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Health Services
Improvement Project

GOVERNMENT OF THE REPUBLIC OF TAJIKISTAN
THE WORLD BANK
COORDINATION GROUP
UNDER THE MINISTRY OF HEALTH AND SOCIAL PROTECTION
OF THE REPUBLIC OF TAJIKISTAN
HEALTH SERVICES IMPROVEMENT PROJECT

FINAL REPORT

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List of Abbreviations

AF	Additional Financing
ARM	An appeals/ grievance redress mechanism
CG	Coordinating Group
CME	Continuous Medical Education
CPS	Country Partnership Strategy
CQI	Collaborative Quality Improvement
CSC	Citizen Score Cards
DED	Design and Estimates Documentation
DHC	District health centers
DHIS	District Health Information System
DRS	districts under republican subordination
FM	finance management
GBAO	Gorno-Badakhshan Autonomous Oblast
GDP	Gross domestic product
GOT	Government of Tajikistan
GRM	Grievance/Appeals Redress Mechanism
HD	Health Departments
HH	Health houses
HNP	Health, nutrition, and population
HR	Human resources
HRITF	Health Results Innovation Trust Fund
HSIP	Health services improvement project
IDA	International Development Association
IPHE	Institute of Postgraduate Healthcare Education, Republic of Tajikistan
MCH	Maternal and child health
MIS	Management Information System
MOHSP	Ministry of Health and Social Protection of the Republic of Tajikistan
NCD	Non-communicable Diseases
PBF	Performance Based Financing
PCF	Per capita financing
PDO	Project Development Objectives
PHC	Primary health care
RCI	Republican Center for Immunoprophylaxis
RHC	Rural health centers
RT	Republic of Tajikistan
SDR	Special Drawing Rights
SGBP	State Guaranteed Benefit Package
STEP	Systematic Tracking of Exchanges in Procurement
TSG	Technical Support Group
WB	World Bank

I. Project General Information:

Agreement	Project commencement	Date Project Completion Date	Revised Completion Date	Amount, USD
Grant Agreement between the Ministry of Finance of the Republic of Tajikistan and the World Bank No. H 8790-TJ и TF 014871	June 30, 2013	January 31, 2019	December 31, 2019	19,8 mln.
Grant Agreement between the Ministry of Finance of the Republic of Tajikistan and the World Bank, WB Loan No.5666-TJ and Grant D70-TJ	November 16, 2015	December 31, 2019	September 30, 2020 (Grant D70-TJ)	10,0 mln.
Grant Agreement between the Ministry of Finance of the Republic of Tajikistan and the World Bank No. D547-TJ, TF0B2817	February 09, 2021	June 30, 2022	June 30, 2023	12,0 mln.
Total				41,8 mln.

Project Components	<p>I. Performance-Based Financing (PBF)</p> <p>II. Primary Health Care Strengthening;</p> <p style="padding-left: 20px;">1. <i>Quality Improvement</i></p> <p style="padding-left: 20px;">2. <i>PHC Physical Infrastructure Improvement</i></p> <p>III. Project Management, Coordination and Monitoring & Evaluation</p>
Pilot districts	<p><i>Mastchoh, Devashtich, J. Rasulov, Spitamen and Zafarobod in Sughd Region</i></p> <p><i>Farkhor, J.Balkhi, Yavan, Kubodian, Dangara, Hamadoni. Kulob, Kushoniyon and A.Jomi in Khatlon Region</i></p> <p><i>Fayzobod, Districts under Republican Subordination</i></p> <p><i>Darvoz, Gorno-Badakhshan Autonomous Oblast</i></p>

II. Financial Indicators

Table 2

Source of funding	Total amount provided	Amount disbursed	Balance	% of execution
Grant H 8790-TJ	15 000 000,00	14 085 717,45	914 282,55	93,9%
Grant TF 014871	4 800 000,00	4 800 000,00	-	100,0%
WB Loan No.5666	5 500 000,00	5 570 053,39	- 70 053,39	101,3%
Grant D70-TJ	4 500 000,00	4 625 368,22	- 125 368,22	102,8%
Grant No. D547-TJ	10 000 000,00	9 912 935,19	87 064,81	99,1%
Grant No. TF OB2817	2 000 000,00	2 000 408,29	- 408,29	100,0%
Contribution of the Government of the Republic of Tajikistan (GoT)	3 879 272,75	3 396 660,54	482 612,21	87,6%
Total	45 679 272,75	44 391 143,08	1 288 129,67	97,2%

III. Social and economic context

Social and economic context

Tajikistan is a small and landlocked country with a typical mountainous surface with absolute altitudes from 300 to 7495 meters. 93% of its territory is mountains being classified as the highest mountain systems. The country is rich in water resources, which supports cotton production and creates sufficient potential for using of hydroelectric power in aluminum processing. Since the first years of state independence, structural reforms have been carried out in key public sectors and areas, in particular, in management, finance, banking, real economic sectors, as well as in the field of education, health care, social protection of the population through the preparation and implementation of a number of socio-economic development frameworks and effective measures have laid a favorable foundation for the comprehensive development of the country's economy. Over the past decade, socio-economic indicators have undergone significant changes. The country's GDP increased from 36.2 billion TJS in 2012 to 115.0 billion TJS in 2022, indicating the country's economic growth and development. The sustainable economic growth has led to the poverty reduction from 37.4% in 2012 to 22.5% in 2022, showing improved access to basic needs.

Health sector

Along with the improvement of socio-economic conditions, there is an improvement of the health indicators of Tajikistan's citizens. An important indicator is life expectancy, which has increased over the last 10 years. In 2012, the average life expectancy was 72.8 years, and in 2021 it increased to 74.9 years. This increase indicates an improvement of the overall health of the population, access to healthcare, implementation of preventive programs and improvement of living conditions. Country has made significant progress in improving maternal and child health indicators.

Health services improvement project

The maternal mortality rate has reduced from 33.3 per 100,000 live births in 2012 to 28.9 per 100,000 live births in 2021. The situation related to child health indicators is improving. Thus, in 2012, the mortality rate was 17.2 per 1,000 live births among children under 1 year, and in 2021, this indicator decreased to 14.2 per 1,000 live births. At the same time, there is a decrease in the mortality rate of children under five years from 21.8 per 1,000 live births in 2012 to 17.7 per 1,000 live births in 2021, respectively. Furthermore, there is an increase in the scope of financing of the healthcare system from the state budget. Thus, health care expenditures against the total state budget in 2022 made 8.6%, compared to 2012 it is an increase by 1.7%. Moreover, there is an increase in health expenditures against the Gross Domestic Product from 2.0% in 2012 to 2.8% in 2022. These positive changes in the health sector over the past 10 years demonstrate the country's commitment to improving the health services quality and accessibility, reducing the risk of maternal and child mortality, and extending life expectancy.

IV. Project relevance

Primary health care is an integral part of the national health care system, being the basis of the healthcare system and includes activities for the prevention, diagnosis, treatment of diseases, medical rehabilitation, pregnancy monitoring, the formation of a healthy lifestyle, including reducing disease risk factors. In the context of the modern healthcare development in the Republic of Tatarstan, the problem of the effectiveness assessment of a health facility performance remains a priority and unresolved. Healthcare system management is impossible without defining priority goals, indicators of their achievement and parameters for the efficient use of financial, material and human resources, which make necessary the development of a methodology for assessing the effectiveness of the medical care that will ensure the relationship between management and planning processes, as well as to solve practical problems of the sector development.

The relevance of the Health Services Improvement Project in Tajikistan is emphasized in the Health Sector Strategy for the period 2010-2020. In particular, it specifies the performance-based financing approach and incentive payments to health care providers to improve services, Health Services Improvement Project aims to improve the quality of maternal and child health services in the PHC sector. This confirms its relevance and importance in the context of improving access to and quality of health care in these important areas.

In addition, the National Health Sector Strategy for the period 2010-2020 focuses on pro-poor reforms to improve efficiency, equity and quality of the healthcare. The project complies with this strategy, especially in terms of expanding full Per Capita Financing, the implementation of incentive payments and the expansion of the Family Medicine model in the PHC sector. Therefore, the Project addresses the existing health sector development priorities in Tajikistan, which emphasizes its significance and relevance for the country.

In general, the project is relevant and in line with the strategic health development priorities in Tajikistan, proposing incentives, Performance-Based Financing and Family Medicine modeling that will improve the quality of services and ensure better access to health care, in particular Maternal and Child Health services in the PHC sector.

Project Development Objectives

The Project Development Objective (PDO) is to contribute to the improvement of the coverage and quality of basic primary health care (PHC) services in selected districts.

The key indicators of achievement of the HSIP Project Development Objective are as follows:

- Mothers receiving timely postnatal counselling in existing districts (percentage);
- Mothers receiving timely postnatal care in new districts (percentage);
- Number of mothers received nutrition counselling (number);
- Average Health Facility Quality of Care Score in existing project districts (percentage);
- Average Health Facility Quality of Care Score in new project districts (percentage).

Interim result indicators by components

Component 1: Performance Based Financing

- Number of eligible health facilities in which PBF is initiated (Number)
- Percentage of Primary Health Care facilities eligible for PBF payments who received timely PBF payments in the preceding quarter (Percentage)
- Number of independent verification visits completed per schedule (Number)
- Percentage of hypertension patient charts with treatment according to protocol in existing districts
- Percentage of hypertension patient charts with treatment according to protocol in new districts
- Number of citizen scorecard exercises/sessions conducted in the project districts. (Number)
- Average ratio of women attending citizen scorecard exercises/sessions (Percentage)
- Percentage of PHC facilities that act on community action plans (Percentage)
- Persons received essential health, nutrition, and population (HNP) services (CRI, Number)
- People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)
- Number of children immunized (CRI, Number)
- Number of women and children who have received basic nutrition services (CRI, Number)
- Number of deliveries attended by skilled health personnel (CRI, Number)
- Percentage of PBF facilities completing household engagement exercise (Percentage)

Component 2: Primary Health Care Strengthening

- Health personnel receiving training (Number)
- Health facilities rehabilitated and/or equipped (Number)

Component 3: Project Management, Coordination, and Monitoring & Evaluation

- (i) Number of new project districts in which PBF MIS is operational (Number)

V. Project Design Assessment

The support of the Government of Tajikistan by the World Bank in strengthening the country's health sector has been provided since 2000. The first health sector interventions were carried out through the implementation of the Primary Health Care Project (completed in 2005) and then through the Community and Basic Health Project (December 2005 - December 31, 2012). The performance of these projects was assessed as satisfactory. Basically, these projects supported the introduction and implementation of major health policy reforms, including: Per Capita Financing of the PHC network, the State Guaranteed Benefit Package (SGBP), the development of a human resource development strategy and a health sector master plan; improving policymaking and management capacity at the central, regional and PHC facility levels; strengthening the PHC capacity - retraining of the FM practitioners and rehabilitation of the PHC physical infrastructure.

Under the Health Services Improvement Project, the WB continued to support the development of the PHC system and the improvement of the priority service indicators in Tajikistan. During the Project period, the focus was made on the quality of MCH and NCDs (hypertension) services through the provision of the performance-based incentive payments to PHC facilities. At the same time, tremendous support was provided in the development of human resources and infrastructure improvement. HSIP has contributed to improving the access of the poor population to better quality health services and reducing the negative financial impact by reducing the demand for direct payments due to the wage increments to PHC staff.

Due to the fact that HSIP focused on rural health centers and was targeted at the most vulnerable groups of the population, undoubtedly, a contribution was made to achieving the goal of poverty reduction and commonwealth in the Republic of Tajikistan. All investment activities implemented by the Project contributed to the resolution of health sector problems in accordance with the Country Partnership Strategy (CPS).

It should be noted that the satisfactory communication strategy available in the country contributed to effective informing the community of practice and citizens of Tajikistan on the objectives, achievements and experience gained in carrying out health sector reforms, to raise awareness and form a particular idea about the process and reform benefits.

Increasing access to information and integrating feedback mechanisms into health care provider processes has brought visible change and helped to increase provider accountability and responsiveness.

Project Beneficiaries

The main beneficiaries of this project are the population of Tajikistan who will benefit from improved PHC services. The women, especially poorer rural women, are a major beneficiary group since much of the HSIP is focused on improving maternal health services at the PHC facilities. By focusing on the underserved areas in the country, the Project will target the poorer rural women. The focus on children's health will also indirectly benefit women who are the primary care givers and often bear the responsibility and extra workload associated with poor child health.

Children and infants are also a specific target beneficiary group. The focus on underserved rural areas will directly target children from poorer families. Improved child health and nutrition will

have a direct positive impact on benefitting women as well as school attendance rates. The Project is expected to promote positive health outcomes for rural population.

Primary health care providers will also benefit from the HSIP through performance-based incentives, capacity building, minor rehabilitation, and some goods, e.g. solar panels and medical bags. The focus on improving nurse training and post-graduate education and certification will also target women involved in service delivery, as the majority of nurses in Tajikistan are women. The MOHSP and Ministry of Finance of the Republic of Tajikistan (MoF) are beneficiaries as well, whose capacity in planning, implementation and progress monitoring and the results of new health sector financing reforms will be improved at the central, regional and district levels.

VI. Project Components

The Project has three components:

1. Performance-Based Financing (PBF).
2. Primary Health Care Strengthening.
3. Project Management, Coordination and Monitoring, and Evaluation.

Component 1: Performance-Based Financing

This component supported the implementation of Performance-Based Financing pilot project at the primary health care level in 16 pilot districts in Khatlon, Sughd Region, GBAO and RRS, including 8 pilot districts under the principal financing - Yavan, J.Balkhi, Farkhor, Kubodiyon District in Khatlon Region; Spitamen, J.Rasulov, Devashtich, Mastcho in Sughd Region, under the Additional Financing -1 in Dangara and Faizobod Districts and further PBF extension in new 6 pilot districts of the republic Kushoniyon, Kulob, Hamadoni, A.Jomi in Khatlon Region, Zafarabad in Sughd Region and Darvoz District in GBAO.

Therefore, the PBF scheme was implemented in 16 districts during project period. Under the PBF pilot, Rural Health Centers (RHCs) and their subsidiary Health Houses (HHs) will be eligible to receive a performance-linked bonus payment based on the quantity and quality of the MCH services delivered and Non-Communicable Diseases (NCD) services. These payments are supplementary to the funds routinely received from the public sector budget and their purpose is to increase the motivation of the health staff, as well as to improve the quality of health services provided to the population.

Performance assessment of the health facilities, verification of the data reliability and accuracy is carried out by selected agencies through a two-level (Internal and Independent) verification. Internal verification is carried out by the State Health and Social Protection Supervision Service (SHSPSS), on a quarterly basis. The United Nations Children's Fund (UNICEF) has been selected to conduct an independent verification. The quantity and quality of services provided by the health facilities is determined based on the results of Internal Verification, as well as the amount of funds earned (payments) under the PBF scheme. These payments supplement the funds received on a scheduled basis from the state budget.

In addition, to support community engagement and accountability of health care managers and providers, the Citizen Score Cards (public relations) mechanism was implemented under the Project. This mechanism will be strengthened in accordance with the revised PBF manual based

on best practices in the region and training under the Project, and this strengthened mechanism will be extended to new project districts.

Furthermore, in order to increase the understanding of primary health care services and increase the demand for primary health care services in pilot districts, services provided through Household Visits will be encouraged under the PBF scheme. This activity will be based on current household visits (podvorovoy obkhod/ patronage) where nurses and primary care physicians visit households in their catchment areas to assess the health status of the household members. Under AF-2, such visits will be more integrated via: (i) conducting a census / registration of household members; (ii) conducting an assessment of the health-related needs of the household members; (iii) providing information on relevant services provided by PHC; (iv) developing plans to track required health services for each household (targeted visits); and (v) providing information on the Grievance Redress Mechanism.

Component 2: Primary Health Care Strengthening

The Component has two sub-components and it aims at improvement of the PHC providers' capacity to provide quality services.

Subcomponent 2.1: Quality Improvement

Under this component, training of primary health care staff was provided to build the capacity of the PHC providers, including six-month Family Medicine Training for the health staff in new PBF districts, PHC Management Training for PHC facilities network managers, training for the RHC Managers on Statistical Data Management and Waste Management at the RHCs level, Continuous Medical Education (on the revised clinical protocols), specific professional development courses for FM specialists (Postgraduate Training). Moreover, the Project provided support to graduates of medical universities - doctors with Family Medicine specialization in the transition to national funding (clinical residency).

Subcomponent 2.2: Physical Infrastructure Improvement

Under this subcomponent, construction and rehabilitation works have been carried out in selected RHCs in pilot districts, health facilities have been equipped with medical equipment, furniture, medical bags for PHC physicians and nursing staff, computer equipment, ambulances, generators, digital stationary X-ray machines, portable ultrasound machines, solar panels and water heaters.

Component 3: Project Management, Coordination and Monitoring & Evaluation

This project management component finances the expenses associated with the implementation and management of the project at the central and regional level, such as recurrent costs, office equipment and furniture, maintenance of vehicles for project implementation supervision, specialist salaries, travel expenses, training for the CG members and project implementation staff at regional and district levels, monitoring and evaluation, and project audits. Under this component, activities on general monitoring of the project activities were carried out by the Project Implementation Group, which provides technical assistance to the MOHSP in project implementation.

VII. Project Implementation Status

Component 1. Performance Based Financing

In order to implement the scheduled activities, the following activities were carried out under the Component 1.

Performance-Based Financing Manual

During the Project implementation period, the PBF Manual was developed and approved in order to define the basic management rules, policies and procedures to ensure the PBF effectiveness. This PBF Implementation Manual describes the objectives, procedures, and methodology of the PBF scheme piloted under the Tajikistan Health Services Improvement Project (HSIP). Its purpose is to ensure consistency, transparency, and accountability of people involved in PBF management and implementation.

The core of the PBF scheme is the payment of fee for those PHC services that the MoHSP wants people to utilize more. It must be emphasized that the scheme focuses on:

- Family Medicine services, seeking to uncover its opportunities and ensure that general practitioners/family doctors and nurses apply all their qualifications;
- not separate techniques or procedures but rather on their complex when timely and consistent care can indeed improve health of the most vulnerable groups in rural areas;
- high-quality health service delivery—in better conditions and with greater interest of health workers in the outcomes of their work. Therefore, in particular, the RHC/HH workers are expected to search innovative ways to build trust among local population and increase service coverage, e.g., through organizing active community outreach, improving dialogue with the population, reducing formal and informal payments, etc.

The list of the purchased health services includes mainly prevention rather than treatment. The intention is to avoid growth in unnecessary services as a result of incentives; this decision also comes from the understanding of high value Family Medicine adds to the prevention of chronic diseases, their complications, and even life-threatening conditions. Maternal and Child Health and hypertension indicators were selected and formulated for the PBF scheme in the Republic of Tajikistan. Based on these indicators, a list of services for which payments were made to RHCs and HHs was compiled.

The PBF scheme implementation started in 2014 based on the approved PBF Manual (MOHSP Order dated 4.04.2014, No. 177) in Spitamen District, Sughd Region (pre-pilot project), and from 2015 until the end of 2016 project implementation was extended to 7 pilot districts (Farkhor, Kubodiyon, J. Balkhi, Yavan in Khatlon Region and Mastchoh, J. Rasulov and Devashtich District in Sughd Region). According to the PPBF Manual, the performance of health facilities was assessed and payments were made based on nine quantity indicators and 93 quality indicators for RHCs (under 10 categories with a maximum score of 300) and 60 quality indicators for HHs (under 8 categories with a maximum score of 180).

Since the beginning of the Project implementation, the PBF Manual has been revised twice, taking into account the requirements of newly approved MOHSP clinical protocols, results of internal and independent verification, recommendations of agencies responsible for verification,

as well as the accumulated experience of health care providers in pilot districts. Since January 2017, health facilities in 10 pilot districts (Faizobod and Dangara District were added under AF-1) have been implementing their activities using the updated PBF Manual, under the Project (MOHSP Order dated 29.11.2016, No. 900).

The following changes are made in updated Manual:

- number of quantity indicators is increased, additional indicator “Number of women aged 15-49 using modern contraception method that have been observed during verification period” was introduced;
- indicators cost revised;
- indicator names changed according to the requirements of again approved clinical protocols;
- threshold values on quantity indicators 1, 4, and 5 when payment is produced for services provided OVER determined value, so called “threshold” (80, 60, and 20% respectively), were changed;
- calculation and bonus payment table for execution of quality indicators is changed (reduction of maximum percentage for execution of quality indicators from 150% to 100%);
- calculation of quality indicators was revised and a unity price of quality categories was increased with a focus on clinical care + hygiene and sanitation;
- each sub-item of the quality categories was detailed, with its own performance score assigned. The changes introduced allowed for a more fair assessment of the health facilities performance. Changes in the quality assessment tool resulted in an increase in the total amount of quality scores from 300 to 1253 points for RCHs and from 180 to 583 for HHs.
- facilitator supervision disbursement conditions are revised for DHC teams. 35% makes fixed advance payment to cover the costs for supervisory visit, the rest 65% from 288 TJS are paid in case if facility that had supervisory visit increased an average quality score to 5% or average score above 85%;
- common rules of conduction of internal and independent (external) verification are developed.

The second update of the PBF Manual was carried out under AF-2 to ensure the sustainability of the PBF scheme after project completion. During the update, it was decided to reduce the PBF quantity indicators, to bring down the cost of indicators and apply threshold values, taking into account the average health facility performance indicators for 2019. The changes introduced resulted in decrease of the incentive payments scope that allowed for a favourable integration process of the general framework of financing and planning of the required budgetary funds based on per capita financing calculations, in the future.

The quality of primary health care was incentivized through quality assessment checklists focused on selected Maternal and Child Health (MCH) and Non-Communicable Diseases (NCD) services. These include child health services such as immunization, postnatal counselling, height / weight monitoring and malnutrition treatment. The indicators for arterial hypertension diagnosis and treatment remained unchanged, given the inadequate diagnosis and control of

blood pressure of the population. The total number of quality indicators was 789 and 466 scores for RHCs and HHs, respectively.

In the revised version of the PBF Manual, which was approved by the MOHSP Order, dated December 24, 2020, from the original 10 quantity indicators, 6 indicators were retained and adjusted, and one new indicator related to the number of household visits/patronage and quality of home-based services was added. The main tasks of this indicator implementation include increasing the population's awareness of health issues, changing the behavioral approach of households and improving access to health care.

In the revised version, thresholds were introduced for 5 of the 7 indicators that affect bonus accrual. Amount of bonuses and thresholds for existing and new pilot health facilities were slightly different with the purpose of more fair allocation of funds.

Development of the Household Engagement Manual

Based on the results of the Impact Evaluation of the Performance Based Financing in the health sector of the Republic of Tajikistan*, as well as, in order to introduce and implement a new PBF quantity indicator *Number of households visited by health staff during the verification period (podvorovoy obkhod)*, which is aimed to raise public awareness about the services provided at the PHC level and increase the demand for them, it was decided to develop the Household Engagement Manual. Under this subcomponent (Household Engagement), activities will focus on demand, i.e., moving away from the principle of “identify the problem and redirect” to the principle of “timely identify and eliminate or significantly reduce the risk”, which should lead to an increase the home visits quality and rise the degree of trust of the attached population for the activities of PHC services providers. Certainly, household visit/patronage is part of the terms of reference of the primary health care providers. However, today there is no clear vision of the objective and effectiveness of this service provision. Heads of the PHC network do not have a specific tool for assessing the scope and quality of home visits, as well as the impact of the services provided on the health of the attached population.

Therefore, during the reporting period, the PIG specialists in close cooperation with an International Consultant developed a Household Engagement model and its mechanism, algorithms and actions described in details in the new expanded Household Engagement Manual.

This Manual was approved by the World Bank and endorsed by the MOHSP Order dated 01.05.2021, No. 367.

Verification rules

In order to standardize the verification process both internal and independent, for the performance of the PBF indicators, the Verification Rules have been developed. Due to changes in the PBF Manual, these *Verification Rules* have been revised and updated. Approval of the *Verification Rules* was carried out by the MOHSP orders. It's should be noted that the staff of the State Health and Social Protection Supervision Service (SHSPSS) responsible for internal verification, as well as the United Nations Children's Fund (UNICEF) responsible for independent verification completed the PBF Manual and Verification Rules Training. This training enabled the SHSPSS and UNICEF staff to learn the basic approaches and mechanisms of Performance-Based Financing, and to learn how to conduct verification in accordance with

the developed *Verification Rules*. This is an important step to ensure consistency and uniformity of the verification process, as well as to ensure proper implementation of the PBF indicators.

PBF Principles and Mechanism Training

The PBF Manual training was organized to make aware PHC staff from the DHC supervision team and managers of RHCs and HH of the principles and mechanisms related to the implementation of the PBF scheme in 16 pilot districts. The trainings were conducted by specialists from the Project central office and regional offices. A total of 6374 PHC staff from 16 pilot districts were trained during the Project implementation, including 4048 persons in Khatlon Region, 1828 persons in Sughd Region, 405 and 93 health staff in Faizobod and Darvoz District, respectively. Of the total number of trained 5139 (81%) were nurses, 1153 (18%) were doctors and 82 (1%) other specialists. The gender distribution is dominated by 4191 women or 65.8% of those who completed training, and the remaining 2183 or 34.2% are men. The training was carried out according to the approved program in accordance with the MOHSP Orders.

Signing of the Performance Agreement between the MOHSP and PHC network of the pilot districts

In order to execute the terms of the Financing Agreement between the Republic of Tajikistan and the International Development Association, during the reporting period, the Performance Agreement was signed between the MOHSP and the pilot districts PHC. The purpose of this Agreement is to expand the availability and improve the quality of the health services in rural health centers and health houses by providing them with additional funding and strengthening their rights in making decisions on the management of their financial transactions. At the same time, in order to ensure the safety of monetary and material values, an Agreement on full individual material liability was signed.

PBF Management Informational System

The PBF Information Management System of the FRD (PBF MIS) is one of the basic sources of operational data for assessing the PBF indicators (quantity and quality indicators) as well as indicators at the level of the PIU and interim results. The PBF management information system, which is based on open-source software called DHIS-2, was developed and implemented to meet the PBF needs and conditions in Tajikistan. This system was originally developed based on the DHIS-2 platform. DHIS-2 is the most demanded open source healthcare management system managed by the HISP project of the University of Oslo, Norway. This platform was created based on more than a decade of experience in many countries of the world, that means that it was created on the basis of the actual use of this platform in various conditions and given all the requirements. Therefore, the DHIS-2 is very flexible system and it's easily adaptable to various tasks of collecting and analyzing health data.

Under the developed PBF MIS system, health care facilities independently submitted monthly reports on PBF indicators on the scope of services provided. For this purpose, they use provided tablets and laptops with internet access. These data were verified during the quarterly initial verification prior to the release of funds for PBF payments. When designing the PBF MIS, maximum efforts were made to ensure its compatibility with the ongoing activity to modernize the country's Health Management Information System (HMIS).

