigned to the unit, compliance with DIP, and appropriate use and reporting of funds. • AKF/Dushambe encourage MOH 1) to inform and/or involve GBAO DoH more in national level HSR activities,
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		national HSR dialogue.	and 2) hold GBAO DoH more accountable for implementing HSR. <ul style="list-style-type: none">• AKF/Dushambe continue the dialogue and coordination with other donors participating in HSR as well as with the MoH.
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Strengths, Challenges and Recommendations Matching Grant 98 Rationalizing Pharmaceutical Policy and Management (RPPM)

	Conclusions		
	Strengths	Challenges	Recommendations
<p>Rationalizing Pharmaceutical Policy and Management</p> <p><u>Training</u></p>	<ul style="list-style-type: none"> • Monitoring has maintained regular supply of pharmaceuticals, rational use of drugs, and knowledge and skills of PHC staff. • Some community monitoring of drug supply, EDL prices, and invoices. • Drug supply is well organized, timely, and according to needs. • Financial reports at PHC facilities and district pharmacies are well prepared, reliable, and accountable. • Controls in place for holding PHC staff and pharmacists accountable for drug mgt. • 5 of 7 district pharmacies and 100% of PHC pharmacies are open and functioning. • Drug news bulletin and quality medical professional workshops provided on rational use of drugs (RUD) annually to all health professionals in the Oblast. 	<ul style="list-style-type: none"> • Identify where lies the responsibility for community or village monitoring of essential drug supplies and prices at PHC facilities. • Two district pharmacies are not functioning well, which makes it difficult to monitor and maintain drug stocks at the PHC centers. 	<ul style="list-style-type: none"> • VO health committee, including CHP and VO accountant, monitor drug prices, supplies and revenues on a monthly or every two-month basis. • See recommendation below, RPPM develop a strategy with OTC for removing the chief district pharmacists from the drug supply and monitoring chain.