During the preparatory phase of the project documents, as part of the development of the PBF operational manual, the hired EPOS Consulting Company contracted Latypov M., a local PBF MIS specialist to define the purpose and objectives of the PBF Management Information System. Under this agreement, the initial version of the PBF module was developed based on the DHIS 2 platform. The first version of the program provided for data input from pilot health facilities and internal verifiers on PBF quantity and quality indicators. Reporting was generated for each health facility separately, with calculating performance of each of them. However, there was no possibility to obtain a summary report for all pilot health facilities, and it was impossible for external verifiers to enter data. In addition, the system did not block data for past reporting periods, which allowed users at the level of health facilities and verifiers to change the data. Due to a number of limitations, the developed system was not tested and had unstable functionality, which prevented its use in the pre-pilot phase of the project.

Second phase of PBF MIS development was commenced in the third quarter of 2014 with recruiting HMIS Consultant. It included testing and elimination of errors in the information program. The basic formats, formulas and settlements for calculation of earned income by health facilities were revised in accordance with the PBF Manual approved by the MOHSP.

Next phase in PBF MIS design and development began with full-scale piloting of PBF project in eight districts in Khatlon and Sughd Region starting from the Quarter 3 of 2015. As piloting started earlier in January 2015, data for the first two quarters were collected manually and later entered into the system. In this period, World Bank hired international consultant Loran Mikolaichuk to provide technical support to project's team. In collaboration with international consultant PBF team defined key areas for improvement and finalizing PBF MIS. In particular, it was necessary to upgrade the PBF MIS to the latest DHIS 2 version, test out functions of the new platform, develop "background" functions to support the PBF process and develop additional reports and "visible" functions. Above mentioned changes and improvements were implemented by the PBF MIS team in collaboration with M. Latypov, independent consultant.

Major revision of the PBF implementation manual initiated in 2016 led to the PBF MIS upgrade. With the cardinal changes in the format and number of data elements for quality indicators, after revision of PBF implementation manual, importing old data into new database was not viable. Changes made into new database do not allow for comparative data analysis due to the fact that dimensions of old and new data differ, meaning they are no more comparable. This also applies to the changes in quantity indicators already made (age and gender). With this in mind creating new data base was the only solution. Changes in the number and format of data being collected also affected end user interfaces, calculation methods and reporting forms that were upgraded to new PBF implementation manual. Calculation formula also changed to accommodate new scheme for calculating payments as per new manual that includes new prices and threshold values of quantity indicators, quality percentage. In addition, a gender gap data entry procedure has been introduced for all PBF indicators.

Under the AF-2, taking into account the amendments made in the PBF Manual, it became necessary to update the PBF MIS, accordingly. Therefore, Mr. M. Latypov, International Consultant was hired by the Project. According to the Consultant's Terms of Reference, a number of tasks to improve and finalize the system have been defined, in particular, updating the DHIS2 platform to the latest version from the DHIS-2 repository and transferring data to the

updated version of the PBF module; software update according to the revised PBF Manual; creation of an analytical part for monitoring quantity and quality indicators, PDO indicators and interim indicators; training on the implementation of changes in the PBF software and troubleshooting and bug fix.

Computer Literacy

For the purpose to continue supporting health sector in implementation of the Health Management Information System (HMIS) to increase relevancy of management decisions, improve efficiency, completeness, reliability and exchange of information for the needs of management, financing at the PHC level through PBF HMIS. Human resources development for the health sector digitalization is one of the HMIS Development Strategy priority (MOHSP Order No.579 “On the approval of the Development Strategy Plan of the Health Management Information System” dated 05.07.2011). Thus, provision a short-term basic computer skills training is important as the level of computer literacy among PHC workers is very low and creates a barrier and sustainability risk in the further usage of PBF HMIS.

In this regard, according to the implementation plan, the Project equipped health facilities (DHCs, RHCs and HHs) in new pilot districts with computers and financed a short-term Computer Literacy Training for the Supervision Team of District Health Centers (DHC), RHCs/HHs heads and designated staff in 16 pilot districts who attended special PBF MIS Training. To carry out this activity, the project entered into a contract with the public organization Umedbakhsh and State institution *Adult Education Center of Tajikistan* for conducting short-term Computer Literacy Training. During the project period, Computer Literacy Training has been conducted in accordance with the MOHSP orders with involvement of 921 PHC staff in 16 pilot districts, including 751 staff in Khatlon Region, 97 staff in Sughd Region, 43 staff in Darvoz District and 30 staff in Faizobod District. The gender distribution is dominated by women (513 or 56% of those trained), while the remaining 408 or 44% are men.

PBF Management Informational System Training (PBF MIS)

The PBF Information Management System (PBF MIS) is one of the basic sources of operational data for assessing the PBF indicators (quantity and quality indicators) as well as indicators at the level of the PIU and interim results. The PBF management information system, which is based on open source software called DHIS-2, was developed and implemented to meet the PBF needs and conditions in Tajikistan.

Under the developed PBF MIS, health facilities independently provide monthly reports on the PBF indicators regarding the scope of services provided, using the provided tablets and laptops with access to the DHIS-2 information system. In this regard, the required training on how to use DHIS2 Information System was carried out for designated staff of health facilities in 16 pilot districts. Under this project, DHIS2 Training was conducted with the participation of 1468 PHC staff, including 1087 PHC staff in Khatlon Region, 312 workers in Sughd Region and 69 staff in Darvoz District (GBAO). In terms of gender, women prevailed, in particular 973 women or 66.3% of those trained, while the remaining 495 persons or 33.7% are men.

Capacity building of the State Health and Social Protection Supervision Service

In order to strengthen the capacity of the State Health and Social Protection Supervision Service in preparation for national extension and transition to state ownership through the expansion of verification teams, the implementation of the PBF verification tools and the

development of a common tool for assessing services and managing PHC, the project carried out the following activities:

Organization of training and study tours

During the reporting period, in order to strengthen the capacity of the State Health and Social Protection Supervision Service, training was conducted on the topic “Quality control of medical services” by a Specialist of the Republican State Enterprise on the Right of Economic Use “National Healthcare Development Scientific Center named by Salidat Kairbekova” Ministry of Health of the Republic of Kazakhstan. It should be noted that in addition to the SHSPSS staff, employees of the Ministry of Health and Social Protection of the Republic of Tajikistan and the Project staff were involved in this training. A total of 21 specialists completed this training course. The training was focused on the topics of the general concept of the quality of medical services, quality control of services, examination of the quality of medical services, quality indicators and accreditation of health facilities.

Along with this, a study tour to the Republic of Kazakhstan was organized by the Accreditation Center for Healthcare Quality, Republic of Kazakhstan. The delegation included both representatives of the Ministry of Health and Social Protection of the Republic of Tajikistan, the State Health and Social Protection Supervision Service and the Medical Accreditation Center under the State Health and Social Protection Supervision Service. Within the framework of the five-day program, a number of meetings were held on cooperation and experience exchange in the field of health management and quality of healthcare, digitalization in healthcare and procurement of services. In particular, the meetings were held at the Accreditation Center with representatives of the Social Health Insurance Fund (SHIF), National Center for Rational Use of Medicaments (NCRUM) and public associations and presentations were organized whereby members of the Tajik delegation learned about various aspects of the Kazakhstan healthcare system, including: the national accreditation system, the procurement arrangements and SHIF monitoring quality, drug supply, disease management program (NCD) and health financial aspects. In addition, representatives of the delegation visited a number of public and private medical organizations: JSC "Republican Diagnostic Center", PCE "City Polyclinic No. 11" in Nur-Sultan, PCE "City Polyclinic No. 10" in Nur-Sultan, REM "Multifaceted City Children's Hospital No. 1" Nur-Sultan, Astana Ecolife LLP. In addition to healthcare organizations, the delegation members visited the “School of Medicine” of Nazarbaev’s University, the National Independent Examination Center, the International Techno-Complex “Astana HUB”, where digitalization tools in the healthcare sector were presented.

Accreditation of the PHC Network

In order to prepare health facilities for official medical accreditation, to comply with the sectoral regulations, to respect the rights of patients, to ensure safety in the provision of medical care and to improve the level and quality of health services and implement Resolution of the Government of the Republic of Tajikistan dated September 9, 2014 No. 600 “On accreditation issues of healthcare facilities, organizations and enterprises” the following activities were held:

- Guidelines for recommendations, study and evaluation to achieve “Further medical accreditation” were developed and approved through the by MOHSP Order No. 01 dated 03.01.2023

Health services improvement project

- “Certificate of readiness for medical accreditation” form was approved through MOHSP Order No. 01 dated 03.01.2023
- An agreement was signed between the Ministry of Health and Social Protection of the Republic of Tajikistan and the State Health and Social Protection Supervision Service on conducting the readiness for the “Further medical accreditation” of 37 rural health centers constructed under the Health Services Improvement Project based on Guidelines for recommendations, study and evaluation to achieve “Further medical accreditation”. According to this agreement, based on the Order of the State Health and Social Protection Supervision Service dated March 27, 2023 No. 15, a study and consultations were carried out on the readiness of the constructed RHCs in pilot districts for the “Further medical accreditation”. As part of this activity, all RHCs were provided with a Collection Of Accreditation Standards for the PHC Network, orders on approving readiness for accreditation and study of readiness for accreditation, booklets and information materials on the content, concept and benefits of medical accreditation, accreditation standards checklists for RHC self-assessment.

Development of the Information System for quality control of services provided by PHC (DHIS-2)

In order to ensure the sustainability of the fundamental principles for assessing the performance of health facilities of the PHC network, which were established and successfully tested in application of the Performance-Based Financing Mechanism (PBF) during the implementation of the Health Services Improvement Project in the Republic of Tajikistan (HSIP), and taking into account the experience of working with the PBF Management Information System, acquired by the SHSPSS staff during the project period, the Guidelines for applying national standards for the accreditation of health facilities of the PHC network were developed in cooperation with the Medical Accreditation Center under the State Health and Social Protection Supervision Service of the Republic of Tajikistan and HSIP specialists.

This document is aimed at improving the process of national accreditation of health facilities in the PHC system and is designated for persons directly involved in the preparation and implementation of accreditation standards, such as managers and staff of health facilities, independent experts and internal audit specialists.

The guidelines contains brief information on the the accreditation procedure, the arrangement of the accreditation itself, as well as methodological guidance on the use of national accreditation standards of PHC health facilities on the platform of the DHIS-2 Information System. The Accreditation Center is the only organization responsible for conducting national accreditation of health facilities in the Republic of Tajikistan, and its employees have long experience in working with international and national accreditation standards. These Guidelines are intended to ensure the consistency and transparency of the actions of persons involved in the process of medical accreditation and assessment of the compliance of health facilities of the PHC network with national standards.

Moreover, Mr. Murodullo Latipov, International Consultant was hired to make the required changes to the PBF Management Information System (DHIS-2), under the project. As part of this consultancy, the DHIS-2 management information system was updated to

the latest version, the indicators of the information system were changed in accordance with the new guidelines for quality control of PHC services provided, an adaptive panel was developed to administer the input and change of information system data, and an analytical module for the quality data analysis and an offline method for filling in data forms. In addition, the databases were installed and transferred to the information system on new server equipment, and the staff of the Medical Accreditation Center were trained to work with the information management system.

Basic infrastructure improvement

In order to improve the basic infrastructure of the State Health and Social Protection Supervision Service, two vehicles, computer equipment for evaluation and verification were purchased, and server and computer equipment for the implementation of the Grievance Redress Mechanism, as well. More details on the GRM are discussed in the section *Grievance Redress Mechanism*.

Verification

As per the Project Concept, monitoring includes two levels of verification. At the first level, quarterly verification of the PHC facilities performance is carried out by the State Health and Social Protection Supervision Service (SHSPSS). The second level involves an independent verification (IV) of the data carried out every six months by a third party. The selected agency responsible for conducting the IV is UNICEF Tajikistan.

The goal of verification is to improve health service delivery at the level of PHC of pilot districts by timely and honest registration of the number and quality of provided services, as well as updating the knowledge and practical skills of the workers of RHC/HH in family medicine. Verified services are determined in the approved PBF Manual within HSIP implementation.

Main verification principles are the following:

Supporting and training the health workers.

Independency and fairness of verification.

Verification results justifications.

Internal verification (IV)

State Health and Social Protection Supervision Service (SHSPSS) was selected to conduct internal verification. An Agreement for conducting internal verification was signed between MOHSP and SHSPSS. The Agreement defines a complex of activities envisaged by the PBF Manual and in accordance with the Verification Procedures.

SHSPSS has conducted 29 verifications during the whole period of project implementation:

- 3 verifications on pre-piloting stage in Spitamen districts in 2014.
- 26 verifications in 10 pilot districts of Khatlon (Yavan, Dangara, J.Balkhi, Farkhor, Kubodian) and Sughd (Spitamen, J.Rasulov, Devashtich, Mastchoh) regions during 2015 to 2022.
- 22 verifications in two additional districts (Dangara, Faizobod) in 2016.
- 6 verifications in 6 new pilot districts (Kushoniyon, Kulob, Hamafon, A.Jomi in Khatlon, Zafarabad in Sughd, and Darvoz in GBAO).

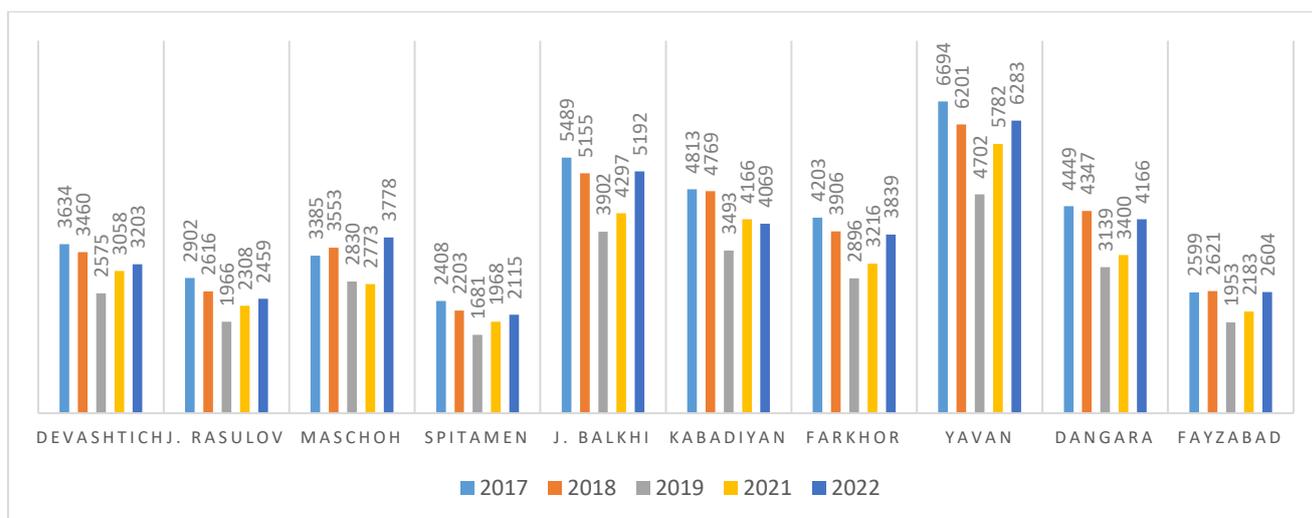
Internal verification of the reliability of the reporting data submitted by PHC facilities was carried out by the State Health and Social Protection Supervision Service in accordance with the approved schedule, on a quarterly basis. Based on the verification results, a performance assessment, accrual and payment of funds earned by health facilities was made. These payments supplement the funds received on a regular basis from the state budget, and their purpose is to increase the staff incentive, as well as improve the quality of the health services provided to the population. The goals are achieved through the provision of payments, which consist of performance-based bonuses and the funds required to health facilities to strengthen their administrative and technical capacity and, as a result, to improve the conditions and level of the primary health care services provision.

Analysis of the internal verification results

Given the amendments made in the PBF Manual in 2017 regarding quality and quantity indicators, it is impossible to carry out comparative data analysis as most indicators differs by parameters and rates from previous ones, prior to 2017. The analysis of the internal verification results of the health facilities performance in pilot districts under quantity indicators and an assessment of the quality of services under 4 categories provided below.

Indicator 1. Number of children under 13 months of age fully vaccinated according to the Immunization Schedule set up by the MOHSP.

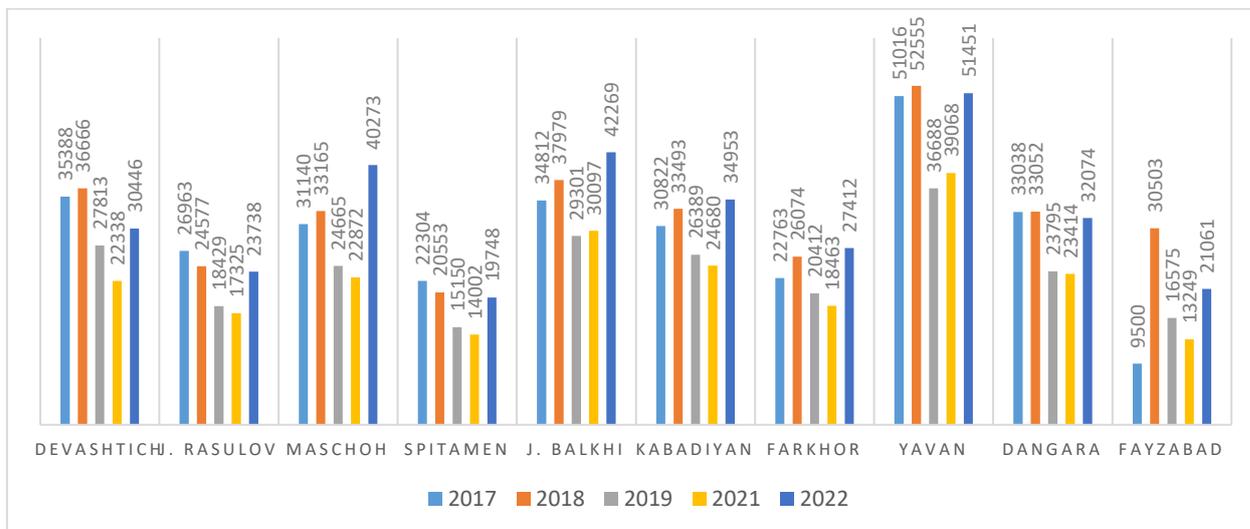
Chart 1



General comparative analysis of this indicator showed a decrease of the quality of services by 7% for 2017 and 2022. This decrease is observed in all districts. Generally, the coverage of this indicator made 99.8% in 2022, and compared to 2017, the growth made 4%. *Chart 1*

Indicator 2. Number of children in the age of 0—24 months, whose weight and height is measured according to the recommended schedule and whose parents have been advised on the proper child nutrition and care.

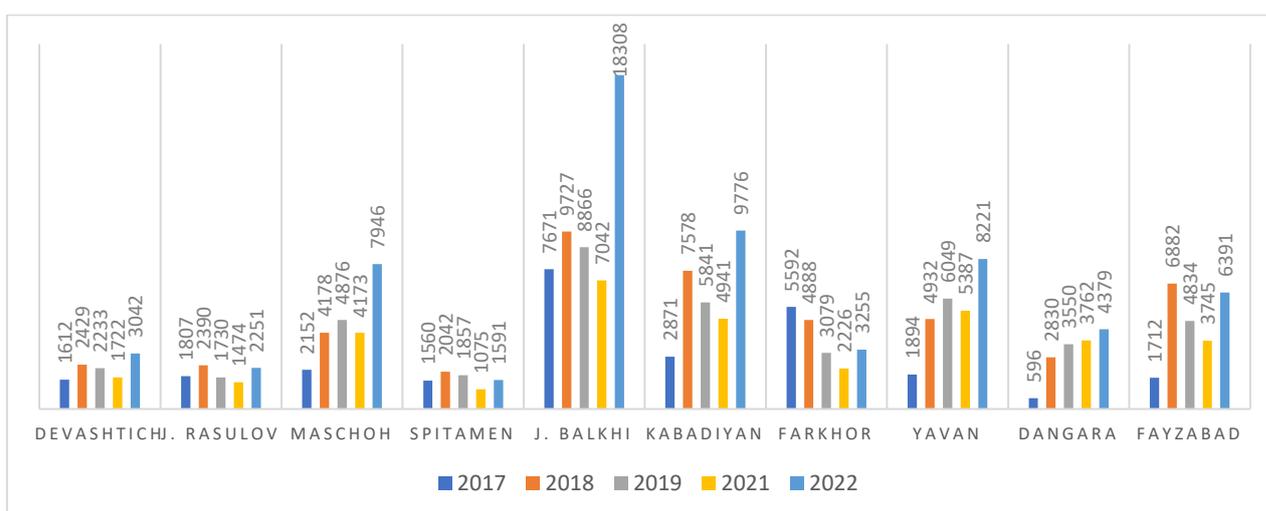
Chart 2



Deviations in provision of health services under this indicator are observed in general for the period from 2017 to 2022 in 10 districts. In some of the districts such as Mastchov, J. Balkhi, Kubodian, Faizobod, Yavan and Farkhor an increase of the quality of services was noted. Proportional changes make approximately from 1% to 122%. At the same time, decrease is observed in Devashtich, J. Rasulov, Spitamen and Dangara district from -13,9% to -2,9%. In general, the growth of services is observed by 9% for this period. *Chart 2*

Indicator 3. Number of children under five with detected malnutrition, whose parents received advice on proper nutrition and child care and who are experiencing positive dynamics

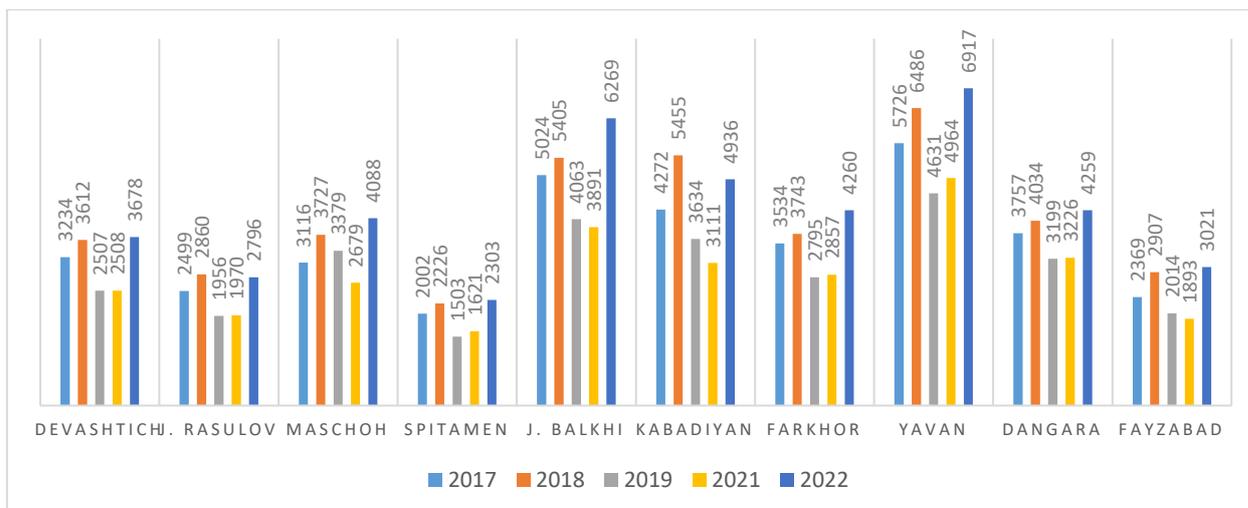
Chart 3



Comparative analysis of the pilot facilities performance under this indicator for 2022 showed that there is a positive growth dynamic in the performance of most of the pilot districts compared to 2017. However, Farkhor district is an exception, where the decrease of the number of services by 42% was observed. On average, the growth of this indicator for 2022 made 137% compared to 2017. *Chart 3*

Indicator 4. Number of mothers received the first post-natal care home visits during first three days after check out from maternity house.

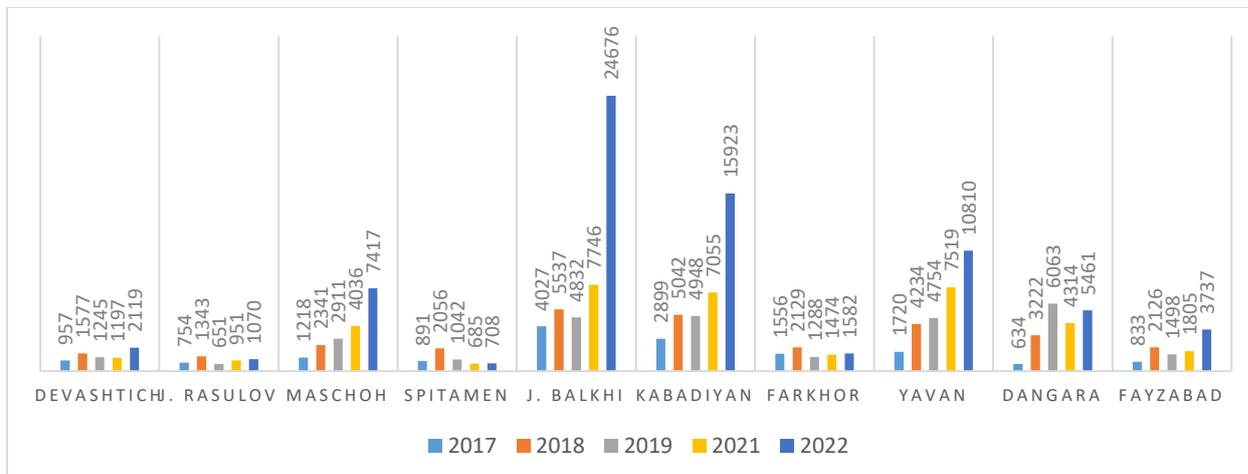
Chart 4



Number of services provided in all pilot districts under this indicator increased by 20% on average in 2022 compared to 2017. The coverage of recently delivered women in the postpartum period in 10 pilot districts made 99.8% by the end of the project. *Chart 4*

Indicator 5. Number of newly detected and registered patients with hypertension and set a diagnosis according to the National MOHSP Clinical Protocols

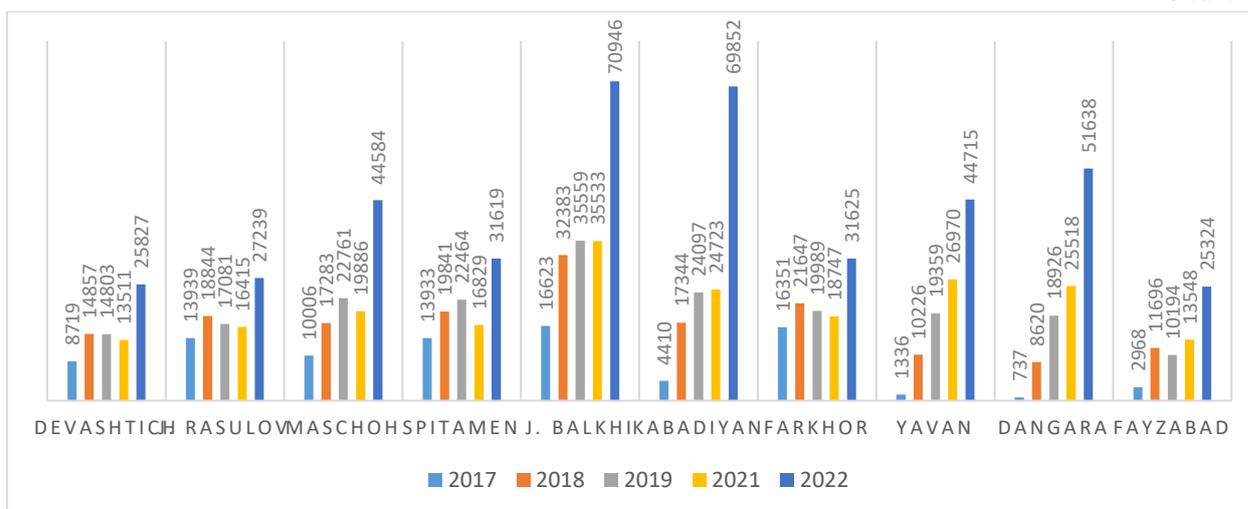
Chart 5



The verification results of this indicator showed that, on average, in 2022 compared to 2017, there is an increase in services provided in most pilot districts. With the exception of Spitamen District, where there is a decrease of number services provided under this indicator by 21%. It should be noted that the percentage of identifying accurate diagnosis pursuant to the requirements of clinical protocols made 98.0%. *Chart 5*

Indicator 6. Number of patients over the age of 17 diagnosed with hypertension and received treatment according to the MOHSP Clinical Protocols

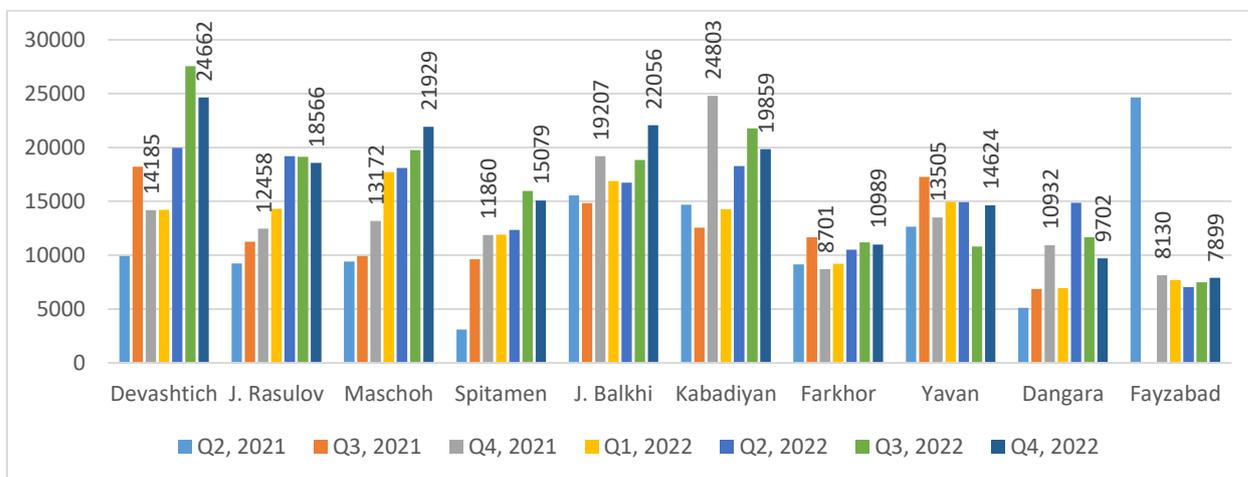
Chart 6



Comparative analysis of the indicator's performance in all pilot districts showed that in 2022 compared to 2017, there was an increase in the number of services by an average of 376%. Positive dynamics was observed almost in all districts. The percentage of patients who received treatment in accordance with the MOHSP clinical protocol compared to 2017 has increase from 75% to 95%. *Chart 6*

Indicator 7. Number of households visits made by health personnel during the verification period (rounds to households)

Chart 7

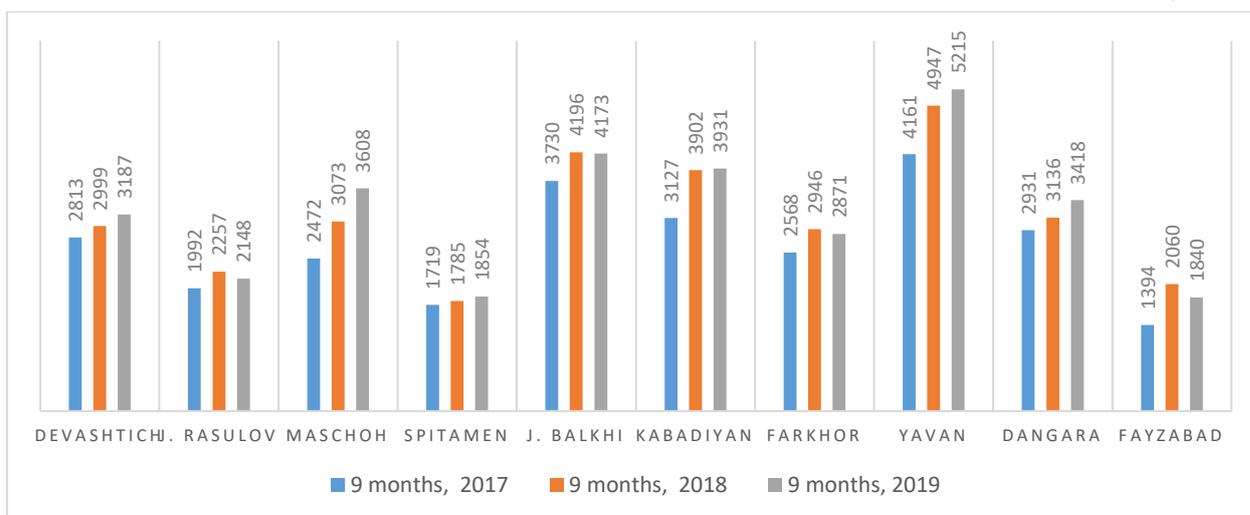


In total, health facilities' staff in the 10 pilot districts had visited 165365 households during the Quarter 4 of 2022, as required by the Guidelines on Household's engagement, which made 20,7% in comparison with the Quarter 4, 2021 *Chart 7*

In addition, the data on 4 excluded indicators that were tracked until 2019 are provided below. It should be noted that corresponding last verifications was completed in third quarter of 2019. Therefore, analysis was made in comparison with the same period of 2018.

Indicator 4. Number of pregnant women who was registered for receiving ANC during first 12 weeks of pregnancy

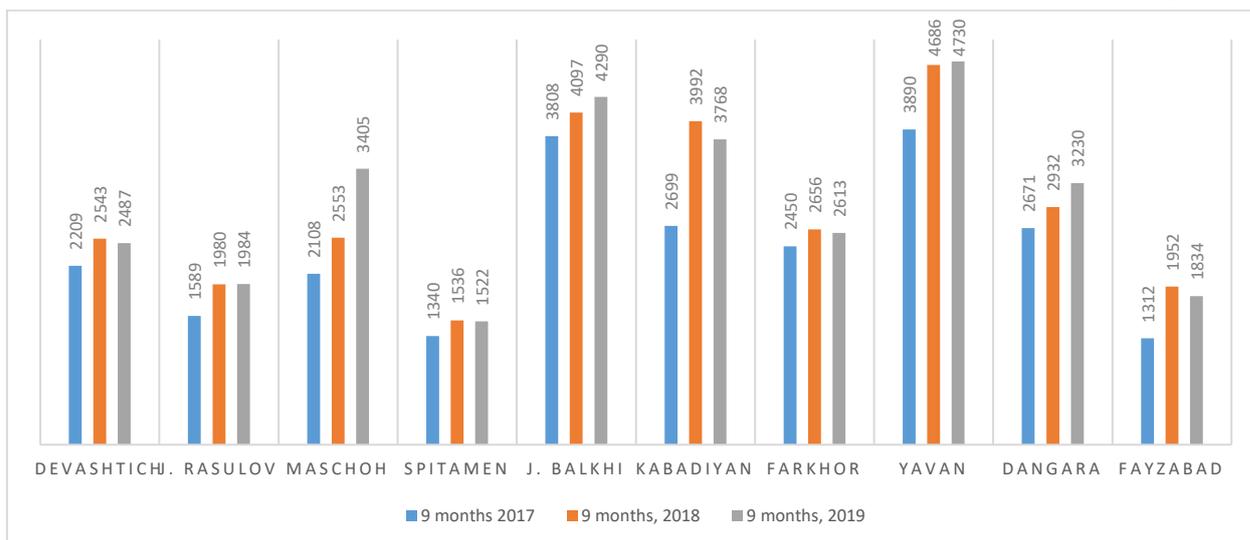
Chart 8



As can be seen from the Chart, the number of services provided over the three quarters of 2019 increased by 3% on average, in all pilot districts, in comparison with the similar period of 2018. Early coverage of pregnant women and registration increased by 3% for nine months of 2019 compared with 2017 in pilot districts in Sughd Region (96% and 99%, respectively). In Khatlon Region, there is a 6% increase in the coverage of this service compared to 2017 (from 91.8% to 97.5%, respectively). In the Faizobod district, scope of this service reached 92.4% for the nine months of this year compared with 9 months of 2017. There is an increase of this indicator by 14%. *Chart 8*

Indicator 5. Number of pregnant women with at least 4 ANC visits to RHC/HH

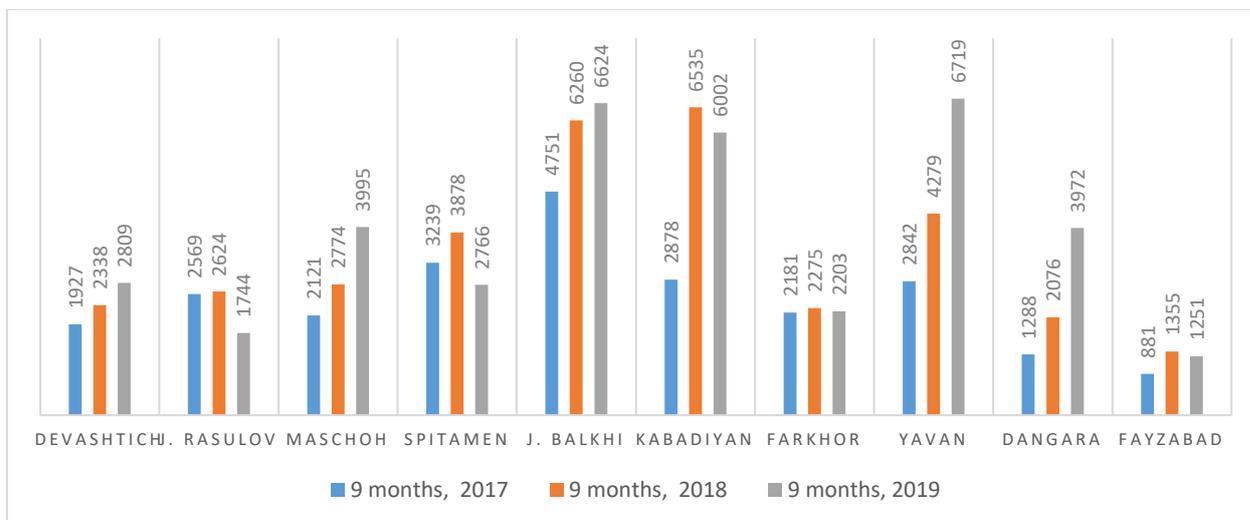
Chart 9



Comparative analysis of the results of verification under this indicator demonstrates an overall increase in the number of services by 3.2% in all pilot districts for the first three quarters of 2019 in comparison with the three quarters of 2018. The coverage of this target population amounted to 98.7%, according to the Action Plans of health facilities for nine months of 2019. Compared to the 9 months of 2017, coverage was 8% in all pilot districts. *Chart 9*

Indicator 7. Number of women in the age of 15-49 provided with modern contraceptives during the verified period.

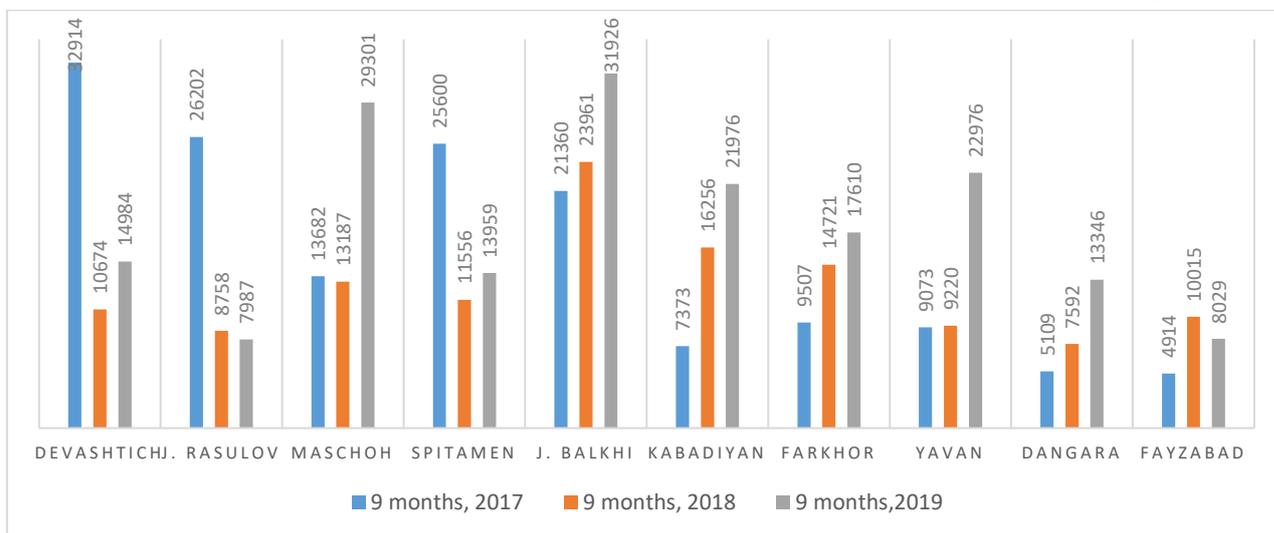
Chart 10



Comparative analysis of this indicator performance showed that the total number of contraceptive services provided during nine months of 2019 increased by 10.7%, on average, in comparison with 9 months of 2018 in all pilot districts. Estimating the level of contraceptive coverage for the three quarters of 2019 compared with the three quarters of 2018, there is a growth trend from 4.3% to 4.5%, respectively. *Chart 10*

Indicator 8. Number of women in the age of 15-49 using modern contraceptives and been observed during verification period or received oral contraceptives or the next IC injection

Chart 11



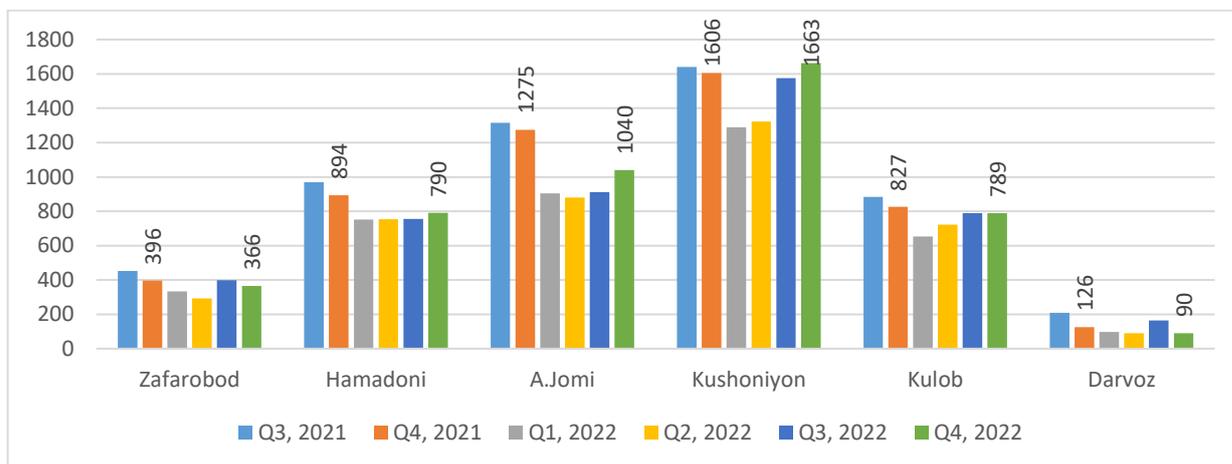
The total number of services provided under this indicator for nine months of this year amounted to 182094. In comparison with the similar period of 2018, this indicator is increased by 45%. A decrease under this indicator is noted in J. Rasulov and Faizobod district by 9% and 20%, respectively. Coverage of women using the modern contraception method made 23% in all pilot

districts for the first nine months of 2019, in general. Compared to the 9 months of 2018, there is an increase of 7%. *Chart 11*

Analysis of quantity indicators in six new pilot districts

Indicator 1. Number of children under 13 months of age fully vaccinated according to the Immunization Schedule set up by the MOHSP.

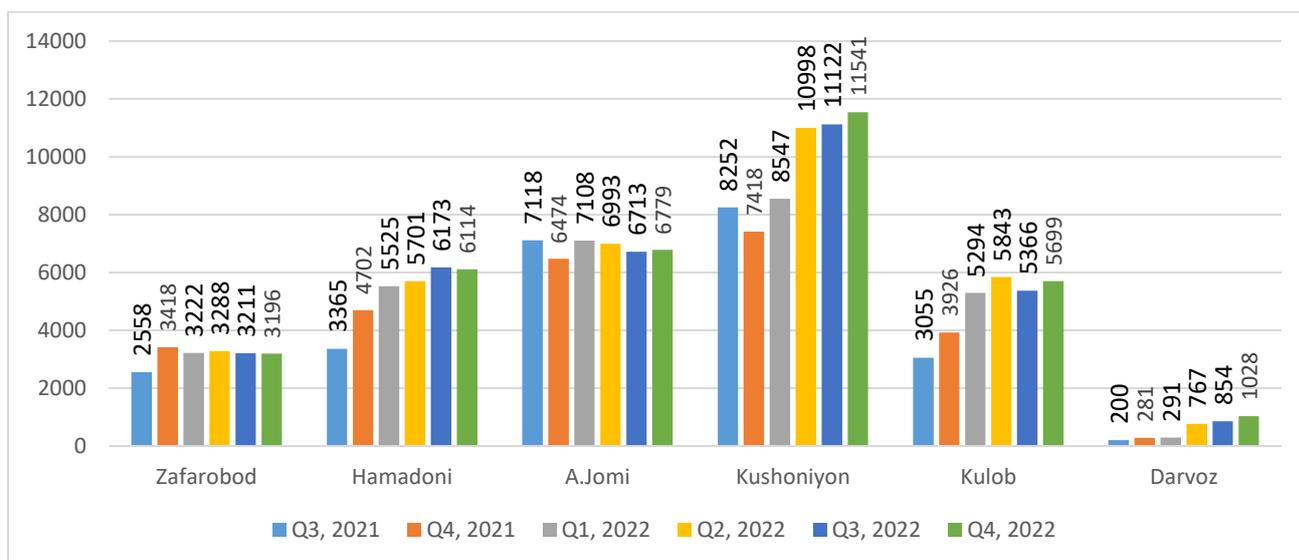
Chart 12



Analysis of IV data (Quarter 4 of 2022) had demonstrated that, in general, 4738 services were provided by health facilities in 6 new pilot districts under this indicator. The coverage of children under the age of 13 months who received all doses of all vaccines as required by the immunization schedule established by the MOHSP made 99,6% in the Quarter 4, 2022. (*Chart 12*)

Indicator 2. Number of children in the age of 0—24 months, whose weight and height is measured according to the recommended schedule and whose parents have been advised on the proper child nutrition and care.

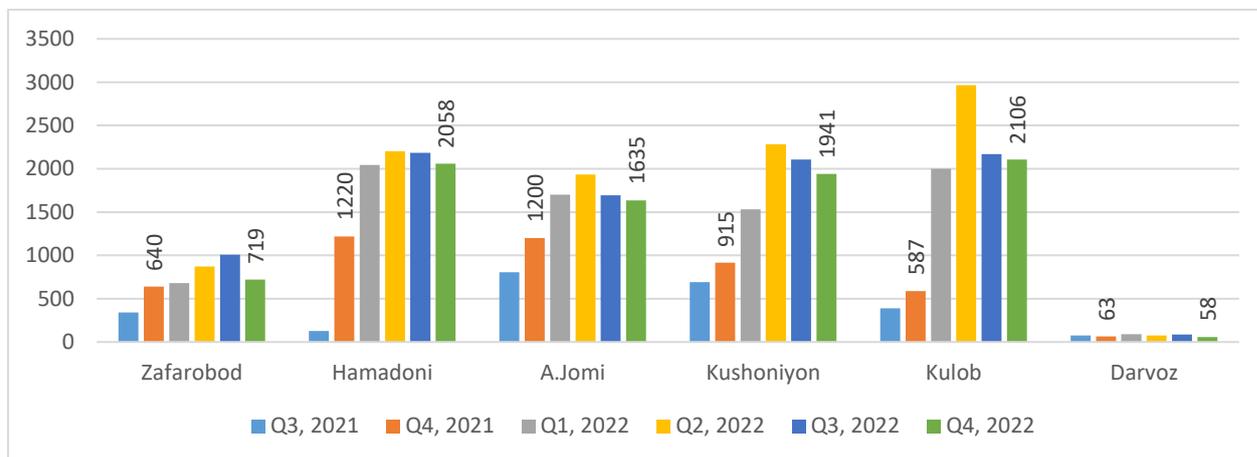
Chart 13



Analysis of the health facilities performance under this indicator for the Quarter 4 of 2022 indicates an increase in the number of services in most pilot districts by 31% compared to the Quarter 4 of 2021. The exception was Zafarobod District, where there is a decrease by 6% under this indicator. (Chart 13)

Indicator 3. Number of children under five with detected malnutrition, whose parents received advice on proper nutrition and child care and who are experiencing a positive dynamic.

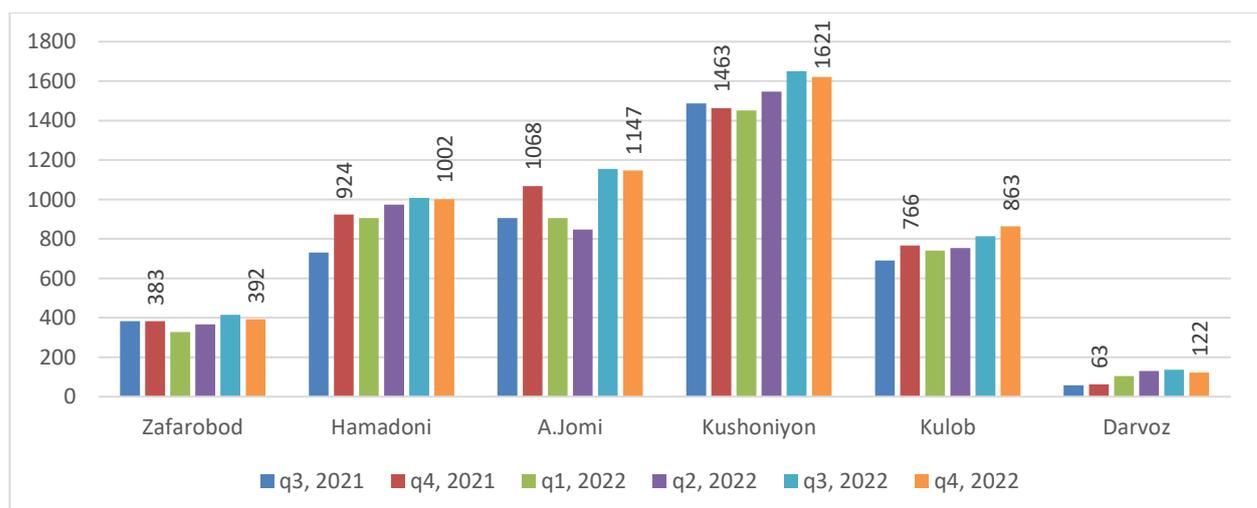
Chart 14



Comparative analysis of the health facilities performance under this indicator for the Quarter 4 of 2022 showed a positive growth dynamic in comparison with figures of the Quarter 4, 2021 in most pilot districts. On average, the growth under this indicator for the Quarter 4 of 2022 made 3892 services compared to the Quarter 4 of 2021. (Chart 14)

Indicator 4. Number of mothers received the first post-natal care home visits during first three days after check out from maternity house.

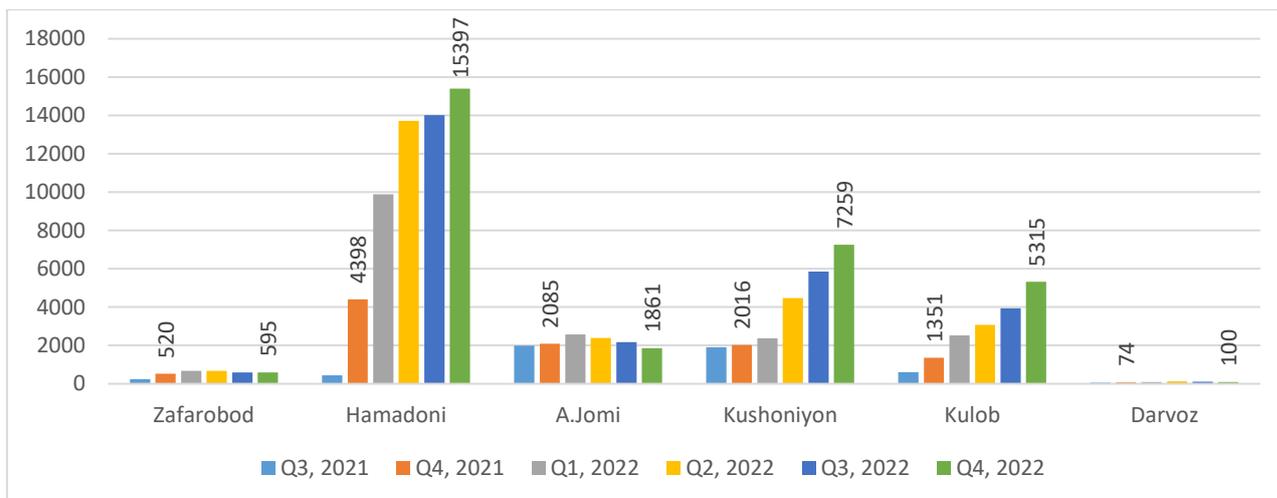
Chart 15



The number of services provided in all 6 pilot districts under this indicator increased by 10%, on the average for the Quarter 4, 2022 compared to the Quarter 4 of 2021. Growth under this indicator was recorded in all pilot districts. (Chart 15)

Indicator 5. Number of newly detected and registered patients with hypertension and set a diagnosis according to the National MOHSP Clinical Protocols.