<p><u>Projected withdrawal of drugs from hospitals</u></p> <ul style="list-style-type: none"> Project will no longer provide EDL drugs to hospitals in 2005 <p><u>Drug Advertising</u></p> <ul style="list-style-type: none"> Private pharmacist do not want to advertise EDL drugs 72% respondents to HNS aware of EDL <p><u>Exemption Policy</u></p>	<ul style="list-style-type: none"> 72.9% of people reported on HNS they were aware of essential drugs. Exemption policy has effectively made drugs available to vulnerable groups in Tajik society. DoH is reimbursing for people falling under the exemption policy. 	<ul style="list-style-type: none"> Planned withdrawal of essential drugs from hospitals will negatively affect availability of essential drugs and rational use of drugs. PSF provides hospitals only 15 to 30% of their pharmaceutical needs. EDL promotion and advertising limited There is room for expanding the number of people familiar with EDL and reinforcing the benefits of EDL, given increasing availability of low quality, high cost private source drugs. Exemption group policy needs to be streamlined and made consistent with MoH exemption policies. 	<ul style="list-style-type: none"> Continue to supply hospitals essential drugs until national Drug Procurement Center is functioning and providing essential drugs; or hospitals agree to assume the cost of drugs covered by the subsidy. Conduct feasibility study for improving communication, training, and/or advertising of essential drugs. Explore use of social marketing concepts (used in promotion of family planning and HIV/AIDS) in collaboration with PSI to promote EDs. Establish essential drug brand logo for product recognition. CHPs can use logo to educate communities about benefits of essential drugs and support an increase in demand for EDs, rather than low quality private source drugs. Work with OTC and MOH to make RPPM exemption policy consistent with MoH policy. More formal collaboration with VOs via MSDSP and <i>jamoats</i>, to identify and ensure drug accessibility to vulnerable community members.
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<p><u>Competition/conflict</u></p> <ul style="list-style-type: none"> • In two districts tension/conflict between CD and district private pharmacist • CD wants pharmacy located in hospital • Lack of pharmacists to open pharmacy's in district hospitals. <p><u>Free drugs and shortage of supplies</u></p> <ul style="list-style-type: none"> • CHPs get ORS directly from AKF • Women don't have ORS at home • It is reported there are shortages, at times, of UNFPA contraceptives provided to PHC facilities. <p><u>Staff turnover</u></p> <ul style="list-style-type: none"> • Village nurse had not received RPPM training after one year on job: -had expired drugs -mixed personal effects with drugs -drugs in home because lock on 		<ul style="list-style-type: none"> • Observed competitive/conflictive relationship between district chief doctor and chief pharmacist or private pharmacy owner over who controls sale of drugs. • Chief doctors want pharmacies in district hospitals • There is a shortage of pharmacists <ul style="list-style-type: none"> • Free drugs and supplies (contraceptives, ORS, PSF drugs) negatively effects RPPM policy that people should pay for drugs and supplies (sustainability). • Supplies provided by other donors are not always regularly available to PHC centers and to CHPs. <ul style="list-style-type: none"> • Newly assigned PHC staff not oriented in drug management soon after assignment to a PHC facility. 	<ul style="list-style-type: none"> • Continue and intensify national dialogue with ADB/PSF/MOH in development of an independent non-profit national drug procurement and distribution system. • If and until a sustainable national pharmaceutical program is in place, RPPM explore feasibility of establishing an independent non-profit entity, such as an NGO, to continue procuring and distributing essential drugs in the GBAO independent of private pharmacies. • Reopen discussions with UNICEF, PSF, WHO and UNFPA to obtain more flexibility in pricing policies and to coordinate procurement to ensure adequate and continues supplies in the oblast. • Working with AK/HS include drug management training in nursing curriculum at national and oblast levels. • RPPM monitors note when there is new PHC staff and arrange training within 6
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<p>safe broken</p> <p><u>Mixing essential drugs and private source drugs</u></p> <ul style="list-style-type: none"> • Observed mixed EDL and private source drugs at a district private pharmacy <p><u>Rational use of drugs</u></p> <ul style="list-style-type: none"> • Data shows slight increase in non-rational use of drugs at PHC level • Project did not train hospital doctors in EDL and rational use, so still use poly pharmacy and non-generic drugs • Doctors and chief pharmacist often working together to sell private sector drugs. 		<ul style="list-style-type: none"> • At times central pharmacists mix EDL and private source drugs and tell patients that all are EDL drugs. • With recent availability of private source drugs, hospital doctors are beginning to prescribe non-generic, more costly, and lower quality private source drugs. • Due to untrained physicians at hospitals, poly pharmacy continues. • Need for increased and improved awareness of EDL drugs by all residents of the oblast. • District level OTC would provide closer oversight to drug procurement and distribution as well as decentralized resolution of pharmaceutical issues. 	<p>months.</p> <ul style="list-style-type: none"> • Request DMs to notify RPPM of new PHC staff. • When essential drugs are delivered to central pharmacies four times per year, ascertain whether EDs are mixed with higher cost, lower quality private source drugs. Correct the situation and report incident to RPPM mgr. If repeated, take to OTC for action, such as discontinuing 20% incentive. • Request RH/CS CHPs and DMs to monitor district pharmacies and report discrepancies. • Reinforce training of PHC staff and, through CHPs, community members in concept of essential drugs, including logo recognition. • Provide training with follow-up to doctors in hospitals on essential drugs and rational use. • Establish district OTCs and develop good communication between district and oblast OTCs.
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<p><u>Sustainability</u></p> <ul style="list-style-type: none"> • Cost recovery funds remain unused. • RPPM cost-recovery perceived as means for sustainability of pharmaceutical system. 	<ul style="list-style-type: none"> • Cost recovery can reasonably be expected to lead to a sustainable pharmaceutical system with gradual withdrawal of subsidy and parallel improved purchasing power within the oblast. 	<ul style="list-style-type: none"> • Accumulated cost recovery funds constitute non-growing capital. 	<ul style="list-style-type: none"> • Explore establishment of RPPM cost recovery fund in an interest-bearing account with AKF bank in Tajikistan.
<p>MG 98 Consultant added Findings:</p> <p>The electricity shortages occur frequently enough to threaten the quality of drug supplies at the warehouse.</p> <p>The plan for the new Drug Procurement Center in Dushambe, under the PSF/ADB/ECHO project, is to deliver essential drugs to the DoH TajikFarmatsia in Khatlon oblast.</p> <p>There is need for household expenditure information regarding the purchase of both essential and private source drugs.</p> <p>There are untapped jamoat budget funds for drugs for each PHC facility.</p>	<p>Strengths/Challenges:</p> <p>In addition, the temperature changes due to electricity outages make physical working conditions for the pharmacist difficult. The computer doesn't work and requires late and week end hours to complete the work on time.</p> <p>TajikFarmatsia exists in both Khatlon and Rasht. In the expansion of RPPM into Khatlon and Rasht, it will be important to establish a Khatlon and Rasht OTC and coordinate drug procurement through their already existing warehouses run by TajikFarmatsia, if feasible.</p> <p>With information on household drug expenditures, RPPM can better regulate essential drugs prices, adjust the subsidy, estimate the amount people pay for private source drugs, and estimate the degree to which there is competition between private source and essential drugs.</p> <p>It is the understanding of the evaluator that jamoat budgets for each PHC facility include some funds for pharmaceuticals, which appears to not be well known, and, hence, go unused for the purpose for which it was intended.</p>	<p>Recommendations:</p> <p>Purchase a large generator capable of maintaining acceptable temperature conditions in the entire warehouse.</p> <p>In expanding RPPM into Khatlon and Rasht, adjust the RPPM model to accommodate the already established TajikFarmatsias in those areas, if it should prove to be feasible.</p> <p>Work with BCRR in designing and conducting a household health expenditure survey in Khorog and in every district.</p> <p>Obtain information about the jamoat budget for PHC. Make it transparent by informing and encouraging all PHC staff to use this fund and account for their use.</p>	

<p>The pharmaceutical information center has not had the funding to up-date pharmaceutical information for the last two years.</p>	<p>This center is used by project staff to plan and run training seminars each year through-out the Oblast to keep pharmacists and other medical staff informed about diseases and the appropriate use of drugs in treating diseases. The center is also used by students of institutions of higher education in Khorog.</p>	<p>Explore the use of these funds for vulnerable villagers who are unable to pay for drugs.</p> <p>Assuming the training component of the pharmaceutical system continues, it will be necessary to devote resources to up-dating the pharmaceutical information in the center.</p>
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Strengths, Challenges and Recommendations Matching Grant 98 Reproductive Health and Child Survival