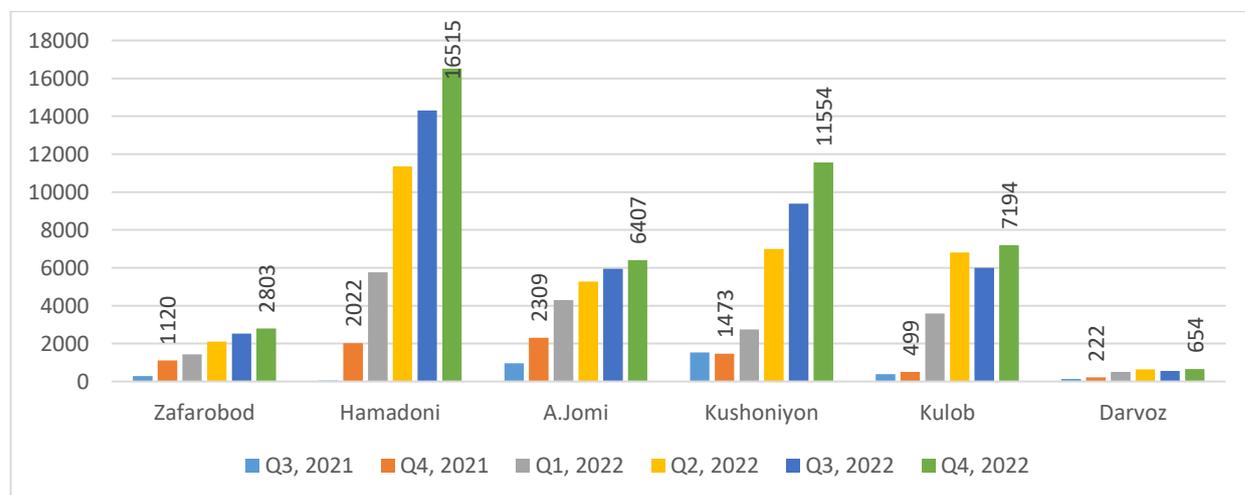
Chart 16



The verification results under this indicator showed that, for the Quarter 4 of 2022 compared to the Quarter 4 of 2021 in pilot districts, there is an increase in the services provided from 10444 to 30527 services provided. It should be noted that the percentage of diagnosing according to the requirements of clinical protocols increased from 93.7% to 99.6%. (Chart 16)

Indicator 6. Number of patients over the age of 17 diagnosed with hypertension and received treatment according to the MOHSP Clinical Protocols.

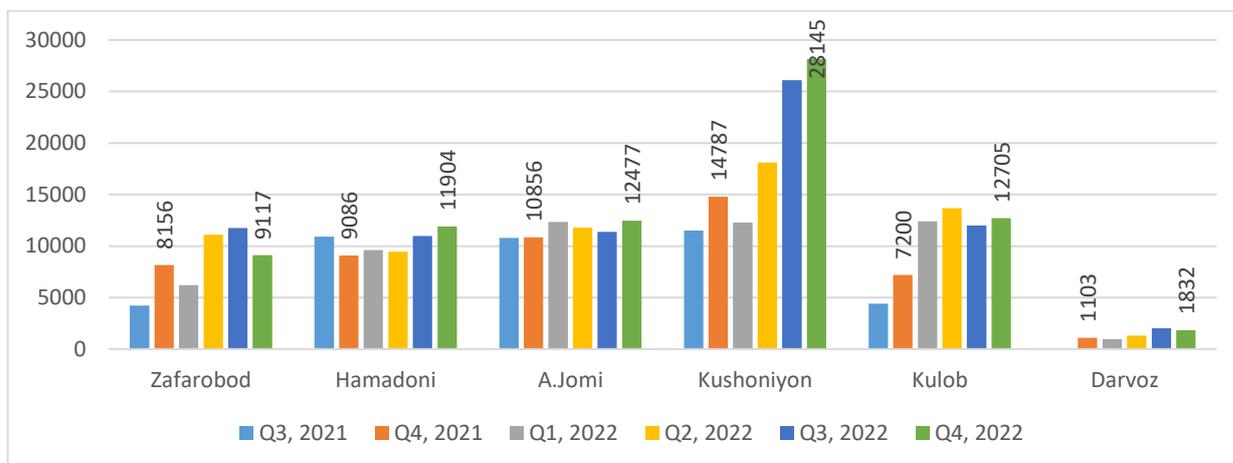
Chart 17



Comparative performance analysis under this indicator for all 6 pilot districts for the Quarter 4 of 2022 compared to the Quarter 4 of 2021 shows an increase in the number of services from 7645 to 45127. Positive dynamics is observed in all districts. The percentage of patients received treatment in accordance with the MOHSP clinical protocol increased from 89.2% to 98.9% compared to Q4, 2021. (Chart 17)

Indicator 7. Number of household's visits made by health personnel during the verification period (rounds to the households).

Chart 18



In general, 76180 households were visited by the health facilities staff in 6 pilot districts during the Quarter 4 of 2022 according to the rules of the Guidelines for Households Engagement. Comparing with the same quarter of 2021, the growth made 48,8%. (Chart 18)

Quality Indicators

The existing PBF Manual has been developed to carry out a detailed and objective assessment of the health facility performance by selected internal and independent verification agencies. In accordance with the requirements of this Manual, uniform rules have been designed for the verification of health facilities at all levels. The obtained information / results allow us to take the timely needed measures to improve the healthcare quality provided to the population by health facilities in pilot districts.

The averaged data on the quality indicator performance in all pilot health facilities are provided below (as per internal verification results).

This assessment provides the aggregated averaged ratio under qualitative indicators as a percentage of the maximum value. In this section, the analysis of quality indicators will be provided separately for 10 existing and 6 new districts due to the fact that the PDO of the Results Project Framework Indicator *Average quality indicator* for 10 existing and 6 new districts are shown separately.

An analysis of the quality indicator performance based on the internal verification results at the RHCs/HHs level is given below.

For analyzing verification results, all health facilities were conditionally divided into four groups (categories), as per the scope of the scores received: up to 55% - a low quality score; from 55% to 75% - the average quality score; from 76% to 85% - a good quality score; from 86% and above - an excellent quality score. In addition, for convenience for submission and review of verification results, the following color principle of ranking results was applied:

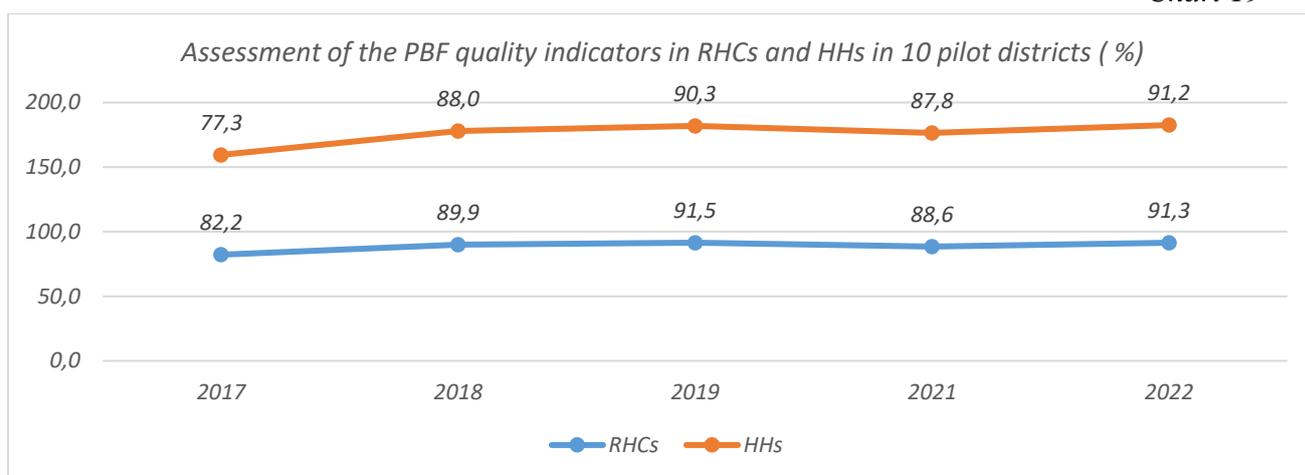
- red color – proportion of health facilities received a score of less than 55% (low score);

- yellow – proportion of health facilities received a score from 56% to 75% (average score);
- light green – proportion of health facilities received a score from 76% to 85% (good score);
- dark green – proportion of health facilities received a score from 86% and above (excellent score).

Analysis of the Quality Indicators in 10 pilot districts

During 2017-2022, rural health centers and health houses demonstrated a significant improvement in the quality of health services. The RHCs have increased the quality score from 82.2% to 91.3%, and HHs – from 77.3% to 91.2%. These facilities also demonstrated a positive dynamic and commitment to constantly improve their health services. *Chart 19*

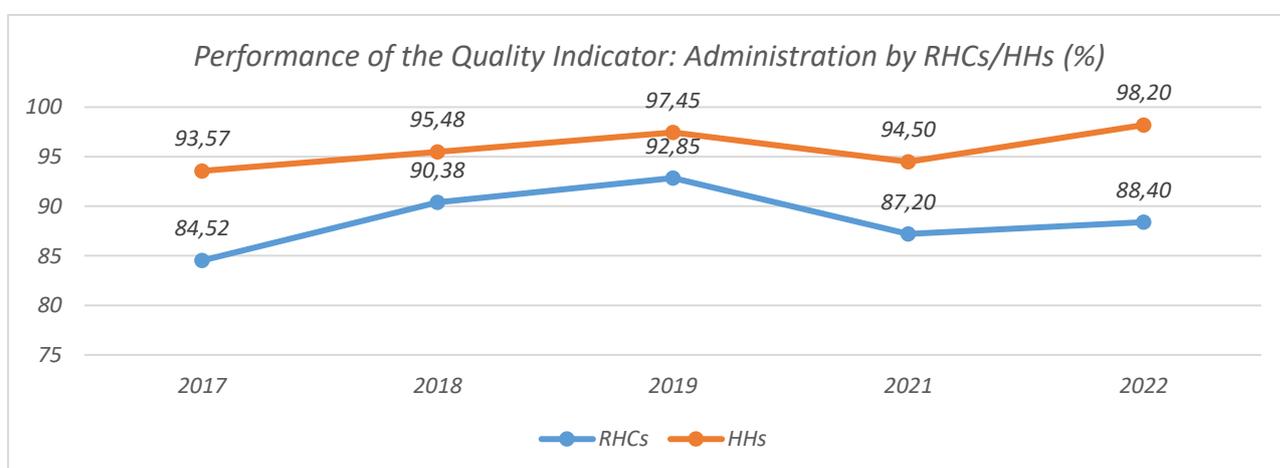
Chart 19



Section 1. Administration

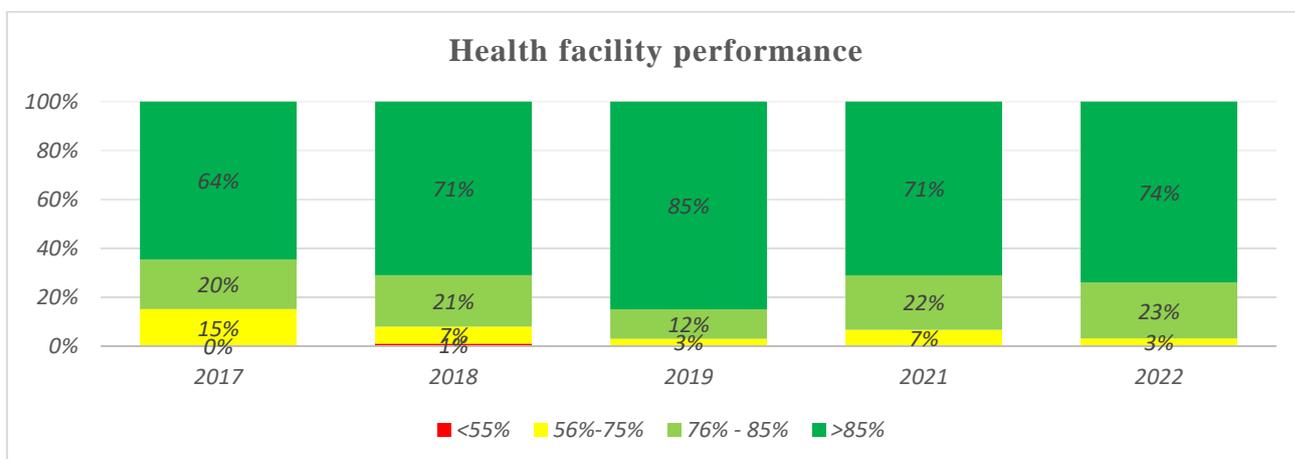
The *Administration* Section consists of subsections *Administration, Hygiene and Sanitation, Reception Room, Laboratory Services* (only for RHCs), *Drug Inventory Management, Medicines and Medical Supplies for Emergency Cases*, as well as the *PBF Management Information System (MIS)*. Since the beginning of project implementation, there has been an increase in quality indicators from 84,5% to 88,4% at the RHC level and from 93,5% to 98,2% at the HH level, under this section. (*Chart 20*)

Chart 20



Following the internal verification results it was found out that 74% of the total number of facilities received high quality score under this section in 2022. There is an increase by 10% compared to 2017. *Chart 21*

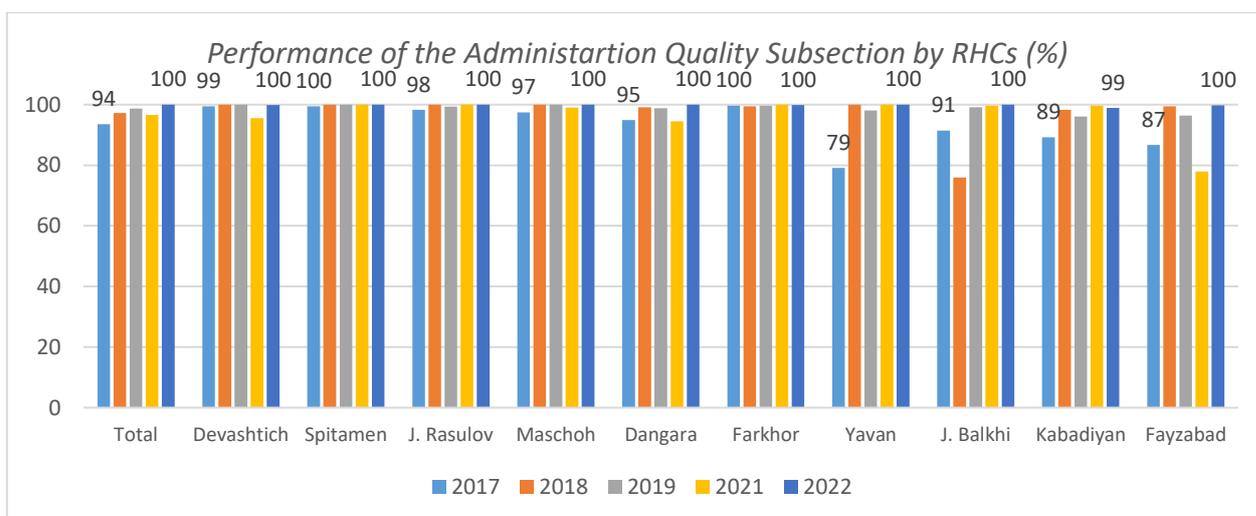
Chart 21

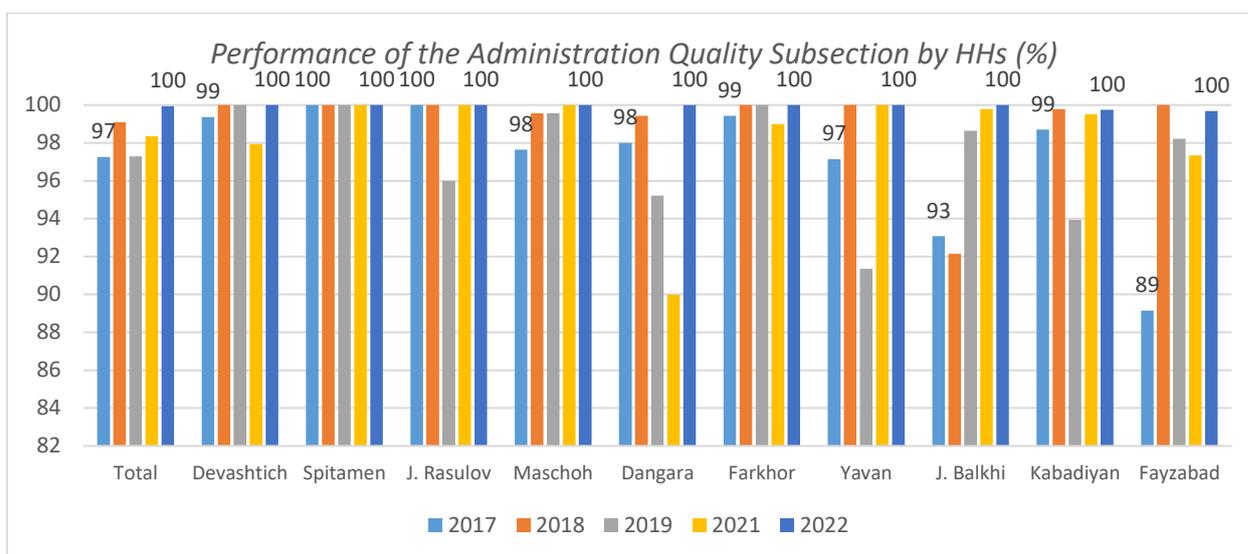


Sub-section 1.1 Administration

Under the Administration section, there is an increase by 13% and 11% under this indicator at the RHCs and HHs level, respectively, in 2022 compared to 2017. This increase was recorded in all pilot districts. *Charts 22-23*

Charts 22-23





Sub-section 1.1 Administration

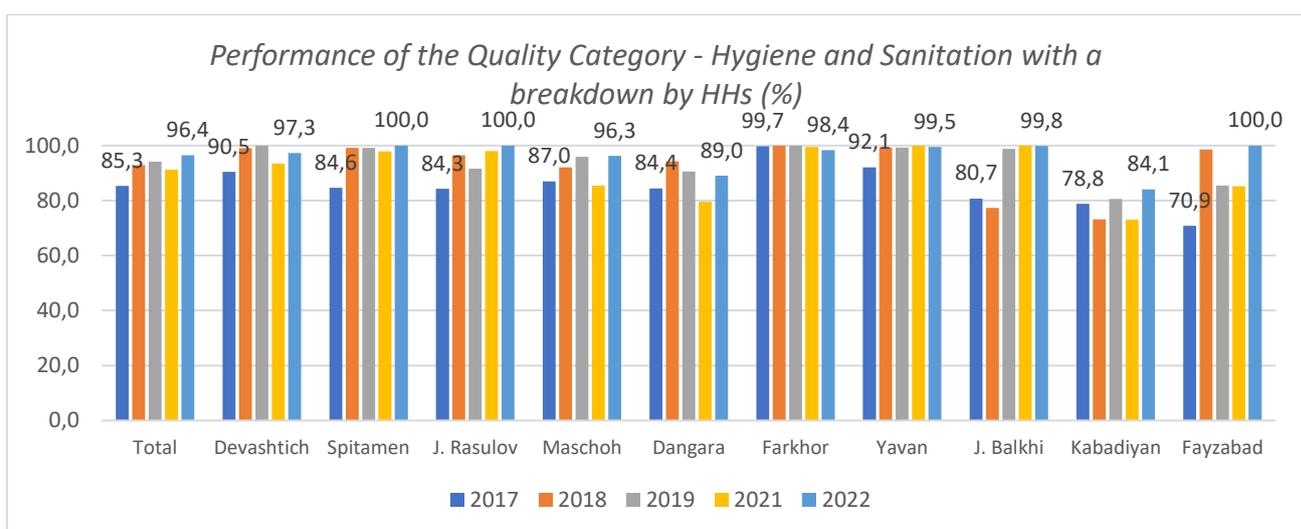
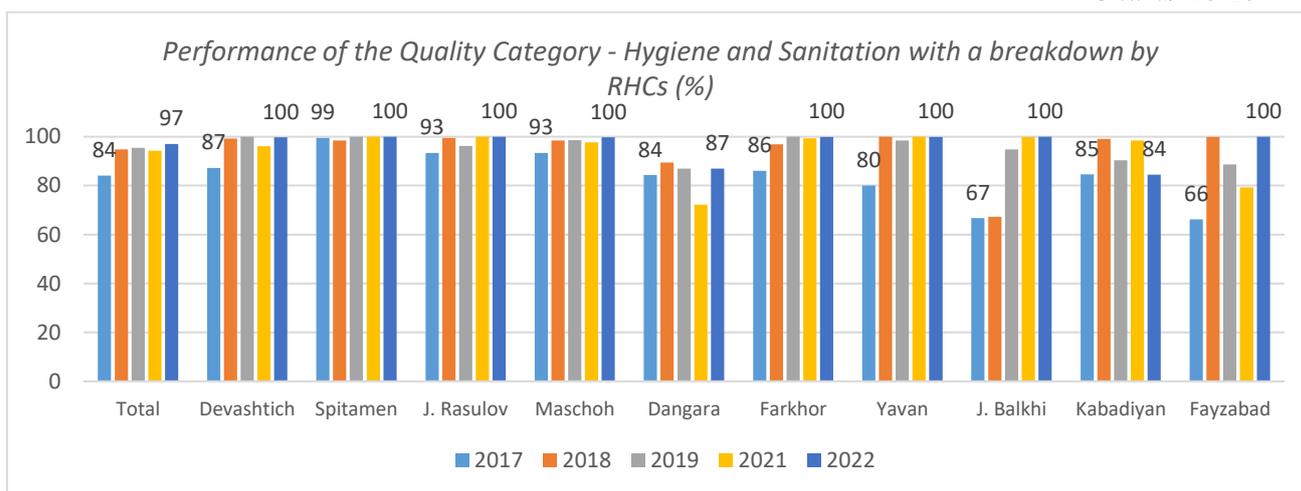
Below there are results of a more detailed analysis under the category "Administration" for the 2017- 2022. The analysis of "Administration" sub-section showed that RHCs and HHs received high scores for all five indicators *Table 3*

Table 3: Components of the Sub-section 1.1 Indicator performance depending on the type of health facility

Section 1. Administration	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
1.1.1 Availability of the map of medical facility coverage area	98%	98%	100%	97,6%	99,8%	99%	99%	98%	99,1	99,8
1.1.2 PBF action plans availability, signed PBF reports and previous PBF quality assessments	97%	98%	98%	98,8%	100,0%	99%	99%	98%	99,6	100,0
1.1.3 Weekly staff meetings and the availability of minutes of the meeting	85%	95%	99%	92,1%	99,5%					
1.1.4 Availability of medical forms	97%	99%	98%	99,1%	99,9	96%	99%	97%	97,3	100,0
1.1.5 Availability of the service phone for communication between the medical facility and the center of the next level, where the patients are referred to	99%	95%	98%	99,7%	100,0	99%	95%	99%	99,6	100,0

Sub-section 1.2 Hygiene and Sanitation

Under this subsection, the average score for the indicator performance made 97.1% and 96.4% in ten pilot districts in 2022 at the level of RHCs and HHs, respectively; comparing with 2017, the growth made 33.7% and 29%, respectively. Insignificant reduction of this indicator was recorded in Kubodiyon and Farkhor districts. (*Charts 24-25*)



When analyzing eight subcategories under this sub-section, the performance of indicators below the average score is observed both in RHCs under subcategory 1.2.6 Sterilization of instruments by staff in accordance with the standards. (Table 4)

Table 4: Components of the Sub-section 1.2 Indicator performance based on the facility type

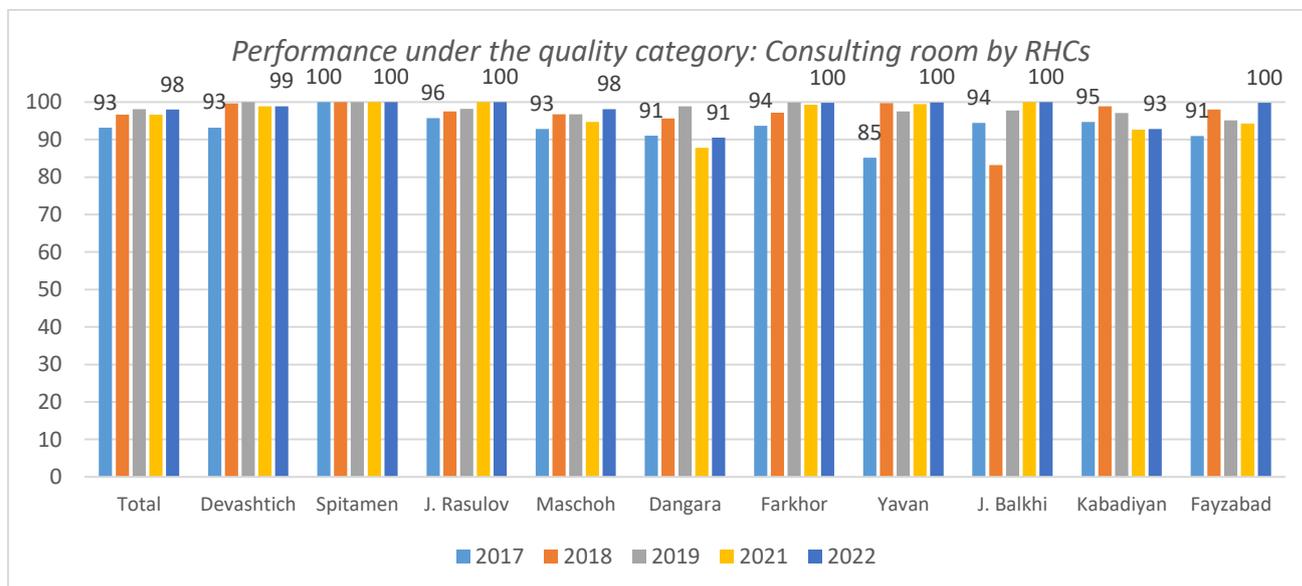
Sub-section 1.2. Hygiene And Sanitation	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
1.2.1 Availability of the fencing at the medical facility and keeping it in order	83%	93%	96%	97,4	99,8	72%	89%	95%	91,0	97,5
1.2.2 Cleaning and maintaining the courtyard	93%	97%	96%	97,3	99,9	93%	94%	95%	94,9	98,9
1.2.3 Availability of toilets / latrines and maintaining them in good order	87%	96%	97%	95,8	99,0	79%	91%	92%	87,1	95,3
1.2.4 Fenced and locked incinerator for incineration of medical	85%	94%	99%	90,2	100,0					

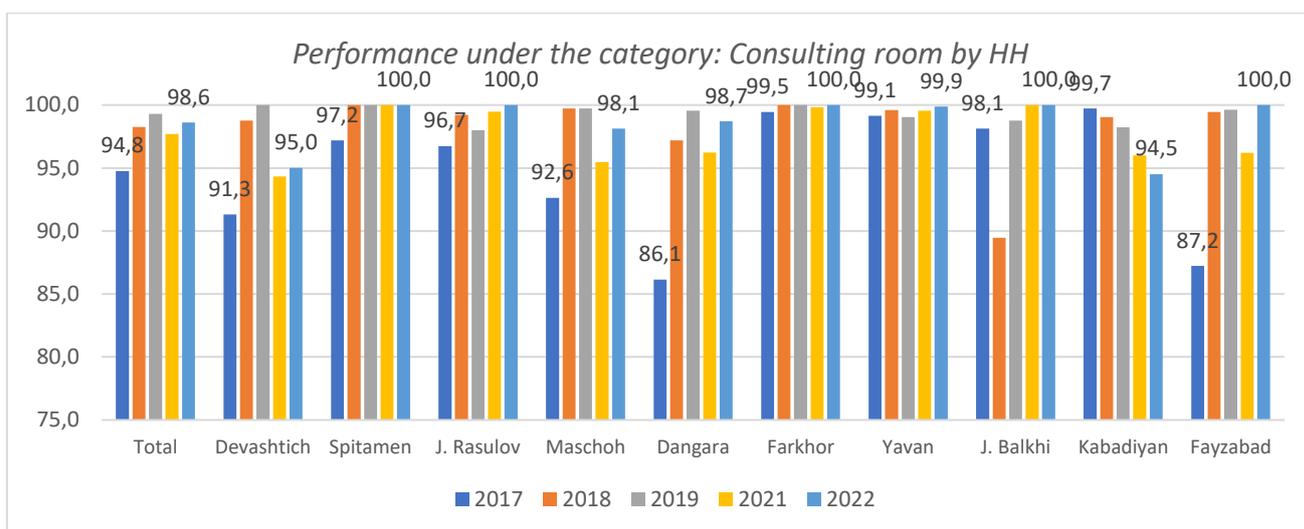
and non-medical waste										
1.2.5 Availability of a pit for non-infected objects	93%	97%	98%	95,1	99,6	83		90	88,4	93,4
1.2.6 Sterilization of instruments by staff in accordance with the standards	52%	87%	83%	86,9	84,0					
1.2.7 Ensuring hygienic conditions and proper sorting of waste in the reception, dressing and injection rooms (check all rooms)	98%	99%	99%	99,6	99,8	95%	98%	99%	97,3	99,1
1.2.8 Availability of a continuous water supply	85%	98%	99%	97,2	98,6	82%	97%	100%	88,2	98,1

Sub-Section 1.3 Consulting room

Comparison of the results of internal verification of the health facilities in the pilot districts showed that the facilities have demonstrated increase of the quality of health services from 93.2% to 98.0% at the RHC level and from 94.8% to 98.6% at the HH level (*Charts*). Decrease was recorded in Kubodian district at the RHC and HH levels by 1.8% and 5%, respectively. In general, 98% of health facilities received high scores for this indicator.