Category/Findings	Conclusions		Recommendations
	Strengths	Challenges	
<p>Community Health Volunteers (CHPs)</p> <ul style="list-style-type: none"> • CHPs training was 5 days initially and they have refresher seminars every two months • ChPs are monitored every quarter • CHP activities were recognized by mothers and health workers • CHPs use registers to track population health status: total population by family, immunization status of children under five, pregnant women, and women using family planning. • New volunteers had received some orientation from AKF, the District Monitors, and/or 	<ul style="list-style-type: none"> • CHPS were well trained and knowledgeable in all relevant PH topics and were actively working in the community • CHPs and HWGs perform a wide variety of health services on many levels (e.g. national level EPI and micronutrient campaigns) and household level advice and services (breast feeding, complementary feeding, STI/HIV prevention, etc.) <p style="text-align: center;">Lessons Learned</p> <p><i>Role of CHPs provided momentum for behavior change</i></p> <p><i>Child Survival project funds and activities were synergistic to MG98 and were needed in order to provided the critical mass for community activities</i></p> <ul style="list-style-type: none"> • Using registers for tracking, CHPs provide information on health from their communities to AKIF, PHC facilities, and district monitors. • CHPs use different methods and channels to sensitize the community: 	<ul style="list-style-type: none"> • It is expensive and time consuming to train and support a lot of CHPs • CHP work at community level must be an ongoing process in order to effect permanent positive behavior change at the household level. • In some areas the level of collaboration between the CHP and the GMP is unclear. • There is no real plan at district level to support or incorporate CHPs in their planning and budgeting. • The system for orienting new CHPs or GMPs who are replacing volunteers who have left is inconsistent and not well developed. • CHPs would like to have a larger role for family planning in the village (e.g. distribute pills, IUDs or spermicides) in addition to condoms. • At DOH level there is inadequate recognition of use of the data generated by CHPs. • HWGs felt home visits were too time consuming. • Bicycles were given as incentives to help carry out their work, but the parameters for their use were not well 	<ul style="list-style-type: none"> • Combine the CHP and GMP roles into one person who would be responsible for both sets of activities. • The oblast PHC centers increasingly assume responsibility for routine monitoring and refresher training of CHPs/GMPs. • Strengthen the training capacity of the PHC center staff. • CHP reports are given to the PHC • District monitors provide CHP reports to AKF. • Strengthen CHP supply (condoms, brochures and ORS) system through PHC staff and district monitors to ensure no gaps. • AKF and district negotiate the number and location of CHPs for adequate coverage. • In Khorog develop the link between CHPs and VOs for community mobilization, and the CHPs and the oblast Centers for technical support and reporting. • The project may need to

<p>their predecessor, but it was haphazard.</p> <ul style="list-style-type: none"> • Staff report that CHPs in Darvaz and Vanj sometimes require financial incentives as motivation. • 10 CHPs in Khorog and 5 in Murghab have left. There has been no attrition in other areas. This is less than 10% attrition overall. • Even District level people appreciate access to new knowledge. Suggest that without AKF they would be isolated and not learn new things. 	<p>brochures, groups seminars, home visits, and discussion at community meetings (school parents, weddings, village organizations, prayer meetings, funerals)</p> <ul style="list-style-type: none"> • Financial incentives are NOT the motivation for volunteers (except in Vanj and Darvaz) • People feel their work is for their Imam, their community, and that their family benefits from their knowledge. They are proud of AKF. They appreciate seeing children doing well. • New knowledge was highly appreciated and desired. In Khorog it was appreciated as “free” education. • The community respects them and uses them as an information source (even more than health providers in some areas) • CHPs feel they are a bridge between the community and the PHC facility. 	<p>defined. In most cases they were not shared with other volunteers.</p> <ul style="list-style-type: none"> • In Darvez District, some CHPs want financial incentives • VO in Khorog town not linked to health activities. 	<p>“market” the benefit of CHPs to higher level decision makers (district chiefs and hukumat, etc.) to ensure their inclusion in planning and budgeting.</p> <p>Lesson Learned:</p> <p><i>Access to new knowledge and strong monitoring support are the most important elements for motivation and quality at both community and facility levels...</i></p>
<p>Behavior Change Communications</p> <ul style="list-style-type: none"> • CHPs and health workers agreed group gatherings were the most effective way to do health education. • Women have information on all 	<ul style="list-style-type: none"> • Brochures were appreciated by everyone – both volunteers and mothers. They seem to have been an effective education tool. • CHPs in Khorog requesting information on a variety of new topics (alcoholism, drug abuse, disabilities, care of the elderly, suicide, etc.) 	<ul style="list-style-type: none"> • No special needs assessment was done to determine if messages in Khorog needed to be different than in rural areas. • Russian brochures too complicated for village people. • The CHLS still has very limited role in supporting this effort, and is very concerned about receiving equipment. 	<ul style="list-style-type: none"> • Carry out a needs assessment in Khorog town to determine priority health information needs.