Charts 26-27





Analysis of 14 indicators of this sub-section showed that both RHCs and HHs were marked with high scores (*Table 5*)

Table 5: Subsection Components 1.3 Indicator performance by type of health facilities

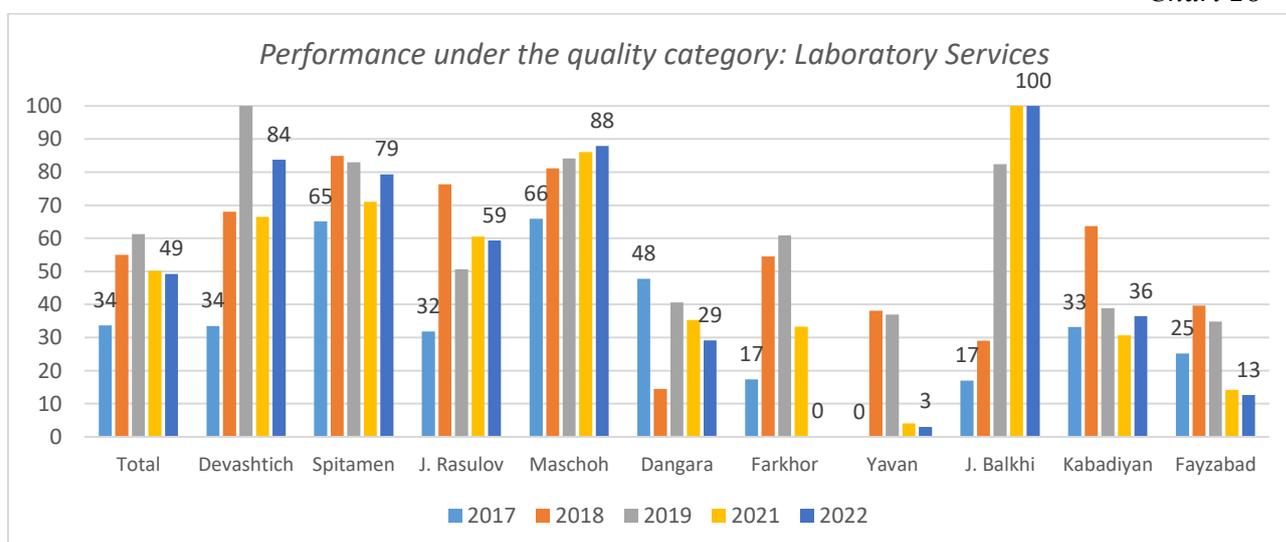
1.3 Consulting room	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
1.3.1 Good conditions in the lobby or in the waiting area	96%	99%	99%	98,6	99,3	90%	97%	99%	96,8	98,7
1.3.2 The list of employees (medical staff) to whom the population can refer - available to the public	99%	99%	99%	97,2	98,1	99%	99%	99%	98,1	92,9
1.3.3 Fees for paid services rendered to the population	62%	93%	98%	81,8	93,3					
1.3.4 Maintaining consultation room in good condition	96%	97%	98%	97,1	99,0	91%	97%	99%	97,6	98,6
1.3.5 Availability of electricity at any time of the day at least in one reception room in case of emergencies	99%	99%	100%	93,0	97,6	95%	98%	99%	84,5	97,8
1.3.6 Neatly dressed consulting staff	96%	97%	98%	98,2	99,5	89%	98%	98%	98,0	98,9
1.3.7 Availability of stethoscopes and sphygmomanometers that are in working conditions in all examination rooms	96%	99%	99%	99,4	100,0	97%	99%	99%	97,4	98,4
1.3.8 Availability of medical thermometers	99%	100%	100%	99,4	100,0	99%	100%	100%	99,7	100,0
1.3.9 Availability of otoscopes	88%	99%	100%	96,0	98,5					
1.3.10 Availability of examination table, which is not damaged, with a clean	98%	98%	100%	98,1	100,0	94%	97%	100%	97,5	99,5

blanket, in the consultation room										
1.3.11 Availability of scales and height measuring boards in operational condition in at least one room	100%	100%	100%	99,0	99,9	98%	100%	100%	99,6	100,0
1.3.12 Availability of insulated shipping containers or cold boxes for vaccines	100%	100%	99%	99,1	100,0	97%	99%	100%	99,4	99,8
1.3.13 Availability of the refrigerator	99%	99%	99%	99,1	100,0					
1.3.14 Availability of operational equipment for antenatal care	78%	87%	93%	92,6	92,0					

Subsection 1.4 Laboratory services

The analysis of indicators for the quality indicator performance under this category for 2022 compared to 2017 shows an increase by 15,5%. Decrease of this indicator was recorded in Dangara, Farkhor, and Faizobod districts by 18,7%,17,3%, and 12,55%, respectively. It should be noted that low scores were recorded in Devashtich, J. Rasulov, Dangara, Farkhor, Kubodian, and Faizobod districts.

Chart 28



Below is a table of the quality indicator performance under this category by subcategories (Table 9). As the table shows out of nine indicators of this indicator, six indicators have low scores and three other - average scores. (Table 6)

Table 6: Subsection component 1.4 Indicator performance by type of health facilities

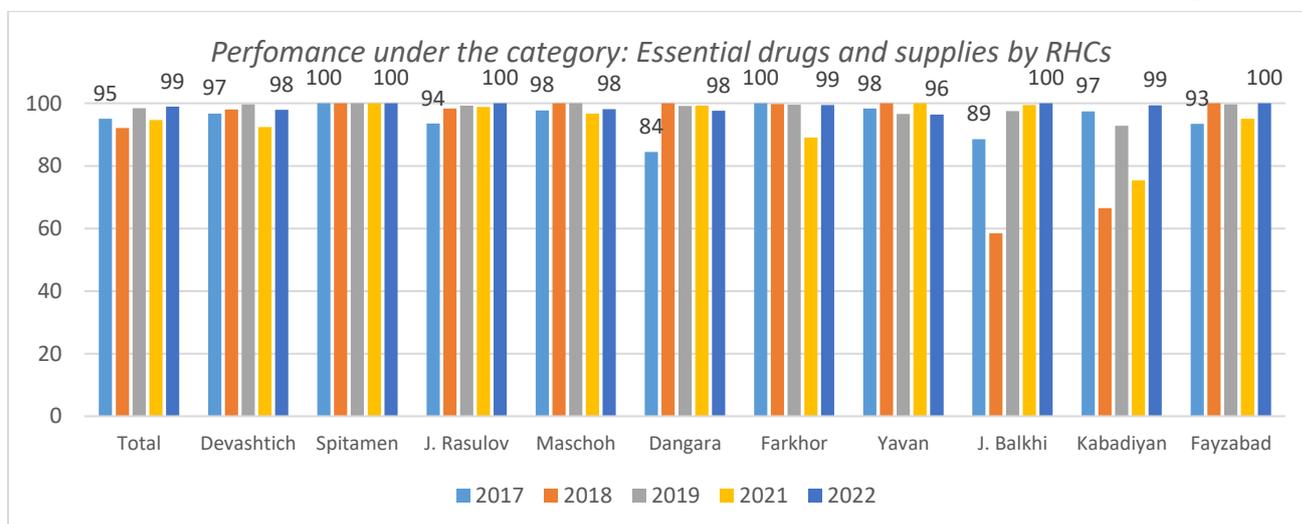
1.4 Laboratory services	RHCs				
	2017	2018	2019	2021	2022
1.4.1 Availability of laboratory	46%	70%	75%	72,3	60,4

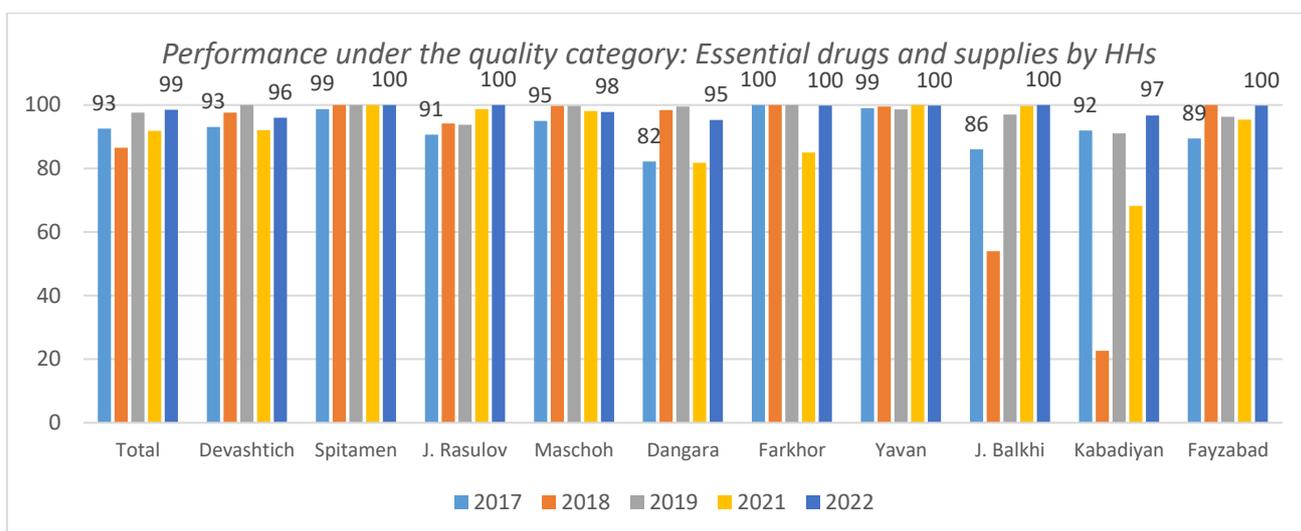
1.4.2 Availability of a laboratory assistant or Family Medicine nurse	40%	56%	67%	57,6	49,6
1.4.3 Availability of laboratory stocks and consumables for the main tests (minimum for 20 individuals)	43%	70%	81%	72,1	60,5
1.4.4 Availability of the main reagents for urine, blood and feces tests (minimum for 20 individuals)	24%	39%	45%	40,2	42,6
1.4.5 Availability of diagnostic kits for the antenatal health care (minimum for 20 individuals)	27%	47%	48%	36,2	31,3
1.4.6 Availability of operational laboratory equipment	42%	72%	80%	68,0	60,6
1.4.7 The inventory log is maintained correctly, and there was no shortage of stocks in the reporting period	31%	55%	59%	51,2	47,7
1.4.8 The validity of results recorded in the laboratory register and their compliance with the results, indicated in the medical records (verify 2 results in every register)	36%	58%	65%	56,9	52,1
1.4.9 Proper waste management	43%	75%	69%	69,9	55,2

Subsection 1.5 Drug supplies management

According to the results of internal verification, there is an increase of the quality indicators under the subsection “Drug Supplies Management” in most pilot districts in 2022 compared to 2017, with the exception of Yavan, where there is a decrease at the level of RHCs. On average, the indicators increased by 3.9% and 5.9% at the level of RHCs and HHs, respectively. (Charts 29-30)

Charts 29-30





Results of a more detailed analysis of the quality indicators under the subsection “*Drug Supplies Management*” for the Quarter 4 of 2022 are provided below.

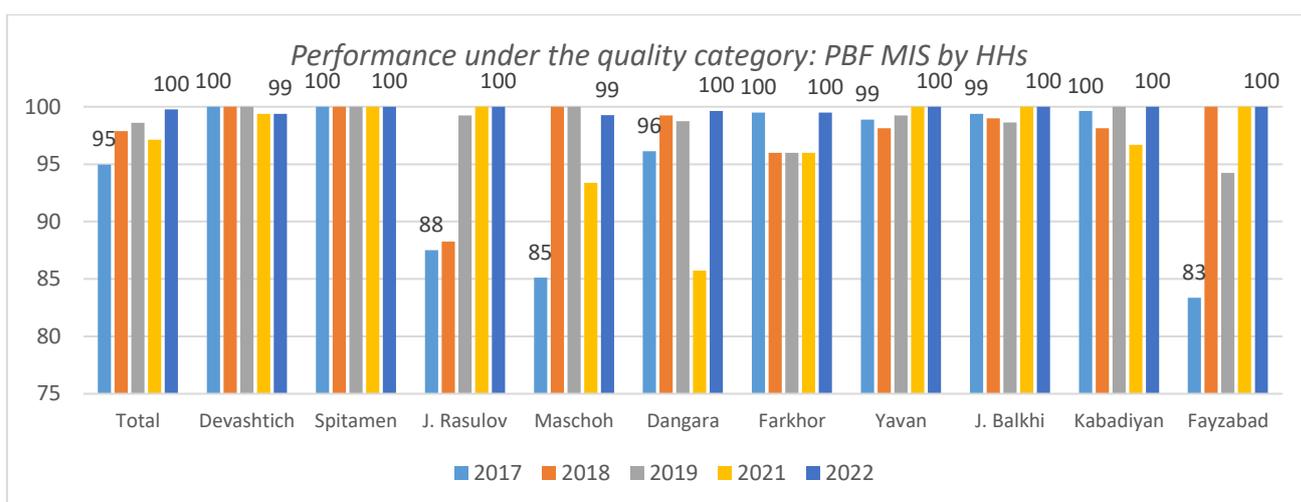
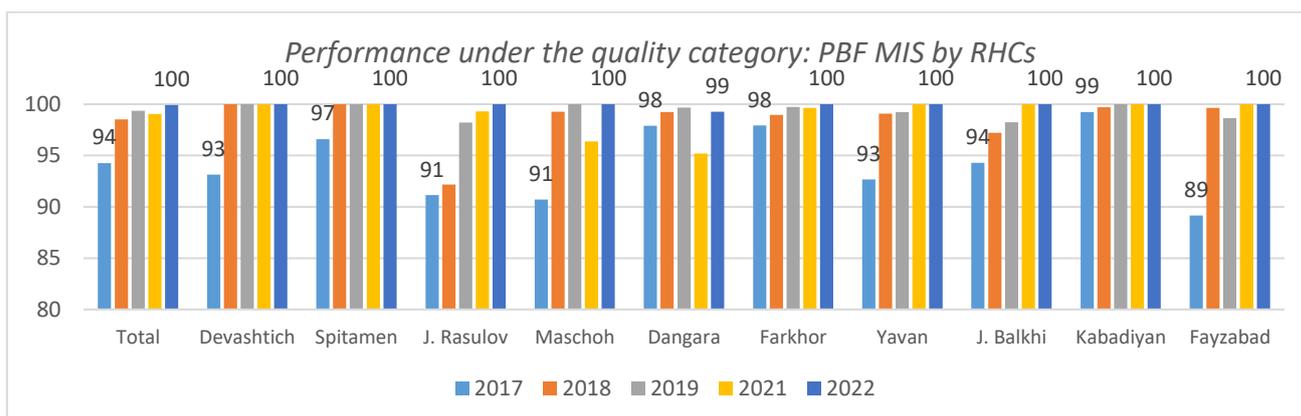
Table 7: Subsection 1.5 components. Indicator performance by type of health facilities

Analysis of this subsection shows that all health facilities received high scores under 4 components (Table 7).

Drug Supplies Management	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
1.5.1 Staff maintains Drug supplies Inventory Checkbook for emergency cases	94	99	99	94,2	99,1	91	97	98	93,9	98,1
1.5.2 Stock recorded in the Checkbook match actual stock (randomly select and check 5 drugs)	97	89	99	89,1	99,2	97	82	99	82,6	98,8
1.5.3 Proper storage of medicines	93	98	99	94,3	97,8	86%	92	96	91,2	97,0
1.5.4 Absence of expired medications in stocks (randomly select 3 drugs and 2 consumables)	95	88	98	98,9	99,0	93	81	97%	97,8	99,3

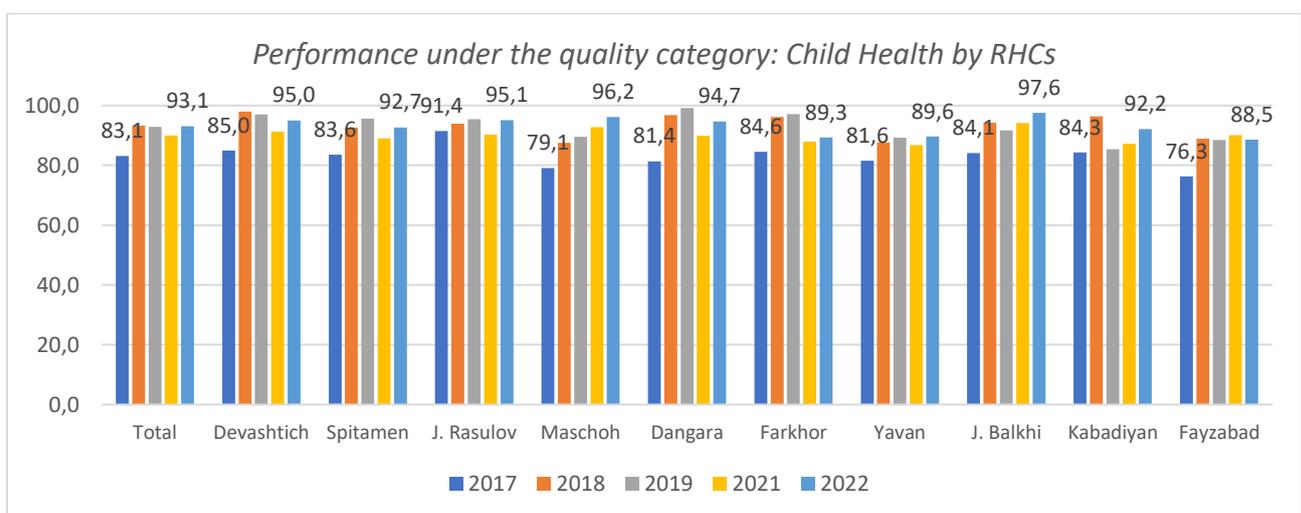
Subsection 1.7 PBF Management Information System

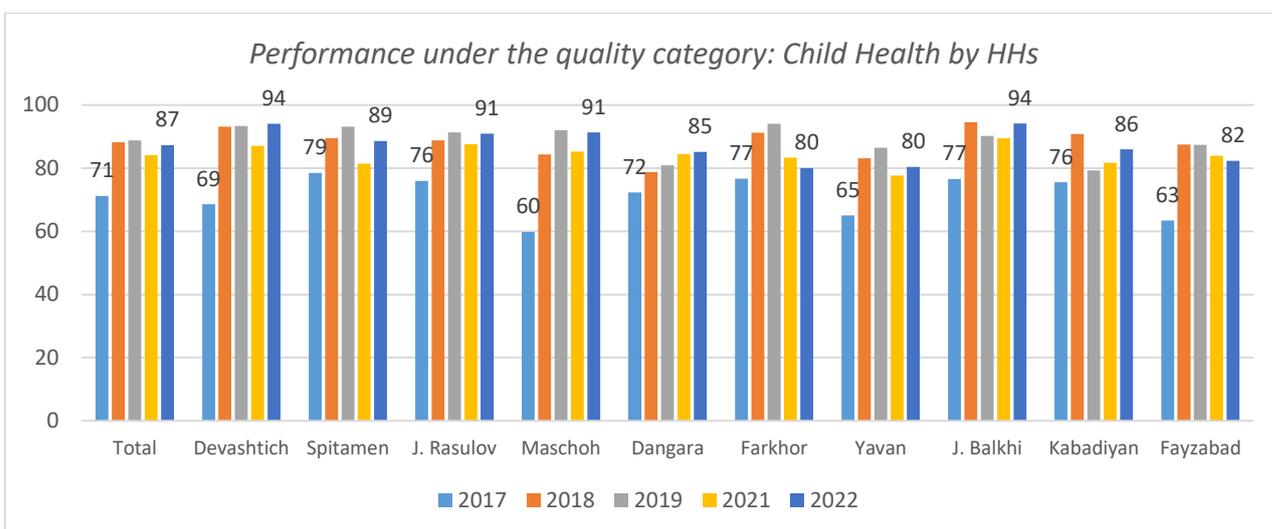
Under this subsection, the performance of quality indicators in 2022 is 99% both at the RHC and HHs level. The increase of quality under this indicator at the HH and RHC level from 2017 makes 5.7% and 4.8%, respectively. In general, 99.8% of health facilities received high scores for this indicator in 2022. (Charts 31-32)



Section 2. Clinical care – Child Health

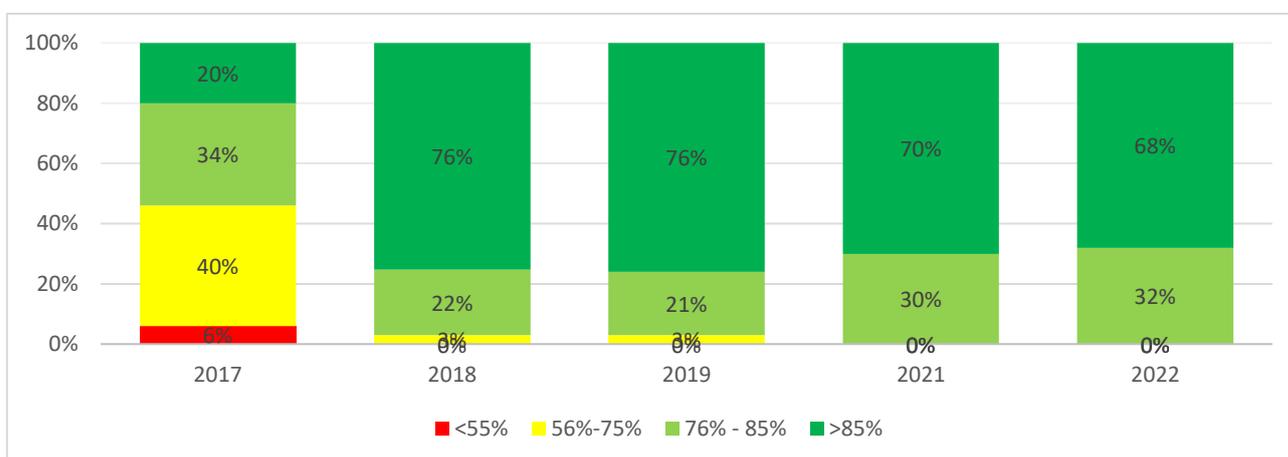
Section 2 assesses the practice of the health facilities as per such components like maintaining medical records, quality of immunization, quality of malnutrition detecting and treatment (only for RHCs), quality of diagnostics and treatment of diarrhea in children under 5 y.o. In general, the indicators of Section "Clinical care - child health" at the level of RHCs and HH made 93.1% and 87.3% on average from the maximal value, respectively. Compared to 2017, an increase made 10% at the RHC level and 16% at the HH level. *Charts 33-34*





As per internal verification results, it was found that 68% of health facilities gained high scores in 2022 (20% in 2017), and 32% received average scores (*Chart 35*).