<p>the different contraceptive methods.</p> <ul style="list-style-type: none"> • Competitions were appreciated as a BCC strategy • Salt package recognized by mothers. They know to read about iodination. • Brochures were developed in Tajik, Russian, and Kyrgyz. 		<p>He has been working for 8 months.</p>	<p><i>Lesson Learned</i></p> <p><i>In a literate society, use of brochures and emphasis on data are feasible and effective.</i></p>
<p>Health Services</p> <ul style="list-style-type: none"> • In Rostkala, project provided IUD equipment at most every rehabilitated facility, and the Chief Dr. inserts IUDs when she does monitoring. • Health facilities have been well renovated and equipped, (129/193) and the project had an engineer on staff. Essential drugs were reliably available for at least the post six months. 	<ul style="list-style-type: none"> • PHC staff is not only motivated by money, but also like serving their population. • New knowledge was highly appreciated and desired. • Health facilities are clean, renovated, and equipped with essential equipment, drugs, and supplies. • Rehabilitation work seems to have been well managed and well done. • CHPs help health center staff • Trained PHC providers give the same messages to the community as the volunteers. • The population appreciates PHC services – feels the providers try their best to help. • Communities report more confidence in their PHC services because the providers have been 	<ul style="list-style-type: none"> • Low salaries are a significant constraint throughout the system leading to high turnover. Turnover tends to be more problem in Khorog town because there are more alternatives. • In rural areas there is an inadequacy of certified medical staff for IUD insertion. • PHC staff report spending their own money for transport to pick up vaccine from the District center, in spite of the fact that jamoat has money budgeted for this. • Khorog medical facilities and local hospitals were not trained in new messages or community approaches so give conflicting messages to those of CHP 	<ul style="list-style-type: none"> • During the next phase include local hospitals and polyclinics when introducing new messages to assure consistent messages and practices between health service providers and community volunteers. • Advocate with the MOH to allow trained and certified nurses (in addition to doctors and midwives) to insert IUDs to improve access.

<ul style="list-style-type: none"> All trained PHC providers indicated they do not use antibiotics to treat normal diarrhea. Services are generally available 24/7, providers make home visits, and charges are reportedly appropriate at PHC level. 	<p>because the providers have been trained.</p> <ul style="list-style-type: none"> Rostkala district chief doctor doing IUD insertions while on monitoring visits. 		<p>Lesson Learned</p> <p><i>PHC staffs need the same training as community volunteers to assure consistent messages as well as to encourage collaboration.</i></p>
<p>District Monitors / Supervision</p> <p>District monitors work very closely with project staff—they are friends and respond to personal motivation. They meet with their chief doctors to report on their activities in all three areas. There has been some turnover due to inactivity (Ishkashim). The new one is active but has limited training. In Roshtkala, the DMs are high level with authority in the district. In other districts they are clinical nurses. The Soviet system had</p>	<ul style="list-style-type: none"> District monitors have a good relationship with chief doctors and AKF They identify and coordinate problem solving at med-point, district level, oblast level, and with AKF as required. Good collaboration with CHP GMP, and med-point. Biannual meeting in Khorog attended by DOH/DM/AKF representatives strengthens all relationships. PHC staff recognizes monitoring as a support and motivation to help them with their work. (rather than “policing”) Supervision check lists are very complete, link supervision to training, and are used for monitoring process indicators. The project has extensive documentation for all its activities – both parameters for implementation 	<ul style="list-style-type: none"> At present, monitoring responsibilities (e.g. 3 hours for general visit) are divided among 3 different people (to combine would require more time/training monitoring). DMs do not take full advantage of each visit by visiting all volunteers or staff. DMs do not monitor local hospitals. The primary CHP supply system for ORS and condoms depends on AKF supply through seminars. Emergency supplies can usually be obtained through the medpoint and/or the district monitor. Some CHPs report shortages of supplies. In most districts PHC staff are not invited to discuss monitoring results (at the collegium), however; in Roshtkala PHC staff are involved. DM <i>per diem</i> for one day equals one month of DOH salary. AKF seen as their primary employer. AKF tends to make the work plan and determine the 	<ul style="list-style-type: none"> GMP and CHP monitoring will be combined when the roles are combined (see CHP section). Monitors of PHC facilities can use the same transport, but should stay focused on PHC. (If supervision visits become overloaded, the quality and effectiveness decreases.) Encourage monthly meetings between Chief Doctor, District Monitors, and PHC staff in the District. Update and revise supervision check lists, developing a way to check different knowledge with each visit, and making sure supervision of routine micronutrient distribution is included. Oblast level may need an adjusted set of check lists.

<p>a lot of outreach from the district level, so dependence on DMs is consistent with this, and provides motivation for both volunteers and PHC staff. Everyone sees DM visit as motivating.</p>	<p>both parameters for implementation and monitoring of activities.</p>	<p>make the work plan and determine the program.</p> <ul style="list-style-type: none"> • Supervision checklists were updated in 2002, and need to be reviewed. • Monitoring relies heavily on project resources (for transport/petrol). • CHP and GMP monitoring done separately. 	
<p>Changes in Behavior</p> <ul style="list-style-type: none"> • Survey data show significant changes for most indicators. • A mother who came from Moscow two months ago did not know anything about these messages. • Immediate and exclusive breast feeding, ORS for diarrhea, increasing food and fluids when kids are sick, family planning, and iodized salt, cleaning their houses, building toilets, SSKS, hand washing, immunizations • Most salt samples were positive for iodine. In one village there was no 	<ul style="list-style-type: none"> • Mothers, PHC staff and CHPs feel there is better immunization coverage, less diarrhea, and less illness. • Family planning readily accepted by everyone (including for unmarried youth) and husbands generally agree. • Doctors have decreased use of injectables and antibiotics. • People report there are no barriers to accepting or practicing the advised behaviors • Exclusive and immediate breast feeding were the first behaviors mentioned in most groups. • Women report looking for iodized salt. • Women and CHPs talk about different family planning methods and their interest in using FP. • People understand the use of condoms for protection against both STIs and pregnancy. 		