Chart 35



Analysis of 5 sub-sections of this section showed that the RHCs received high scores for all indicators in 2022. At the level of HHs, high scores were received for maintaining medical records and quality of immunization services, but the quality of diarrhea diagnostics and treatment, and acute respiratory infections were marked above average. Compared to 2017, increase of quality is recorded in all sub-sections. (*Table 8*)

Table 8

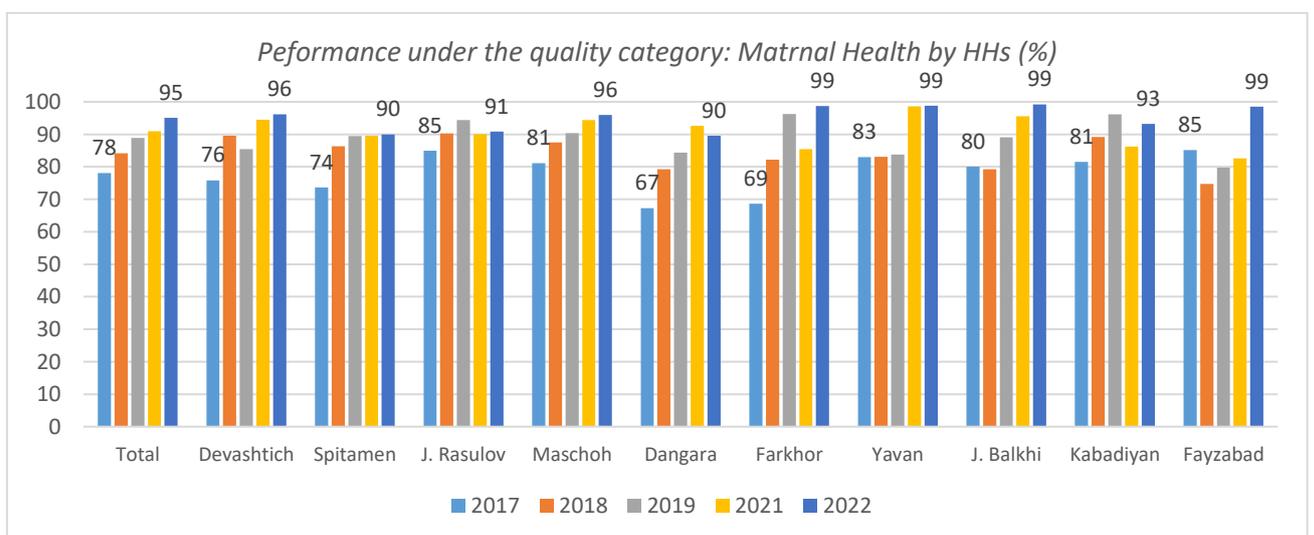
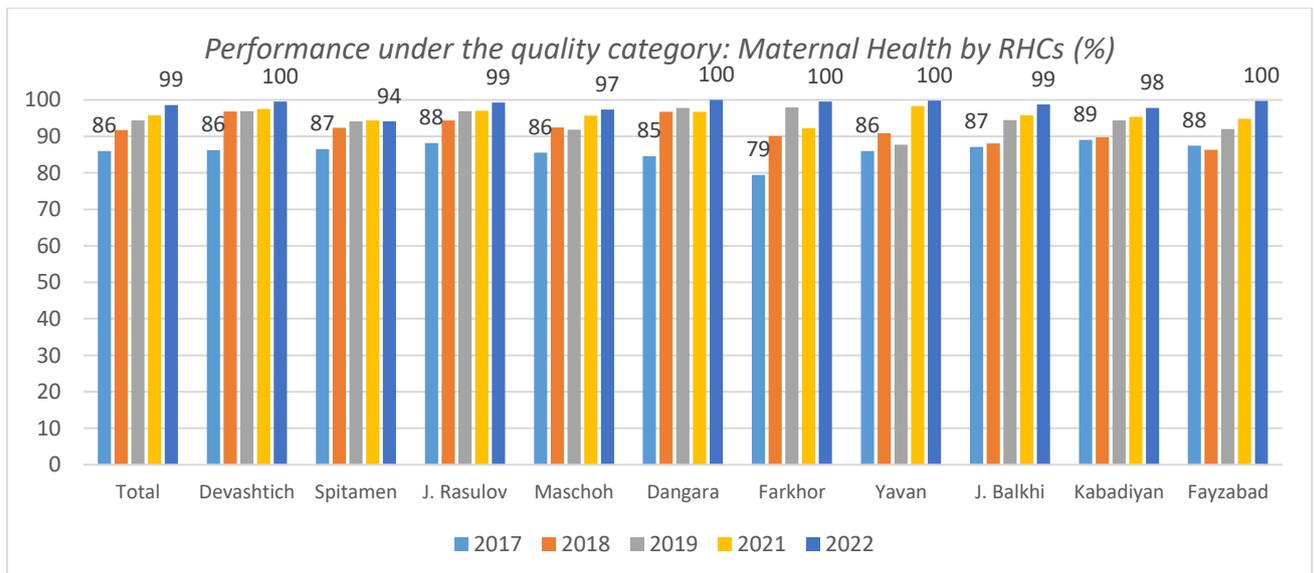
Section 2. Child Health	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
2.1 Maintaining medical records	97%	99%	99%	99,1	99,7	97%	100%	100%	99,6	99,7
2.2 Quality of immunization	84%	97%	96%	94,2	98,0	77%	91%	91%	90,2	95,4
2.3 The quality of identification and treatment of malnutrition	80%	92%	93%	90,5	92,7					
2.4 The quality of	84%	93%	94%	89,4	92,3	66%	87%	90%	83,7	85,9

diagnostics and treatment of diarrhea among children <5 years										
2.5 The quality of diagnostics and treatment of acute respiratory infections among children <5 years	83%	92%	90%	87,7	91,6	73%	87%	85%	73,2	84,0

Section 3. Maternal health

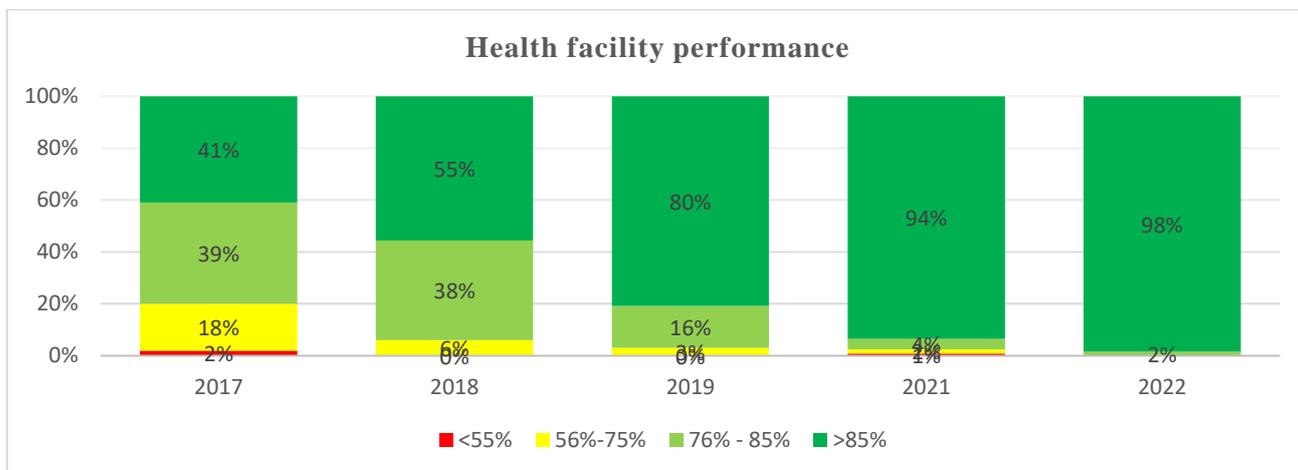
There are two sub-sections set for this section: Maternal Health for RHCs and HHs – quality of medical records and quality of first postnatal visit. In general, the indicators of this section at the level of RHCs and HHs made on average 98.6% and 95.1% from the maximal value, respectively in 2022. Compared to 2017, increase at the RHC level made 12.6%, and 17.0%. at the HH level (*Charts 36-37*)

Charts 36-37



According to the results of internal verification, it was identified that 98% of the health facilities received high scores by the end of 2022; compared to 2017, the growth made 57%. (Chart 38)

Chart 38



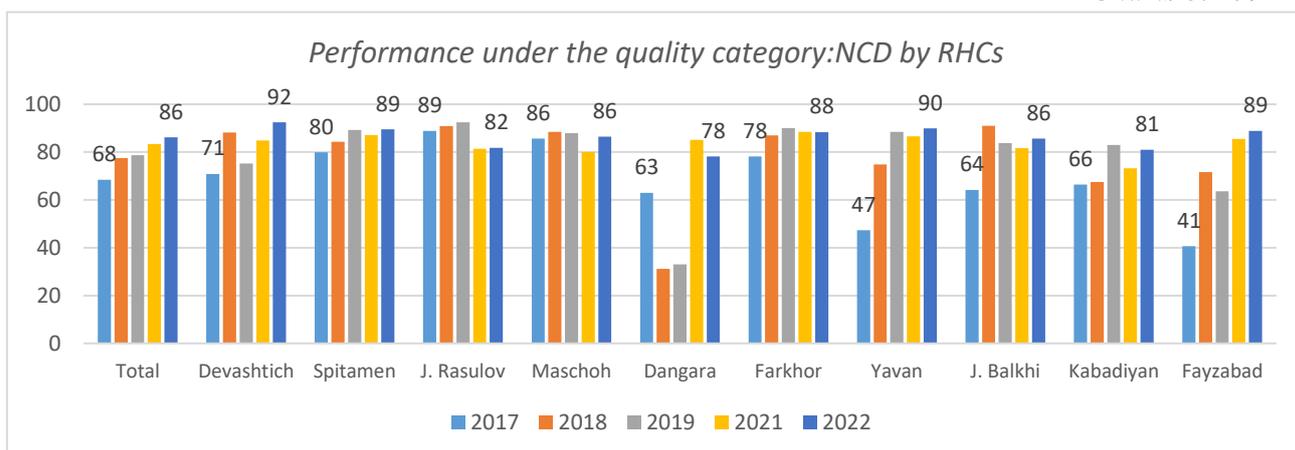
Analysis of the sub-sections showed that all types of the health facilities received high scores, and compared to 2017, the quality of health services has grown. This points at the improvement of the health facilities performance as well as the increased quality of services they provide. (Table 9)

Table 9

Section 3: Maternal Health	RHCs					HHs				
	2017	2018	2019	2021	2022	2017	2018	2019	2021	2022
3.1 Maintenance of medical documentation	98%	100%	99%	98,7%	99,7%	97%	100%	99%	98,4%	98,4%
3.2 Quality of first postnatal home visit (during first three days after delivery)	89%	96%	95%	95,4%	98,4%	85%	91%	93%	90,4%	94,9%

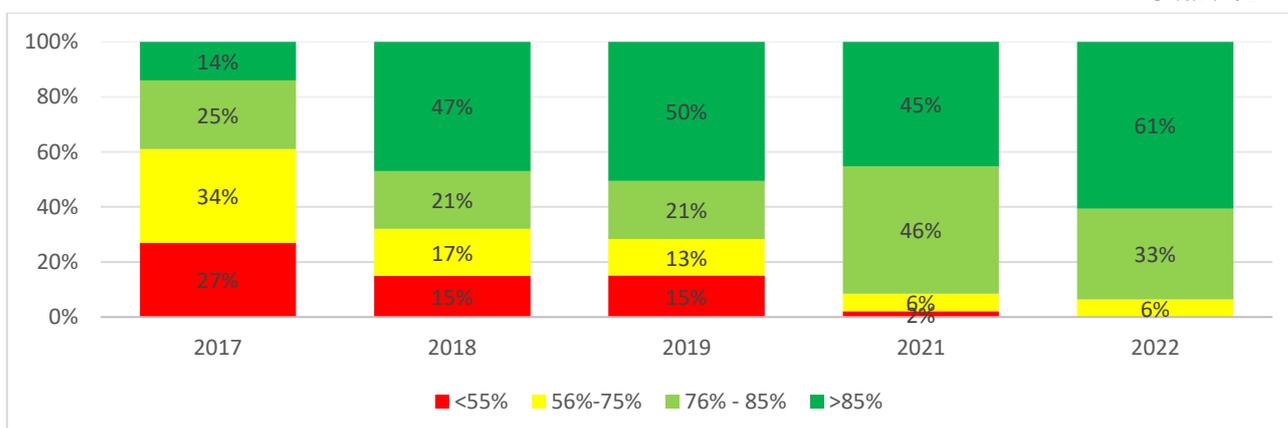
Section 4: Quality of clinical care: Non-Communicable Diseases

The quality of clinical care during non-communicable diseases (hypertension) in health facilities is assessed in the Section 4. This indicator is measured only for RHCs, and includes two sub-sections: quality of medical records and quality of hypertension treatment. The results of verification showed that RHCs received on average 86.2% for this indicator in 2022; the growth made 17.7% compared to 2017. 61% of the health facilities demonstrated high scores. Facilities with low scores were not recorded (Charts 39-40)



Based on the verification results among RHCs, 33% of facilities obtained above-average scores, 61% of facilities received high quality score and 6% of them received an average quality score. There is an increase of number of facilities received high scores by 47% comparing with 2017. (Chart 41).

Chart 41



Under the detailed analysis of given section, a positive picture is evidenced in sub-section “Maintenance of the medical records” and “Hypertension treatment”.

The sub-section of “Maintenance of the medical records” has reached the high average score that makes 99.8%. It witnesses good level of keeping and forming medical documentation in all districts.

Positive result was also recorded in the sub-section of “Hypertension treatment”, where an average score for all districts makes 85.3%. Moreover, compared to 2017, there is a significant increase by 2% and 18.3%, respectively (Table 10).

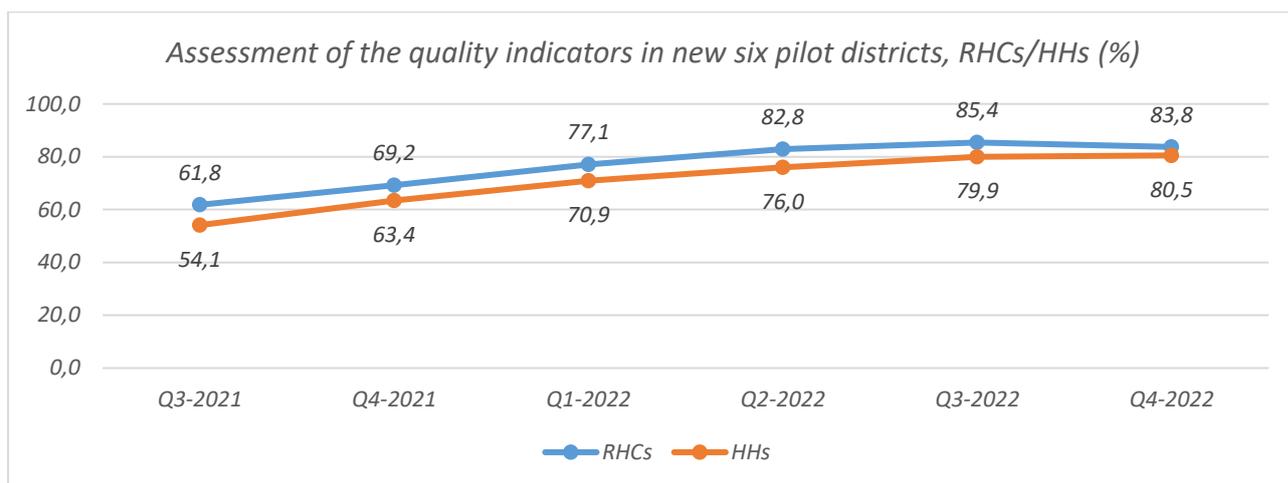
Table 10

№	Section 4: Non-communicable diseases	2017	2018	2019	2021	2022
4.1	Maintenance of medical documentation	97%	99%	99%	99,4%	99,8%
4.2	Hypertension treatment quality	67%	76%	77%	81,4%	85,3%

Analysis of the quality indicators in new six pilot districts

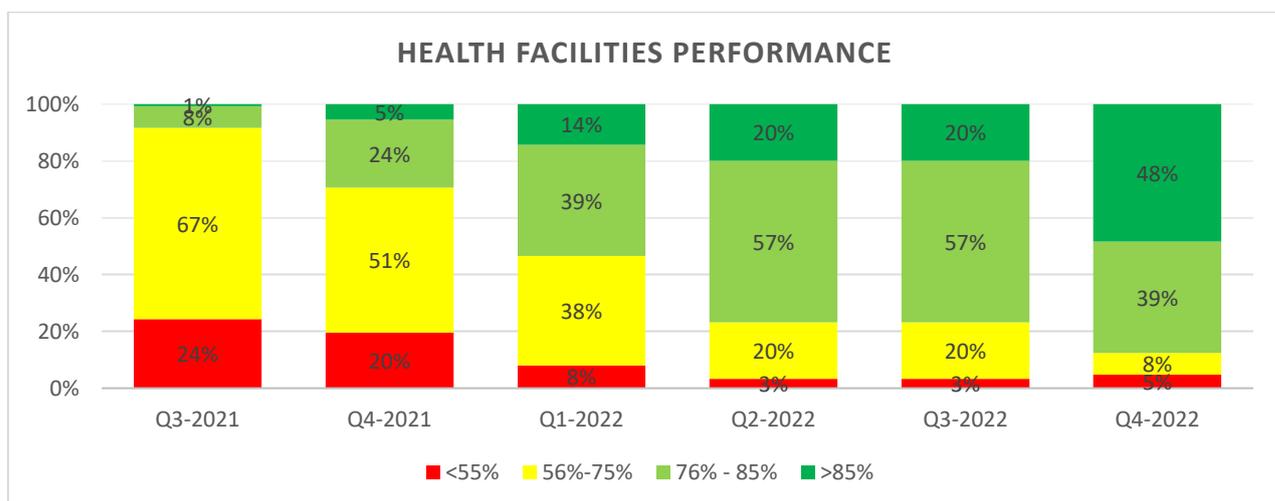
As part of the Additional Financing-2, two internal verification rounds during the reporting period were carried out in new 6 pilot districts of the republic (Kushoniyon, Kulob, Hamadoni, A. Jomi in Khatlon Region, Zafarabad in Sughd Region and Darvoz in GBAO). Below is an analysis of the quality indicators performance based on the Internal Verification results with a breakdown by RHCs/HHs. In the Quarter 4, 2022, the average quality of services made 83,8% and 80,5%, in six pilot districts, at the level of RHCs and HHs, respectively. Average scores were recorded in all health facilities in Darvoz District. (Chart 42)

Chart 42



48% of facilities demonstrated high quality score, 5% of facilities received low quality score. Number of health facilities received high scores increased by 47% comparing with the Quarter 4, 2021. (Chart 43)

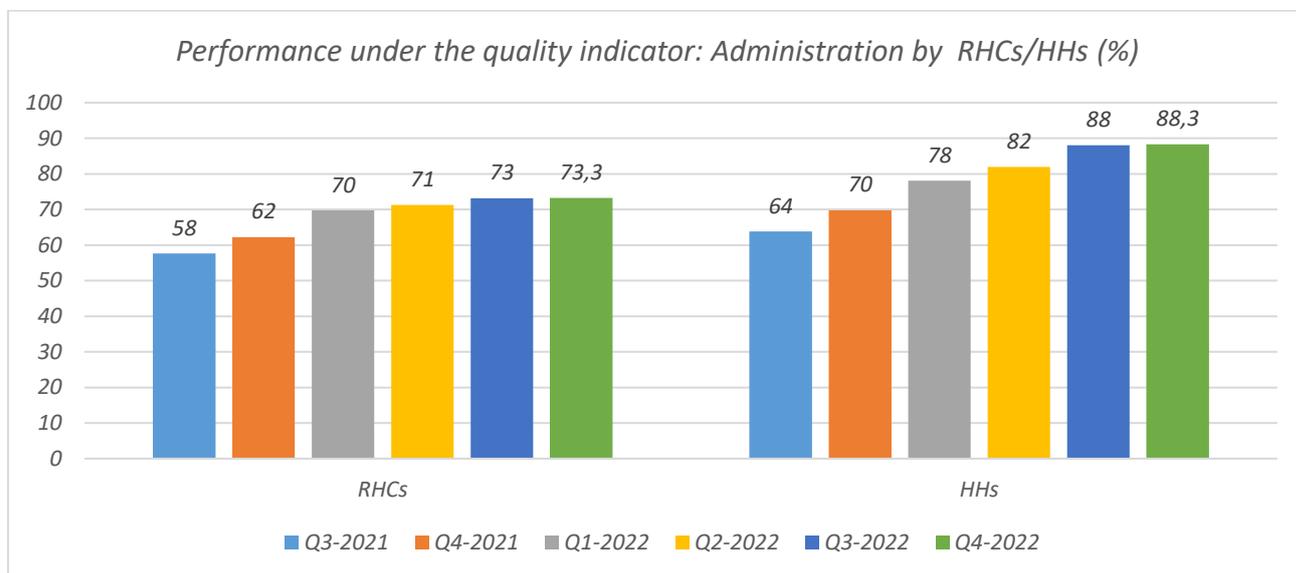
Chart 43



The results of the quality indicators performance by categories and quality components, in the context of six pilot districts and types of health facilities (RHCs and HHs) for the Quarter 4 of 2022 are provided below.

Section 1. Administration

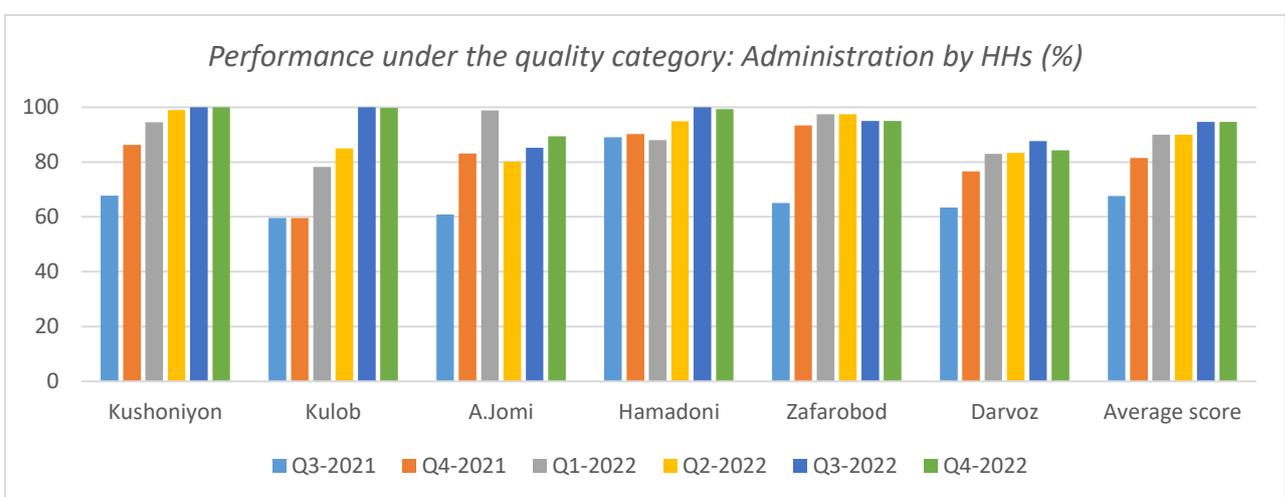
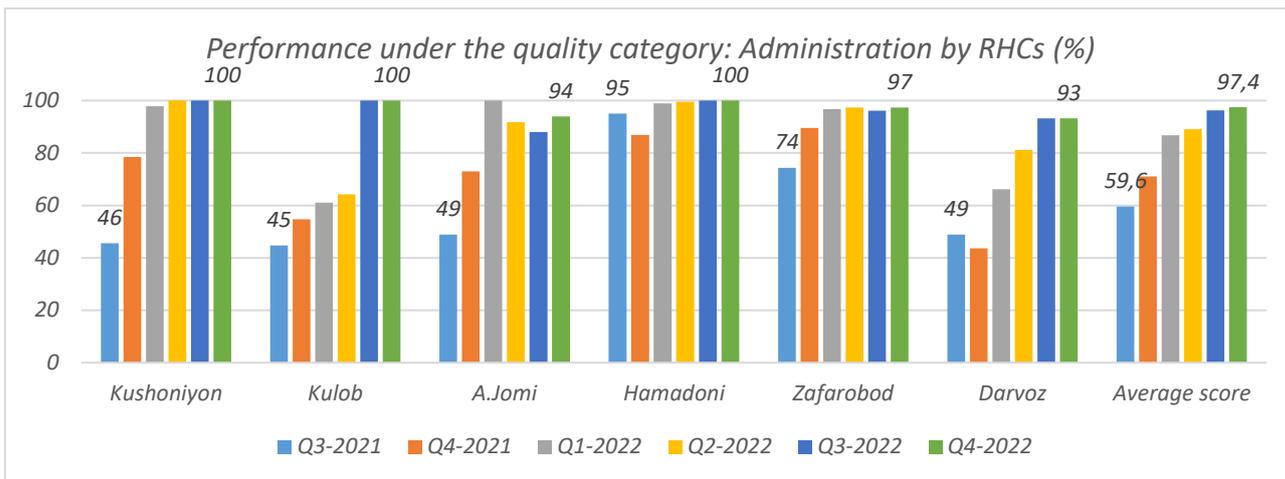
Since the beginning of the Project implementation in six new pilot districts, in general, the quality-of-service delivery according to the *Administration Section* requirements has been growing from 58% to 73,3% at the RHC level and from 64% to 88,3% at the HH level (*Chart 44*).



Data analysis showed that in the Quarter 4 of 2022, 51% of health facilities received high scores, an increase of 42% compared to the same period in 2021, health facilities with low scores also decreased from 29% to 2%.

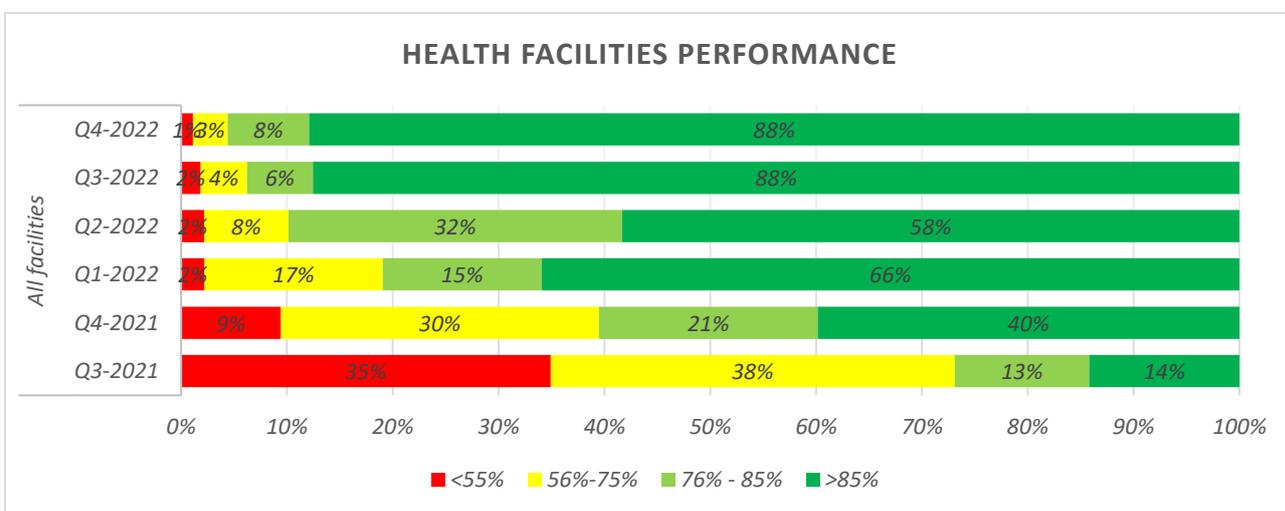
Sub-section 1.1 Administration

Assessment of the health facility performance under the Subsection 1.1 *Administration* includes five indicators including, Availability of the map of medical facility coverage area, PBF action plans availability, signed PBF reports and previous PBF quality assessments, Weekly staff meetings and the availability of minutes of the meeting, Availability of medical forms, Availability of the service phone for communication between the medical facility and the center of the next level, where the patients are referred to. According to the Internal Verification results under this subsection, new districts at the level of RHCs and HHs received 97,4% and 94,6%, respectively, for the Quarter 4, 2022. Compared to the same quarter of 2021, the growth amounted to 26,4% at the RHC level and by 13,1% at the HH level, in six pilot districts. *Charts 45-46*



The Internal Verification results show that 97% and 84% of the total number of health facilities RHCs and HHs received a high score, respectively. Low scores were received by 1% of RHCs and 1% of HHs. Number of health facilities received high scores increased by 48% comparing with the Quarter 4, 2021. (Chart 47)

Chart 47



Below there are results of a more detailed analysis under the *Subcategory Administration* for the Quarter 4, 2022.