<p>iodized salt due to repayment problems. In another, the only uniodized salt came from a woman recently returned from Moscow who didn't know better. (It seemed her friends did not tell her about health).</p> <ul style="list-style-type: none"> • 12.5% of FP non-users are not using due to fear of side effects. • ***Anemia in women of reproductive age and a high infant mortality in Murghab persist, which may or may not be ameliorated by changes in behavior. 	<ul style="list-style-type: none"> • CHPs are working with youth including counseling on HIV prevention and family planning, and condom distribution. 	<ul style="list-style-type: none"> • A better understanding of the causes of anemia in reproductive women and of infant mortality, particularly in Murghab, is needed to reduce the incidence of both. 	<ul style="list-style-type: none"> • ***Conduct research into the causes of anemia in women of reproductive age and of infant mortality (particularly in Murghab) in phase II of the Aga Khan health program, which includes a research component.
<p>Health Information System and Use of Information There were PHC registers for population, immunization, pregnancies, family planning, immunization complications, growth</p>	<ul style="list-style-type: none"> • PHC centers have many registers that were generally completed and understood. They make reporting easier. • Chief Dr. uses information from district monitors to identify and solve problems at high level (e.g., immunization planning). 	<ul style="list-style-type: none"> • Multiple registers may be too much work and their may be duplication between registers. • Utilization data not reviewed or used by project. • Analysis of data collected for making decisions limited at all levels. 	<ul style="list-style-type: none"> • Train PHC staff and CHPs to use their own data to track trends and progress, e.g., review utilization data, morbidity and mortality trends, family planning users, skilled deliveries, etc.) • ***Establish a unified

<p>monitoring, patient visits, infectious diseases, inspections, monitor visits, etc.</p>	<ul style="list-style-type: none"> • Ambulatoria Dr. feels data show decreasing mortality and morbidity. • Ambulatoria makes recommendations to district level. • CHPs and HWGs use information from their community to advocate for better services (e.g. IUD access for vulnerable women) • PHC staff report appropriate case management (based on training) • District monitors and AKF staff are able to conduct LQAS on their own—data collection, analysis, and drawing of conclusions relevant to their districts. 	<p><i>Lesson Learned:</i></p> <p><i>LQAS can be simple enough for district staff to carry it out on their own and draw their own conclusions with project support.</i></p>	<p>automated information system across health programs (RPPM, RH/CS, AK/HS) for aggregating data, analyzing trends, and conducting studies.</p> <ul style="list-style-type: none"> • ***Funds permitting, institutionalize the information system in the DoH.
<p>Health Technical Concerns</p> <p>Consultants provided TA in nutrition (TIPS and salt), behavior change, HMIS, HIV, and LQAS.</p>	<ul style="list-style-type: none"> • All technical interventions were research based with support for qualified consultants. (nutrition, EPI, ARI, diarrhea, FP, SM, STI/HOIV, hygiene) • All PHC and community staff received training in an integrated package of messages. • Structures are in place (CHPs, VOs, GMPs, transport, PHC, hospitals) o which to build a SM initiative. • Condoms promoted for both STI prevention and family planning. • Women prefer IUDs because they are cheap and long term. • Micronutrient distribution through PHC staff with community mobilization by GMPs and CHPs is functioning effectively. • 	<ul style="list-style-type: none"> • There may be a barrier to BCG vaccine if there are not enough babies at once to warrant opening the bottle. • People take micronutrients, but report they don't have money for fruit. • Emphasis on newborn and post partum care has not occurred to date. Overall emphasis on safe motherhood has also been limited. • HIV Center reports HIV testing is available, but it seems Districts are lagging in implementation and /or people don't know the service is available. • Micronutrients are distributed through a campaign approach with AKF providing logistic support. 	<ul style="list-style-type: none"> • AKF and DOH should send a joint letter to UNICEF requesting vials with fewer BCG doses. • Depending on the availability of funding, a safe motherhood initiative, also including newborn care, should be undertaken. • Continue to work on implementing HIV testing. • Provide micronutrients as part of routine care, and use ORS and condom supply system for micronutrient distribution to PHC centers (see CHP recommendations). • Integrate monitoring of micronutrient distribution with other PHC monitoring.

<p>Training and Capacity Building</p> <ul style="list-style-type: none"> • PHC staff able to describe case management for diarrhea, ARI, faltering children, and family planning. • Training provided in immediate and exclusive breast feeding, complementary feeding, immunizations, ARI, prevention and management of diarrhea, use of iodized salt, prevention of STI/HIV, and family planning. This was provided to volunteers and PHC staff. • GMP training provided to volunteers and all DoH staff including polyclinic and local hospital staff, as well as MSDSP. 	<ul style="list-style-type: none"> • CHPs, PHC staff, HWGs, all agreed their training was extensive and they have put it into practice. • Chief pharmacist received training in drug management. • Drug bulletin provided to PHC facilities is channel to increase knowledge. • MSDSP, district monitors, HWGs, local hospital and Polyclinic staff, and PHC staff were trained together for GMP. • Some people received training on social mobilization, gender, management, and adult education in addition to the technical training. • All AKF and DOH trainers received training in participatory adult training methodologies. 	<ul style="list-style-type: none"> • Because training was done one topic at a time, people who may come sporadically are missing essential information. • Some district monitors requesting additional training in statistics, financial management, and health sector reform. • PHC staffs need training in use of new equipment. • Lack of training in local hospital and polyclinic levels make it difficult to mobilize support and provide consistent messages at the community level. • The CHP training did not involve so many different partners. • Ambulatoria staff requested information on child development – physical and mental. • Staff feel counseling skills are weak. 	<ul style="list-style-type: none"> • Develop a counseling component integrated with all training topics. • Incorporate the IMCI approach to better integrate training across more than one topic. • Discuss the possibility of including health staff in MSDSP trainings on management and statistics. • Involve PHC staff and perhaps VO representatives in CHP training and seminars.