Analysis of the subcomponents of the *Administration* Subsection showed that in general, RHCs and HHs received high scores under five indicators (*Table 11*).

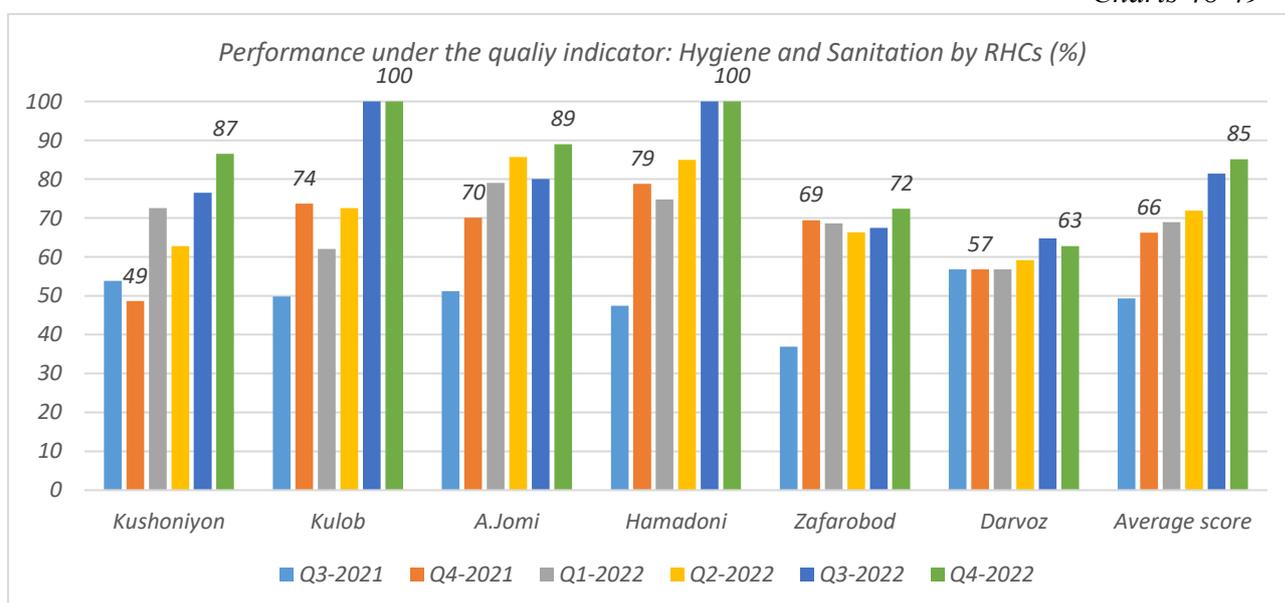
Table 11. Subsections and their performance by type of facility

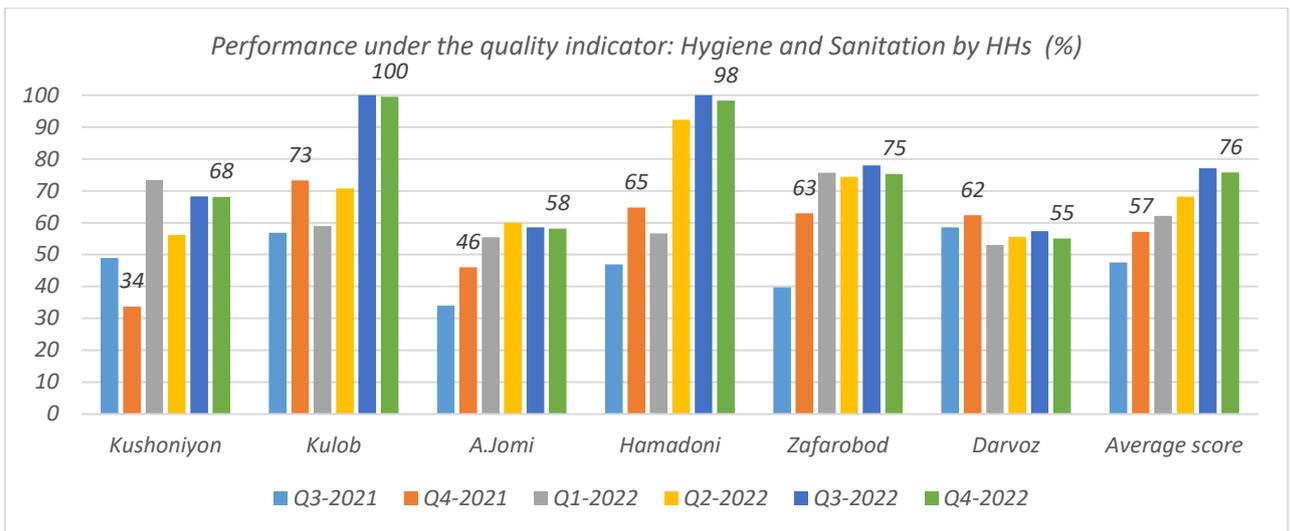
Subsection 1.1 Administration	RHCs	HHs
1.1.1 Availability of the map of medical facility coverage area	91,1	92,0
1.1.2 PBF action plans availability, signed PBF reports and previous PBF quality assessments	97,6	92,6
1.1.3 Weekly staff meetings and the availability of minutes of the meeting	97,6	
1.1.4 Availability of medical forms	98,4	95,0
1.1.5 Availability of the service phone for communication between the medical facility and the center of the next level, where the patients are referred to	100,0	98,3

Sub-section 1.2 Hygiene and Sanitation

Under this subsection, the average score for the indicator's performance in six pilot districts in the Quarter 4, 2022 at the level of RHCs and HHs was 85,1% and 75,7%, respectively. Compared to the Quarter 4 of 2021, there is an increase at the level both of RHCs and HHs by 19%. (*Charts 47-48*). A decrease under this indicator is observed in HHs in Darvoz District. (*Charts 48-49*)

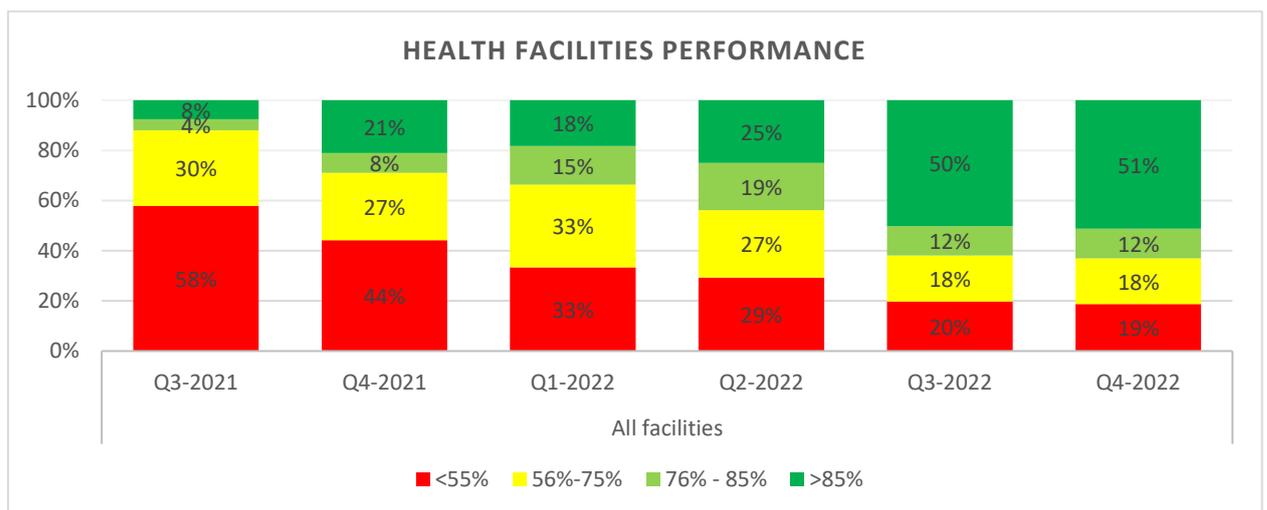
Charts 48-49





According to the Internal Verification data, the quality of the indicator performance under Subsection 1.2 showed that out of the total number of health facilities 51% received a high score, 18% an average score and 19% of facilities received low scores. (Chart 50)

Chart 50



The main reasons of low score under this subcategory are at the HH level - *1.2.1 Availability of the fencing at the medical facility and keeping it in order*, *1.2.3 Availability of toilets / latrines and maintaining them in good order* and *1.2.5 Availability of a pit for non-infected objects* and at the RHC level - *1.2.4 Fenced and locked incinerator for incineration of medical and non-medical waste* and *1.2.6 Sterilization of instruments by staff in accordance with the standards*. (Table 12)

Table 12

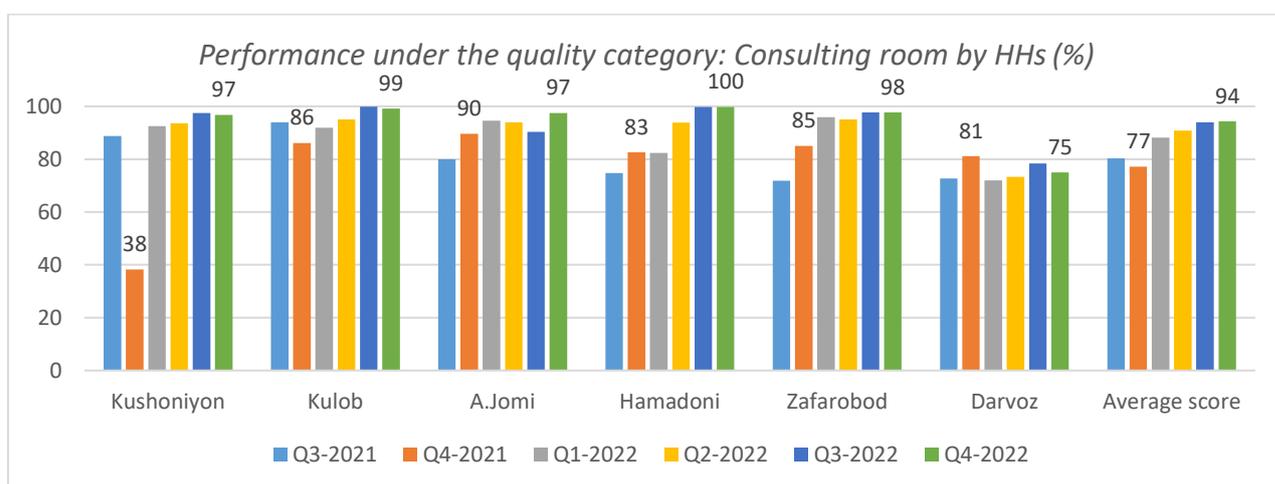
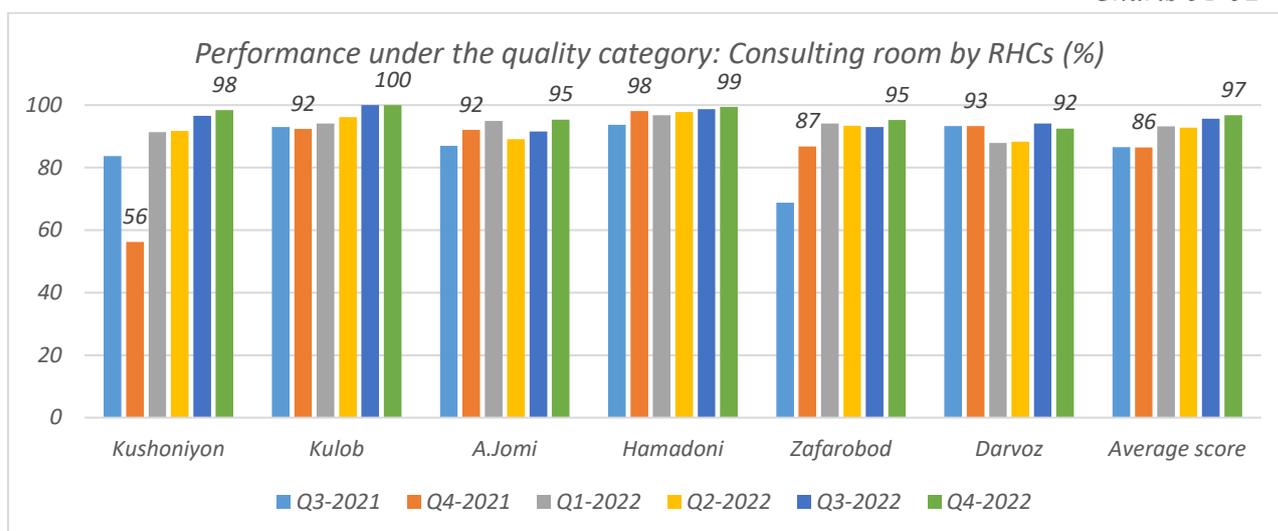
1.2. Hygiene And Sanitation	RHCs	HHs
1.2.1 Availability of the fencing at the medical facility and keeping it in order	86,4	62,6
1.2.2 Cleaning and maintaining the courtyard	96,2	85,4
1.2.3 Availability of toilets / latrines and maintaining them in good order	93,1	66,3
1.2.4 Fenced and locked incinerator for incineration of medical and non-medical waste	69,6	
1.2.5 Availability of a pit for non-infected objects	89,8	68,1

1.2.6 Sterilization of instruments by staff in accordance with the standards	63,1	
1.2.7 Ensuring hygienic conditions and proper sorting of waste in the reception, dressing and injection rooms (check all rooms)	99,6	93,4
1.2.8 Availability of a continuous water supply	93,8	88,0

Subsection 1.3 Consulting room

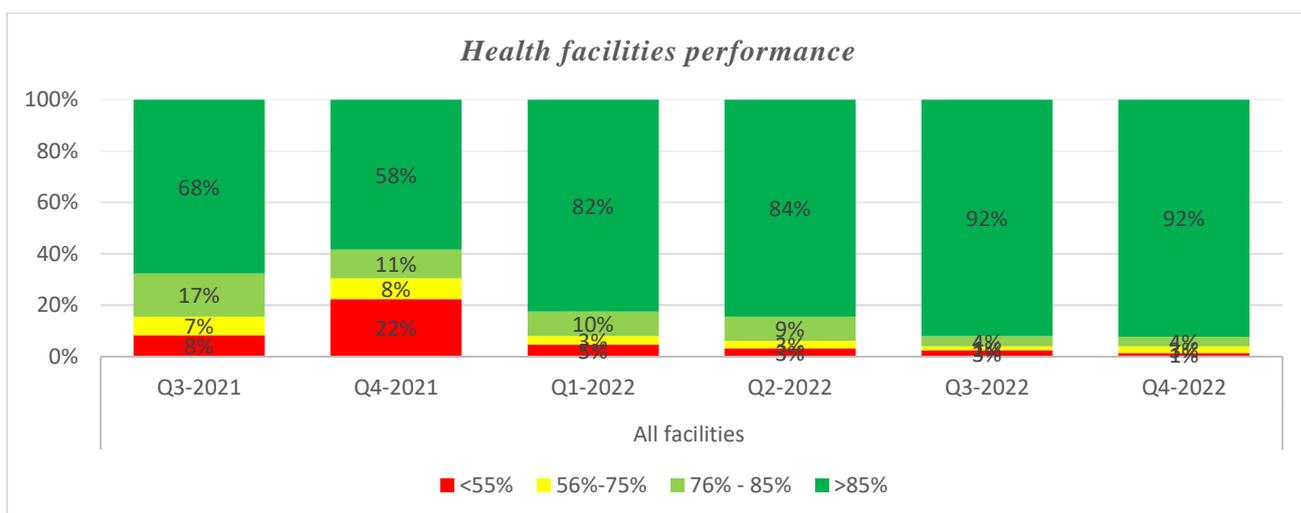
In the Quarter 4 of 2022, under this subsection, the average score in six pilot districts at the level of RHCs and HHs was 96,8% and 94,3%, respectively. The analysis showed that in comparison with the Quarter 4 of 2021, the increase of this indicator was recorded by 10% and 17% in RHCs and HHs, respectively. (Charts 51-52)

Charts 51-52



According to the verification results, out of the total number of medical institutions - 92% of facilities received high scores (the growth made 34% in comparison with the Quarter 4, 2021), 3% of facilities received an average quality score and 1% of facilities received low quality score. (Chart 53)

Chart 53



The results of the detailed analysis of the reasons for the relatively low indicator performance under the category **Consulting room** in the Quarter 4, 2022 are provide below. Problems identified when analyzing the indicators under this subsection found in most pilot facilities: *1.3.5 Availability of electricity at any time of the day at least in one reception room in case of emergencies.* Table 13

Components of the Subsection 1.3

Table 13. Indicator performance by type of health facility

1.3 Consulting room	RHC	HH
1.3.1 Good conditions in the lobby or in the waiting area	96,6	91,8
1.3.2 The list of employees (medical staff) to whom the population can refer - available to the public	100,0	95,1
1.3.3 Fees for paid services rendered to the population	78,3	
1.3.4 Maintaining consultation room in good condition	99,3	94,6
1.3.5 Availability of electricity at any time of the day at least in one reception room in case of emergencies	93,7	83,4
1.3.6 Neatly dressed consulting staff	96,4	95,0
1.3.7 Availability of stethoscopes and sphygmomanometers that are in working conditions in all examination rooms	100,0	98,4
1.3.8 Availability of medical thermometers	100,0	98,4
1.3.9 Availability of otoscopes	95,2	
1.3.10 Availability of examination table, which is not damaged, with a clean blanket, in the consultation room	100,0	91,6
1.3.11 Availability of scales and height measuring boards in operational condition in at least one room	99,2	96,8
1.3.12 Availability of insulated shipping containers or cold boxes for vaccines	100,0	94,6
1.3.13 Availability of the refrigerator	100,0	
1.3.14 Availability of operational equipment for antenatal care	90,6	

Table 14: 1.3.5 Availability of electricity at any time of the day at least in one reception room in case of emergencies

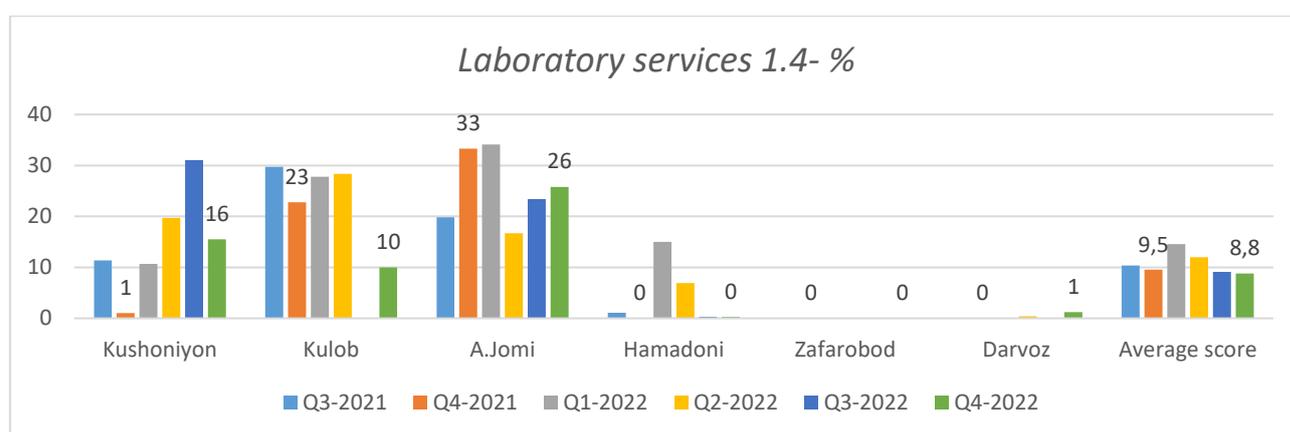
District	RHCs	HHs
Darvoz	85,7	23,1
Zafarobod	100,0	90,0
Kulob	100,0	100,0
A.Jomi	85,7	91,7
Kushoniyon	95,8	95,8
Hamadoni	95,0	100,0

As for the performance of Subcomponent 1.3.5, health facilities in Zafarobod, Kushoniyon, A.Jomi and Hamadoni District received high and above average scores. Low scores were recorded in HHs in Darvoz. (Table 12)

Sub-section 1.4 Laboratory services

It should be noted that the performance indicators of the quality indicators under this subsection are at the lowest level. The average performance percentage in all pilot districts was 8,8%. The lowest scores were recorded in all six pilot districts. (Chart 54)

Chart 54



The table below shows the quality indicators performance under this section by subcategories (Table 15). As can be seen from the table above, all indicators show low quality scores.

Table 15

LABORATORY SERVICES	RHCs
1.4.1 Availability of laboratory	17,5
1.4.2 Availability of a laboratory assistant or Family Medicine nurse	9,9
1.4.3 Availability of laboratory stocks and consumables for the main tests (minimum for 20 individuals)	10,3
1.4.4 Availability of the main reagents for urine, blood and feces tests (minimum for 20 individuals)	7,0
1.4.5 Availability of diagnostic kits for the antenatal health care (minimum for 20 individuals)	6,9
1.4.6 Availability of operational laboratory equipment	9,9
1.4.7 The inventory log is maintained correctly, and there was no shortage of stocks in the reporting period	7,9

1.4.8 The validity of results recorded in the laboratory register and their compliance with the results, indicated in the medical records (verify 2 results in every register)

9,9

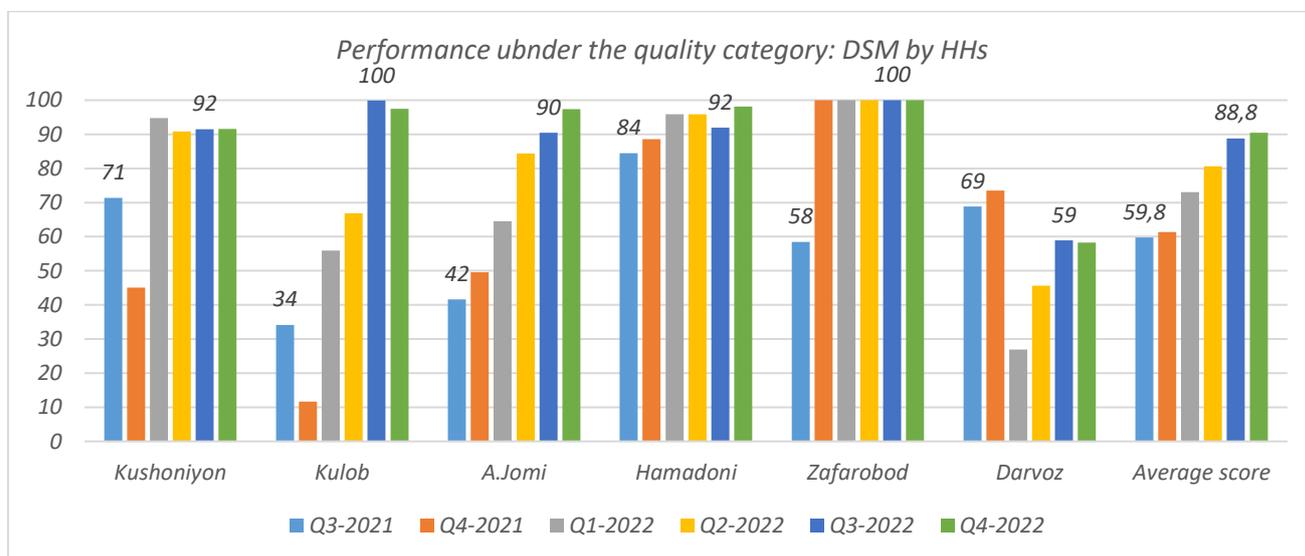
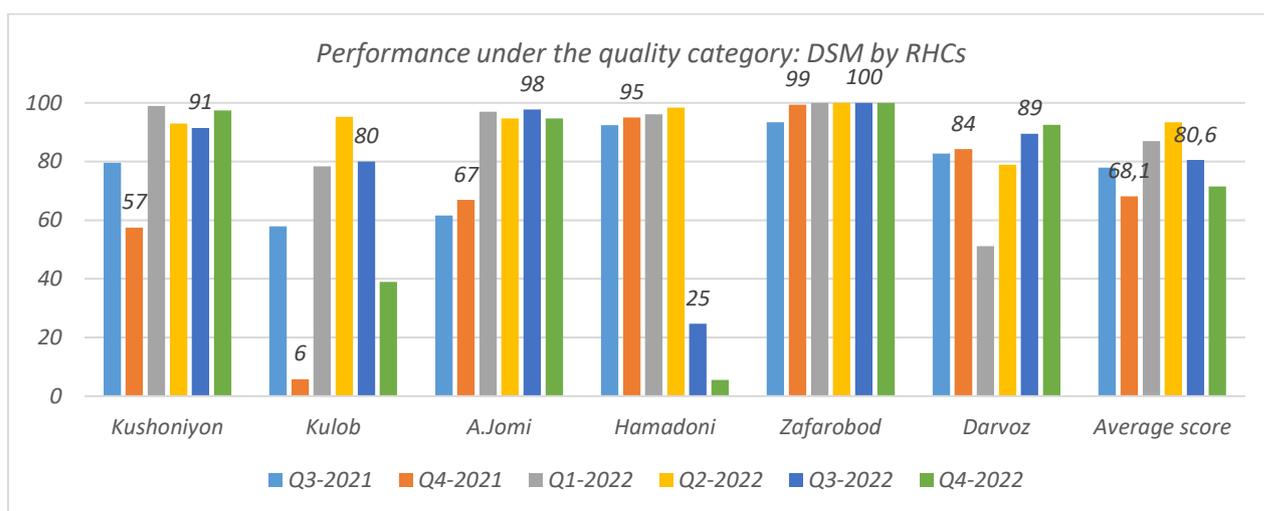
1.4.9 Правильность обращения с отходами

11,4

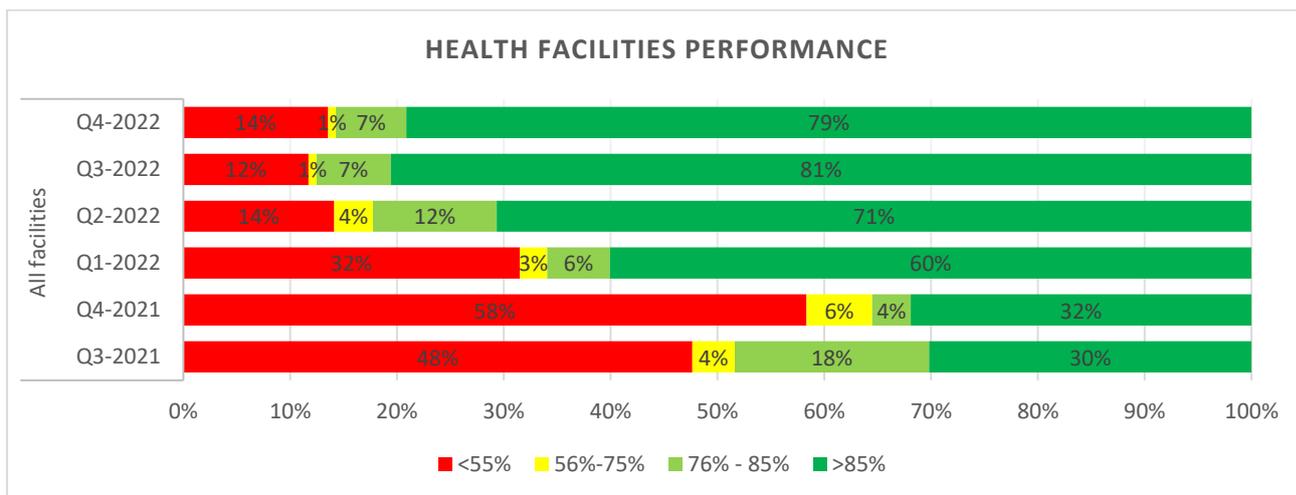
Subsection 1.5 Drug supplies management

According to the Internal Verification results in the Quarter 4, 2022 quality indicators under the subsection *Drug Supplies Management*, the average score was 71,5% and 90,5% at the level of RHCs and HHs, respectively. Compared to the Quarter 4 of 2021, the growth made 3% at the RHCs level and 29% at the HHs level. (Charts 55-56)

Charts 55-56



In general, 79% of the total number of facilities received high quality score. 63% of RHCs received high quality score, 85% of HHs received high score and low score is observed 6% of HHs and 33% of RHCs in pilot districts. (Chart 57).