<p>Sustainability / Interviewee Recommendations</p>	<ul style="list-style-type: none"> • PHC staff recognizes and values the importance of CHP and GMP activities. • PHC staff indicate that growth monitoring, immunization, breast feeding counseling, are part of their job whether or not AKF is involved. • Suggest charging for clinic visit in order to have money to pay for salaries, competitions, and rewards. • Everyone values the new knowledge as a priority. 	<ul style="list-style-type: none"> • PHC staff recognizes that they depend on the motivation and control that regular monitoring offer. • All supervision and training activities still fully depend on AKF. There has been very limited handover of responsibility, nor is there a plan for gradual handover. 	<p>(see CHP recommendations)</p>
<p>PARTNERS MSDSP By the time cost from the factory, transport, packaging, and incentives are put together, salt costs .50/Kg, which is the price at which it is sold in the community. This is cheaper than other commercial salt in the market, which may be .70/Kg. It appears MSDSP is essentially recovering its costs. Salt is delivered to the VO chairman who sells it for an incentive of .05/kg. sold. His accounting is not transparent with other VO members, so it is</p>	<ul style="list-style-type: none"> • MSDSP supports the inclusion of CHPs in VO. • Iodized salt available everywhere – mothers' samples were mostly positive for iodine. 	<ul style="list-style-type: none"> • MSDSP awareness of and support for health committees on VOs is inconsistent. • MSDSP is aware of salt shortages/payment problems, but salt is distributed directly to VO chairmen without transparency and regulation at the community level. • There may be delays in the delivery of iodized salt by MSDSP even when ordered in advance due to shortage in Khorog. 	<ul style="list-style-type: none"> • Continue coordination efforts with MSDSP to integrate community volunteer activities with those of the health committees. <ul style="list-style-type: none"> ○ Encourage VO (health committee) to review salt distribution responsibilities and controls. ○ Involve the VO in med-point financial support and accountability. ○ ***With AKF/RH/CS expand and strengthen the role and responsibilities of VO health committees. • Encourage increased distribution of MSDSP salt through shopkeepers (free market—increasing supply) while also sensitizing the community to quality and storage issues in addition to the benefits of iodine

<p>unclear where the problems are when there are repayment problems. (Alichur) Huge gains according to the survey.</p> <p>PARTNERS - GOVERNMENT/ JAMOAT</p> <p>Jamoat requires MOU between themselves, AKF, VO, ambulatoria, and DoH to define clear lines of responsibility.</p> <p>PARTNERS-DOH</p>	<ul style="list-style-type: none"> • In most cases Jamoats will help fund med-point operational costs and health program supplies when informed. • Jamoat monitors use of its budget funds at the medpoint by checking receipts. • Hukumat has supported health needs at district level through rehabilitation/infrastructure commitments. • Jamoat and VO work together to meet health needs (food, wood, maintenance, personnel) • Chief Doctor is aware of/familiar with the activities of PHC facilities • Chief Doctors appreciate the importance of monitoring—for example, one CD monitors HH and med-points over and above designated responsibilities • Success of pilot (in Roshtkala) due to strength of CD—characteristics include: leadership, progressive-thinking, and initiative. 	<ul style="list-style-type: none"> • In some jamoats it is argued that support cannot be provided according to need (or at all) because the budget is fixed. • Health team doesn't always inform Jamoat of health activities or plans. • Jamoat does not keep track of drug expenses/allowances for exempted groups at the medpoints. • Some hukumats not supportive of the role/idea of CHPs. • Level of involvement of Hukumat is limited at best, minimal at worst. • No support structure for CHPs in Khorog town other than AKF. (because no PHC/ltd. contact with VOs) --difficult collaboration between CHPs and medical facilities. • Polyclinic/local hospital not included in AKF project activities, which hurts access to primary health care and support for community volunteers. • There is no real plan at district level to support or incorporate CHPs in their 	<p>(particularly Khorog)</p> <ul style="list-style-type: none"> • ***Working with MSDSP, district hukumats and their respective jamoats, establish an agreement defining the role of the local jamoat, VO, VO health committee, PHC staff, CHP and GMP in health promotion at the village level. • ***Agree on the use of jamoat funds for PHC facilities and on how to make the jamoat health budget amount and use accountable and transparent. • ***Take officials who doubt the efficacy of CHPs to observe them in action in the villages, to talk with villagers about what they have learned and who taught them, and make a point of showing them the statistical results of their efforts. • ***As part of BCRR, conduct an analysis to show the
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<p>PARTNERS-COMMUNITY VOLUNTEERS AND MEDPOINTS</p> <ul style="list-style-type: none"> • CHPs provide information on health needs in the community (immunization, pregnancy, etc.) and make referrals. • Health center staffs are resource people to CHPs providing information and treating patients. They also assist with education seminars. • Concept of HC accountability to VO is new and may be un-Russian. 	<ul style="list-style-type: none"> • CD is able to modify AKF work plan according to local conditions and transport availability. • Good collaboration between CHPs, HWGs and med-point staff (immunization, births, child care, pregnant women, health promotion, reports) plus exchange experience and resources. • Mothers/population reported behavior change, awareness of project activities, and access to drugs. • CHPs can access emergency supplies (ORS, condoms) via DM or PHC staff. • CHPs/med-pt staff jointly coordinated building and rehabilitation efforts. Community supports the heating and cleaning of med-pts, distribution of IEC, measles campaign, immunization, and toilet construction. • VO supports and funds many 	<p>planning and budgeting.</p> <ul style="list-style-type: none"> • Although two district CDs supported the idea of CHPs, one district CD and one district hukumat chairman thought CHPs were social workers and did not deserve incentives—no support. • Chief doctors do not always receive support or stay in contact with health centers. • At Oblast level, the Centers appear to have limited coordination and tend to approach implementation vertically. • Collaboration depends on the level of training and commitment, particularly of the health post staff. • Village leader/VO may make health plans without considering the input of the health committee, or working with health committee suggestions. • CHPs are not always included in the health committee (only informal collaboration). • No VO monitoring of med point and use of resources. 	<p>relative benefit/cost of incorporating CHPs, who are volunteers, into the PHC program.</p> <ul style="list-style-type: none"> • ***RH/CS negotiate with DoH to assume costs of PHC training, supervision, monitoring and education materials, and include support costs for CHPs as well. • ***Work with oblast Centers to improve collaboration and more program integration with each other and with the Districts. • ***Conduct workshops with VOs, VO health committees, CHP, GMP, medpoint staff, and jamoat to strengthen the membership and role of the VO health committee, define its role and responsibilities, and, build a team relationship to support health promotion in the community.
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	<p>project/CHP activities, in particular health promotion activities (seminars/IEC), rehabilitation, maintenance, and petrol for emergencies.</p> <ul style="list-style-type: none"> • VO helps to identify most vulnerable villagers, and then supports/funds drugs and food. • Health worker reports to VO on health/drugs in the community to enlist financial support. • HWGs report problems to health committee at VO. 		
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*** MG98 evaluation consultant added changes and/or additional recommendations.

DIP RESULTS STATUS

DIP Objective	DIP Indicator	Baseline	Targets	Achieved	*Data Verified	Comments
BCRR 1) Redefine the roles and responsibilities of the DOH, increasing managerial authority at district and community levels	Annual work plans defined;	No work plan		Health Sector Reform Program of Work 2003-2005 developed and approved 3/04 AKF-prepared HSR work plan developed 4/04		The Health Sector Reform Program of Work does not spell out roles and responsibilities;
2) Strengthen systems within the DOH required for needs assessment, planning and monitoring of field-based activities.	Monitoring and supervision visits completed;	No planning unit in DoH		Special studies conducted: 1) Health Expenditure Studies for 2000, 2001, and 2002 2) Health human resources, 2001 Oblast DoH planning unit established 4/04		The new (2004) planning unit is not staffed with appropriate skills to perform its responsibilities;
3) Introduce mechanisms for collaboration and interaction among stakeholders;	Increase # of new partnerships formed between DoH and key stakeholders;	Non		Annual health topic-specific joint planning exercise with DoH/partners. Joint plans developed for iodized salt, HIV/AIDS, healthy life-styles and immunization.		
4) Improve the capacity of senior and mid-level health officials in strategic management and program supervision;		NA		Senior and mid-level staff made study visits to other HSR sites. 202 PHC staff and accountants trained in planning and budgeting		Rationalization plans from two districts have been submitted to the DoH.
5) Improve the MIS by applying PHC MAP training series (or other mgt. tool) where appropriate;		NA		PHC-MAP course on planning and budgeting conducted for 119 oblast health care staff.		

6) Facilitate dissemination of results of policy and field-level activity in health reform in GBAO to other regions of Tajikistan and other countries in Central Asia.	Number of articles or reports on the lessons of local reform activities presented in the Regional Health Bulletin.				National level presentation by DoH on Program of Work for HSR. Exchange through study visit to GBAO from other pilot districts in Tajik.		
RPPM 1) Create a supportive environment for health sector reform, including a policy for the rational use of essential pharmaceuticals.	-Essential pharmaceutical policy defined and implemented in GBAO; -Oblast policy on Essential Pharmaceuticals Management defined and implemented;				The MOH and oblast have established a policy in support of use of essential drugs, including an order stipulating that the MOH and DoH may only purchase essential drugs with state funds. Only essentials drugs are sold at PHC facilities.		
2) Increase the potential for ensuring a sustainable supply of essential pharmaceuticals by testing and implementing locally-managed financing mechanisms; and	-All districts in GBAO receiving a regular supply of pharmaceuticals; -Increased % of prescribers following rational prescribing guidelines; -Means test for exempting the poor from paying for pharmaceuticals defined and routinely				There is reliable essential drug availability in 5 of 7 district pharmacies and all PHC facilities in every district in the GBAO. All measurements show an increase in rational use, particularly by PHC staff. (Example: average number of drugs/patient decreased from 4.5 to less than 1.5 by 2004.) Exemptions categories are defined and applied; however, at PHC levels the poor are identified by the community and covered by village organization (VO) funds.		Uniform pharmaceutical equal access and affordability in urban and rural areas of the oblast. The project plans to work with MSDSP to formalized this role and ensure financial access

	<p>applied.</p> <p>-Proportion of costs recovered through fees increased annually during the grant period.</p>				<p>Over the course of the project the subsidy has been reduced from 80% to 50%.</p>		<p>by those unable to pay.</p> <p>The project will reduce the subsidy again in the near future—perhaps as much as 25%.</p>
<p>3) Promote/facilitate the transformation of the former state-owned pharmaceutical organization into a private, non-profit;</p>	<p>Increased capacity of managers of TajikFarmatsia to plan, implement and assess operations.</p>				<p>TajikFarmatsia became non-functioning and was eventually privatized by the state as a for-profit entity.</p>		<p>No MoH or DoH structure with which to develop a non-profit entity.</p>
<p>RH/CS</p> <p>1) Ensure that women can achieve their desired fertility by increasing access to safe, hygienic and high quality FP and delivery services;</p>	<p>-% of health staff trained versus target in annual work plan.</p> <p>-% of PHC facilities stocked with essential commodities;</p> <p>-% of PHC facilities routinely offering RH, FP and CS services;</p> <p>-% of couples using modern contraceptives;</p>	<p>2001--38%</p>			<p>All PHC staff trained in management of childhood illness and reproductive health.</p> <p>All PHC facilities stocked with FP commodities</p> <p>All oblast PHC facilities offering RH, FP and CS services;</p> <p>There is an inadequate # of certified PHC staff in rural areas to insert IUDs.</p> <p>2004—45.1% married women; 45.9% non-acceptors stated they were pregnant, or wanted more children; 1.1% stated non-availability, 1.4% cited expense as a</p>	<p>Yes</p>	<p>-Occasionally there are gaps in FP stock due to unreliable delivery by DoH Reproductive health center.</p> <p>-PHC facilities are closed at times due to staff working in the fields or no heat, but PHC workers are available 24/7 in their homes and communities.</p>

	-Monitoring reports, annual assessments and annual program report undertaken by DoH and staff at central level.				deterrent, and 1% cited 'lack of knowledge.' District monitors, who are DoH staff, collect monitoring data, which is passed to AKF and district chief doctor for forwarding to DoH. The DoH compiles an annual report.		
2)Protect women's nutritional status through provision of nutritional information and supplementary micronutrients as required;	No indicator in MG 98	NA			2004 -- 77% of women with live births in last five years received iron tablets; 2004 -- 55.2% pregnant women received iron tablets; 2004 -- 39.8 % of women receiving Vit A within 40 days after birth	Yes	95% micronutrient coverage; distribution with community mobilization by GMPs and CHPs
3) Reduce morbidity, mortality and disability of women through provision of diagnostic and curative services for sexually transmitted diseases;	No indicator in MG98; -% mothers of children 0-23 months who cite at least two know ways of reducing the risk of HIV infection; -% mothers of children 0-23 mos. who cite at least two known ways of reducing the risk of STI infection.	LQAS 2003 – 55%			LQAS 2004 – 65%	Yes	50% of mothers
		2001-- 17.9% use condoms 62.9% abstain from sex			2004 – 40.8% use of condoms. 19.2% abstain from sex	Yes Yes	
4) Reduce morbidity and mortality related to infectious	% of mothers using ORS to Rx children with	2001 – 38.3%			2004 – 76%	Yes	

diseases e.g. diarrhea;	diarrhea;						
5) Achieve and sustain improved nutritional status for children under 5 years of age.	-% of children 0-23 mos. with weight for height less than 2Z scores.	2001—47% stunted			2004 – 32% stunted	Yes	10% reduction (2004) 93.7% of children 6-59 months received Vit..A within the last six months
	-% children 0-23 mos. Underweight (-2Z from the median for weight for age)	2001—35%			2004 – 23.9%	Yes	
	-% of children 24-59 months with Vit A deficiency	2002 – 2%			2004 – 1.9%	Yes	
	-Children <5 years who had night blindness	1998--2.6%			2004 – 1.6%		
	-Feeding children during illness	2001--22%			2004--69.6%		
	-Children breastfed within 24 hours	2001—72%			2004—90%		
6)	% of deliveries assisted by a trained attendant;	2001—76.4%			2004 --76.1%	Yes	20% increase
7)	% of children fully immunized;	2001—71.6%			2004 – 69.3%	Yes	90% children 12-23 months vaccinated against 6 diseases before first birthday

*Data verified either by the 1998, 2001 and/or 2004 Health and Nutrition Surveys (HNS), or the now annual 2003 and 2004 LQAS surveys.

Individuals and Groups Interviewed

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Davlat Alinazarov, Director of Department of Health, GBAO

Saidbek Davlatbekov, Chief of DoH Planning Unit

Zulfiya Gulkmadshoeva, Director of the DoH Statistical Unit

Imonbek, Head of Psychiatry Services and staff in Planning Unit

Tenurbekov Temurbek, Deputy of DoH and Chairperson of the Oblast Therapeutic Committee

Three representatives from MSDSP in GBAO regional office.

Dr. Miraliev, Director of MoH Department of Health Reform, Planning, Coordination and Implementation.

AKF

Baig, M.D., Director of AK/DN

Wendy Darby, Acting CEO, AKF/Tajikistan.

Yodgor Zayzov, CEO, AKF/Tajikistan

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Elza Saidibroimova, Pharmacist, Pharmacist Assistant

Umed Nazrishoev, Pharmacist, Chief Field Officer

Asim Gulamadshoev, Accountant, Chief Accountant

RH/CS project staff

Shazeen Virani, Director Education, Learning and Communication

District Level

Mothers, CHPs, GMPs, PHC facility staff, pharmacists, chief doctors, hukumat chaiman, jamoat officials, VO leader, and DM.

Organizations represented at the evaluation debriefing in Dushambe — ECHO, SDC, Mercy Corps, Project HOPE, ACT Central Asia, ZdravPlus/USAID, PSF/ADB, Merlin

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