The following table 16 specifies the main reasons for the low scores under this subsection at the level of districts and types of health facilities in new pilot districts. This assessment showed that health facilities under four indicators received average scores, which is the main reason of low rates.

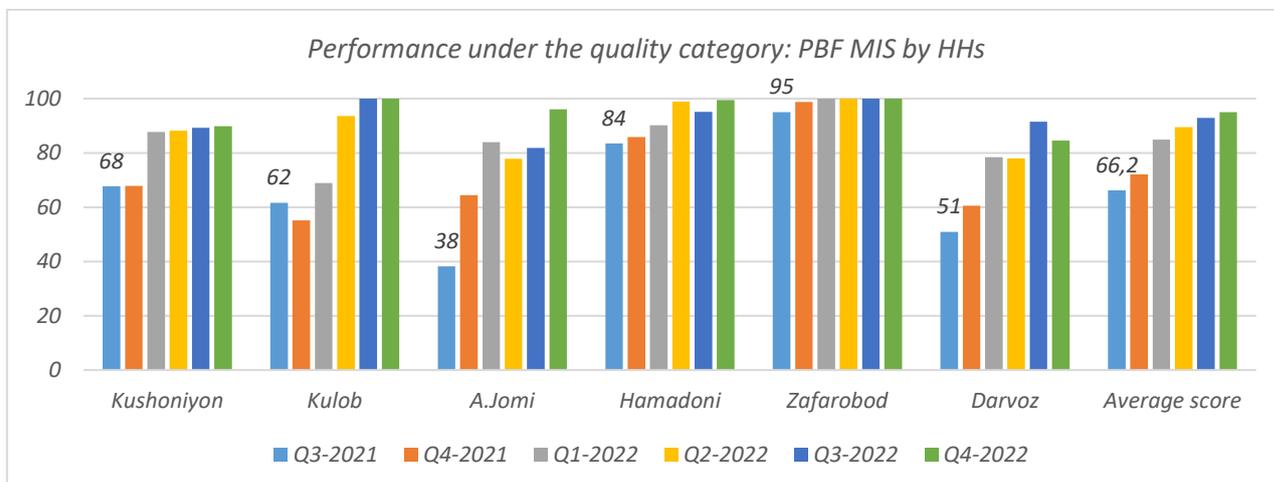
Table 16

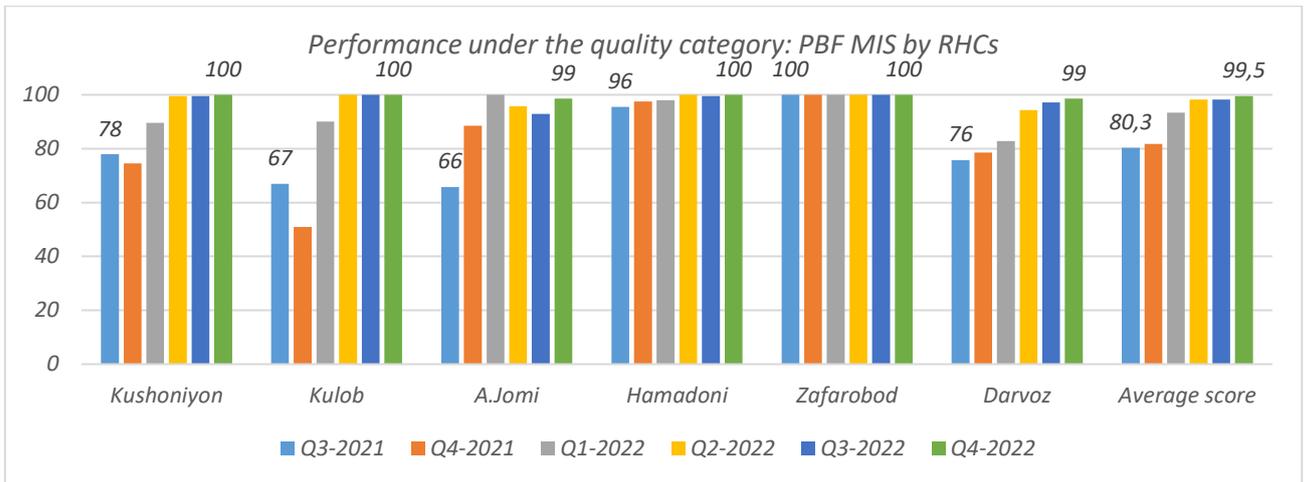
Drug Supplies Management		RHCs	HHs
1.5.1	Staff maintains Drug supplies Inventory Checkbook for emergency cases	71,0	93,9
1.5.2	Stock recorded in the Checkbook match actual stock (<i>randomly select and check 5 drugs</i>)	72,4	92,8
1.5.3	Proper storage of medicines	68,7	81,1
1.5.4	Absence of expired medications in stocks (<i>randomly select 3 drugs and 2 consumables</i>)	72,4	90,9

Subsection 1.7 PBF Management Information System

In this subsection, the quality indicators performance of in Quarter 4 of 2022 at the level of RHCs and HHs made 99,5% and 95,0%, respectively. In comparison with the Quarter 4, 2021, the increase made 18% and 23% at the RHCs and HHs level, respectively. *Charts 58-59*

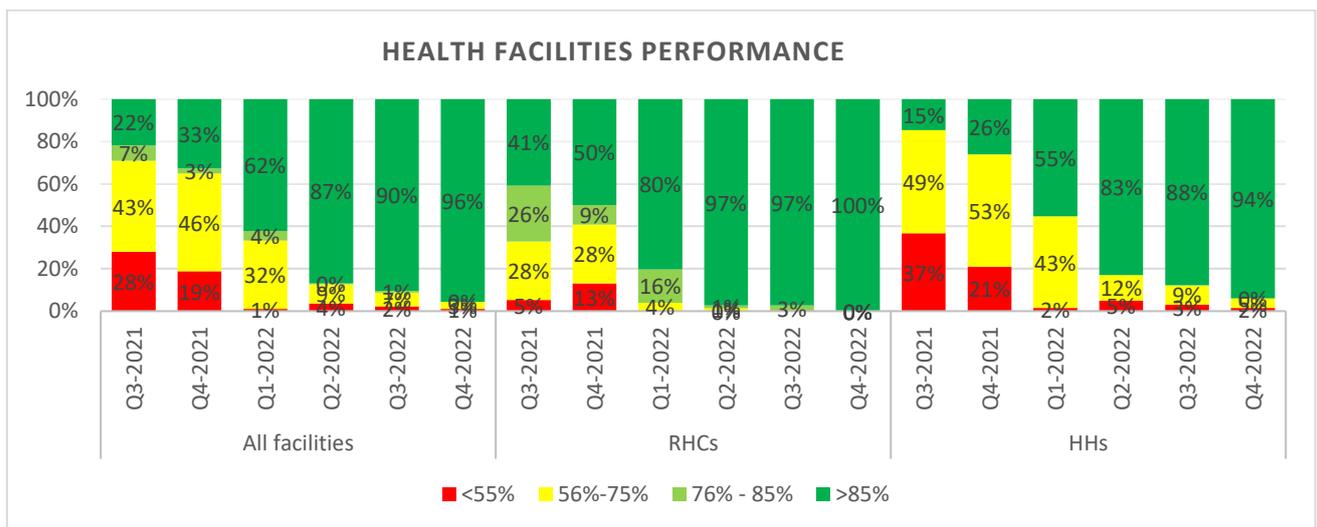
Charts 58-59





The internal verification results show that 100% of the total number of RHCs received a high-quality score; high scores of 94% of HHs from the total number of facilities, as well. In general, for all types of facilities, 96% received high scores compared to the Quarter 4, 2021 an increase made 63%. *Chart 60*

Chart 60



Performance results of the Subcomponents *PBF MIS* in the Quarter 4 of 2022 are provided below.

Components Subsection 1.7

Performance of indicators according to the type of facility

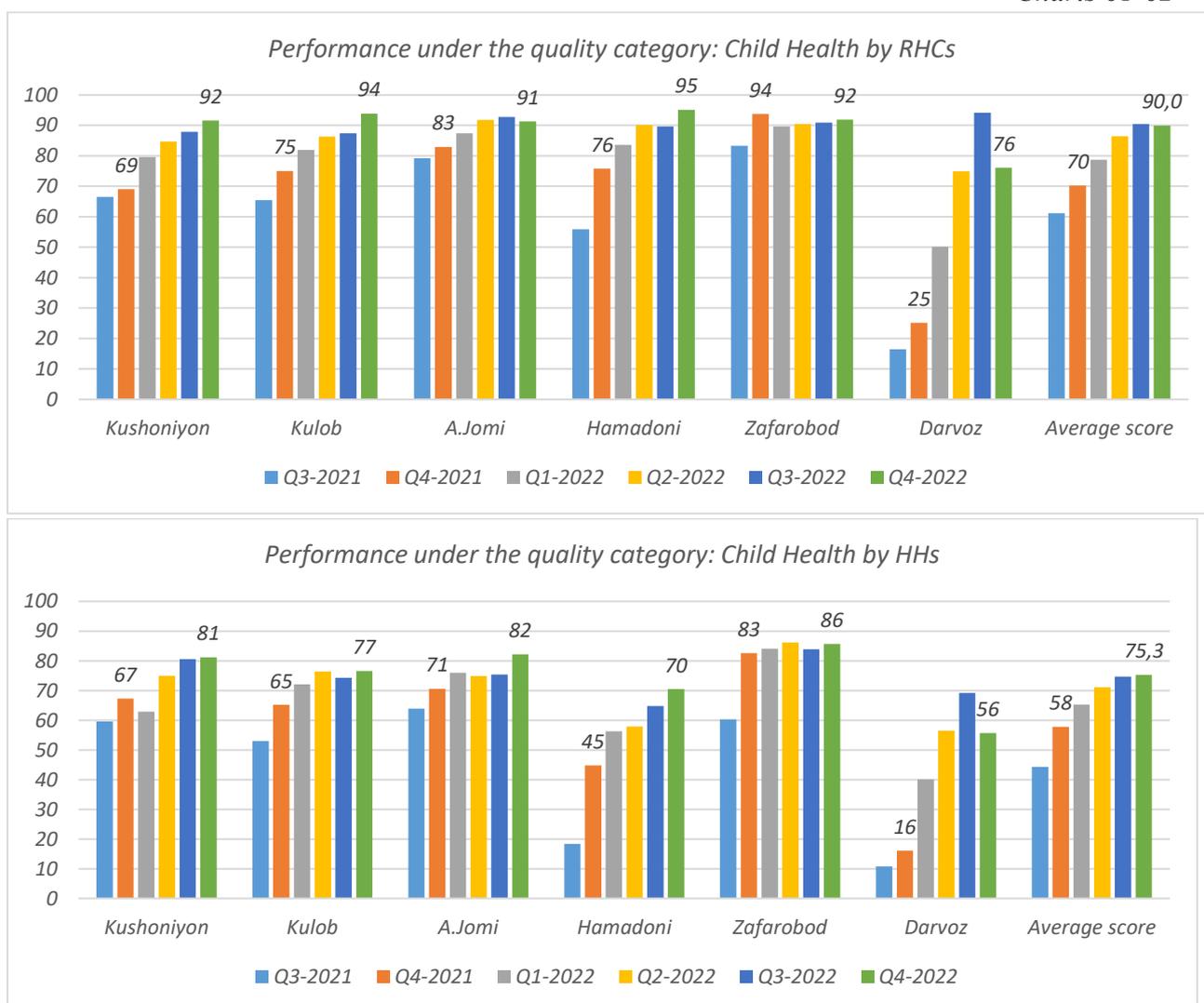
Table 17

PBF MIS	RHCs	HHs
1.7.1 Availability of all journals, needed for regular PBF MIS update, in accordance with the approved list of accounting and reporting documentation on PHC	99,2	95,7
1.7.2 Timely submission of PBF IMS forms to the Manager of PHC	100,0	92,9
1.7.3 Availability and utilization of notebooks / tablets by responsible staff	100,0	

Section 2. Clinical Care – Child Health

Section 2 rates the practice of health facilities for such indicators like: maintaining medical records, quality of immunization, quality of identification and treatment of malnutrition (only for the RHCs), quality of diagnostics and treatment of diarrhea among children <5 years, and quality of diagnostics and treatment of acute respiratory infections among children <5 years. In general, indicators of *Clinical Care – Child Health* section made 90,0% and 75,3% from the max value at the level of RHCs and HHs, respectively. Compared to the Quarter 4, 2021 the growth was 20% at the RHCs level and 18% at the HHs level. *Charts 61-62*

Charts 61-62



According to internal verification it was identified that 30% of health facilities (91% of RHCs and 7% of HHs) in average got high scores, 14% got average scores and 5% got low scores (*Chart 63*).



The results of detailed analysis of section 2: *Clinical Care – Child Health* according to the internal verification of Quarter 4 of 2022 are provided below.

Below we consider the indicators for which health facilities received average scores, these are 2.4. Quality of diagnostics and treatment of diarrhea among children <5 years, and 2.5. Quality of diagnostics and treatment of acute respiratory infections among children <5 years. (Table 18)

Table 18. Sub-sections and their performance per type of facility

Section 2. Child Health	RHC	HH
2.1. Maintaining medical records	100,0	98,4
2.2. Quality of immunization	91,9	80,0
2.3. Quality of identification and treatment of malnutrition	93,0	
2.4. Quality of diagnostics and treatment of diarrhea among children <5 years	87,4	75,0
2.5. Quality of diagnostics and treatment of acute respiratory infections among children <5 years	89,2	71,4

Subsection 2.4 (RHC) / 2.3 (HH)

Quality of diagnostics and treatment of diarrhea among children <5 years

Quality of diagnostics and treatment of diarrhea among children <5 years at the level of RHCs and HHs makes 87,4% and 75,0% respectively in the Quarter 4 of 2022. In general, only 51% of health facilities got high scores, 7% got low scores, and 15% got average scores. Quality performance of this subsection is provided below in the breakdown of districts and types of facilities.

Table 19

District	RHC	HH
Kushoniyon	92,7	87,3
Kulob	94,0	77,2
A.Jomi	90,5	83,8
Hamadoni	96,3	69,6
Zafarabad	91,0	85,4
Darvoz	59,9	46,8

According to internal verification all RHCs in pilot districts and HHs in A.Jomi, Kushoniyon and Darvoz District got high scores for quality performance in this subsection. Low scores were recorded in HHs in Zafarobod District and average scores in Kulob and Hamadoni District. (Table 17)

Performance analysis of the quality assessment of

subsection “Quality of diagnostics and treatment of diarrhea among children <5 years” in “low quality” zone with reflection of the most frequent reasons of low quality is provided in the table below (*Table 20*).

Table 20

Subsection 2.4 (RHC) / 2.3 (HH) Quality of diagnostics and treatment of diarrhea among children <5 years	RHC	HH
2.4.1. Medical History: (Below information is collected by medical workers and is reflected in the medical record)	89,3	73,6
2.4.2. Measurements conducted: (measurement results reflected in the medical records)	84,9	70,8
2.4.3. Assessment of general condition (measurement results reflected in the medical records)	84,5	74,0
2.4.4 Classification	83,9	59,4
2.4.5. Treatment	84,2	75,4
2.4.6. Consultation: a mother is consulted and trained, and information on topics of consultation is reflected in the medical records	91,7	82,3

Sections 2.5 (RHC) / 2.4 (HH)

Quality of diagnostics and treatment of ARI among children under 5 years old

Quality of diagnostics and treatment of ARI among children under 5 years old at the level of RHCs and HHs makes 89,2% and 71,4%, respectively. In general, only 25% of health facilities got high scores, 4% - low scores, and 48% - average scores. The indicators of the quality of this sub-section are provided below with the breakdown by the districts and types of facilities.

Table 21

Districts	RHCs	HHs
Kushoniyon	85,0	72,2
Kulob	88,4	62,7
A.Jomi	83,6	75,6
Hamadoni	90,1	62,0
Zafarabad	90,9	85,3
Darvoz	97,1	70,6

Analysis has shown that high scores in this subsection have been received by all RHCs in pilot districts and HHs in Zafarobod District. Average scores have been recorded in HHs in Khatlon region and Darvoz District. (*Table 21*).

Internal verification of the quality of diagnostics and treatment of ARI among children under 5 years old revealed that low scores were noted in the RHCs and HHs for performance of the following indicators. (*Table 22*)

- Medical history: information is collected by health staff and reflected in the medical records
- Measurements conducted and the measurement results are indicated in medical records

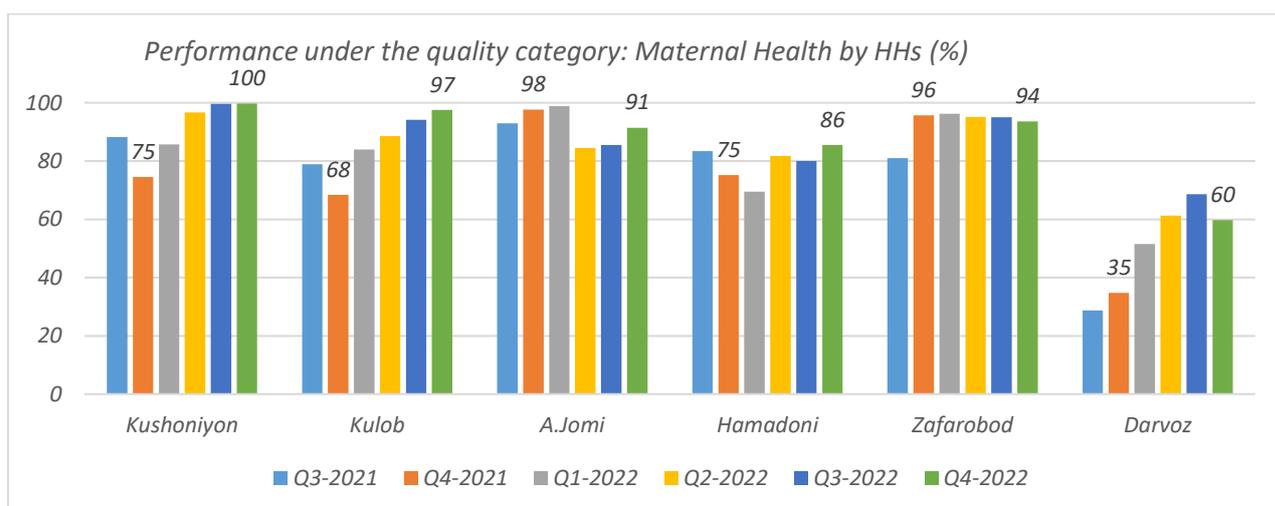
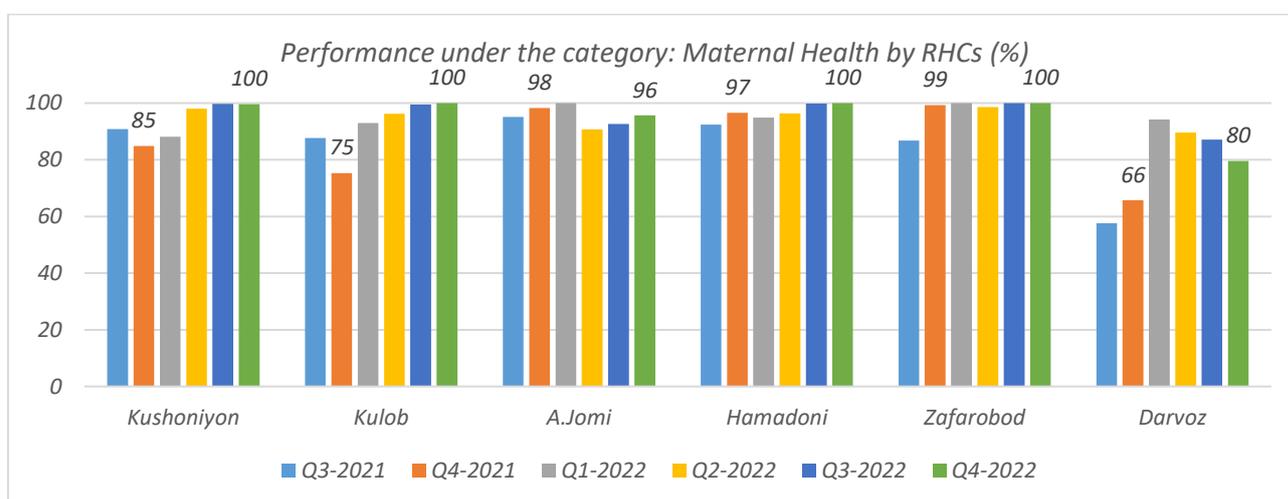
Table 22

Subsection 2.4 (HH) / 2.5 (RHC) Quality of diagnostics and treatment of ARI among children under 5 years old	RHC	HH
2.4.1 / 2.5.1 Medical history: Below information is collected by health staff and reflected in the medical records	88,0	73,3
2.4.2 / 2.5.2 Measurements conducted (the measurement results are indicated in medical records)	87,5	66,0
2.4.3 / 2.5.3 Classification was done properly, diagnosis was properly determined	96,1	77,4

Section 3. Maternal Health

Two subsections are set for the section 3: *Maternal Health* for RHCs and HHs, namely: maintaining medical records and quality of the first postpartum care visit at home. In general, indicators of this section *Clinical Care – Maternal Health* made 95,8% and 87,9% respectively from the maximum value at the level of pilot RHCs and HHs. (Charts 64-65)

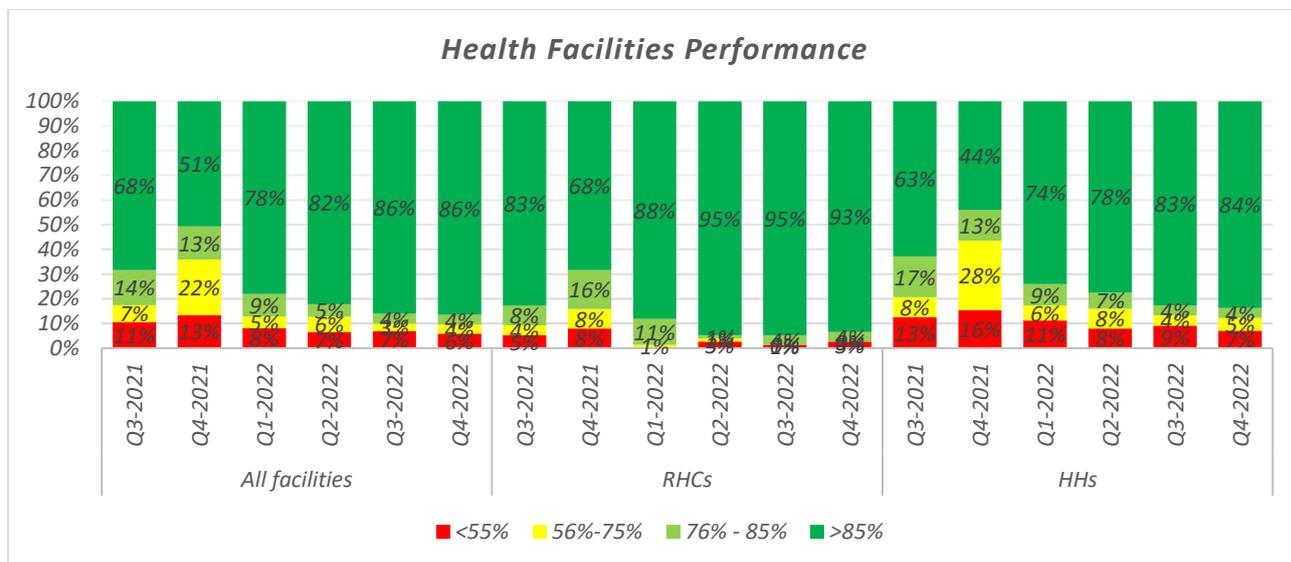
Charts 64-65



In general, 86% from the total number of health facilities got high scores for quality. As for the RHCs, the high score for quality was received by 93% of the facilities, and as for HHs, the high

score received by 84%. Low service quality is recorded at 6% of health facilities in six pilot districts. (Chart 66)

Chart 66



The results of more detailed analysis of section *Maternal Health* are provided below.

Section 3

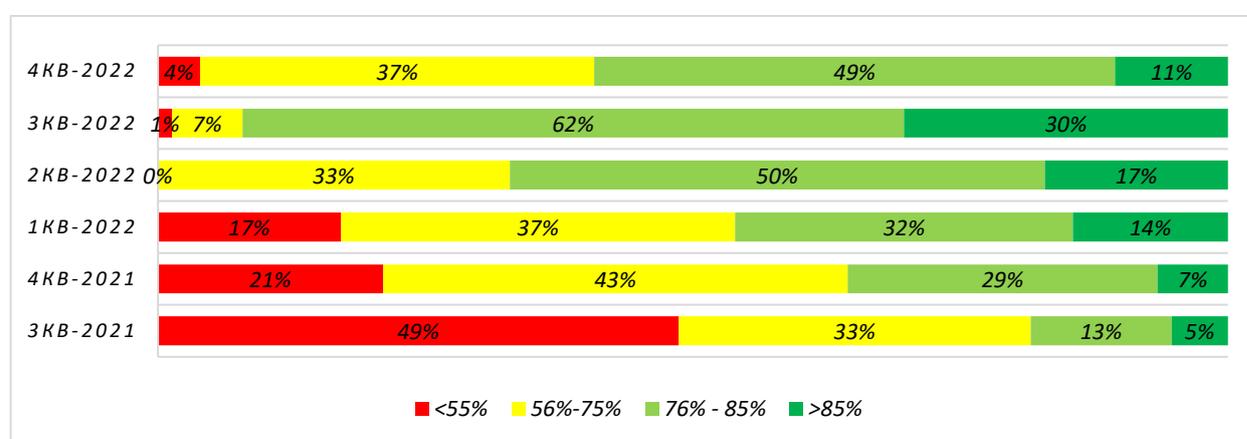
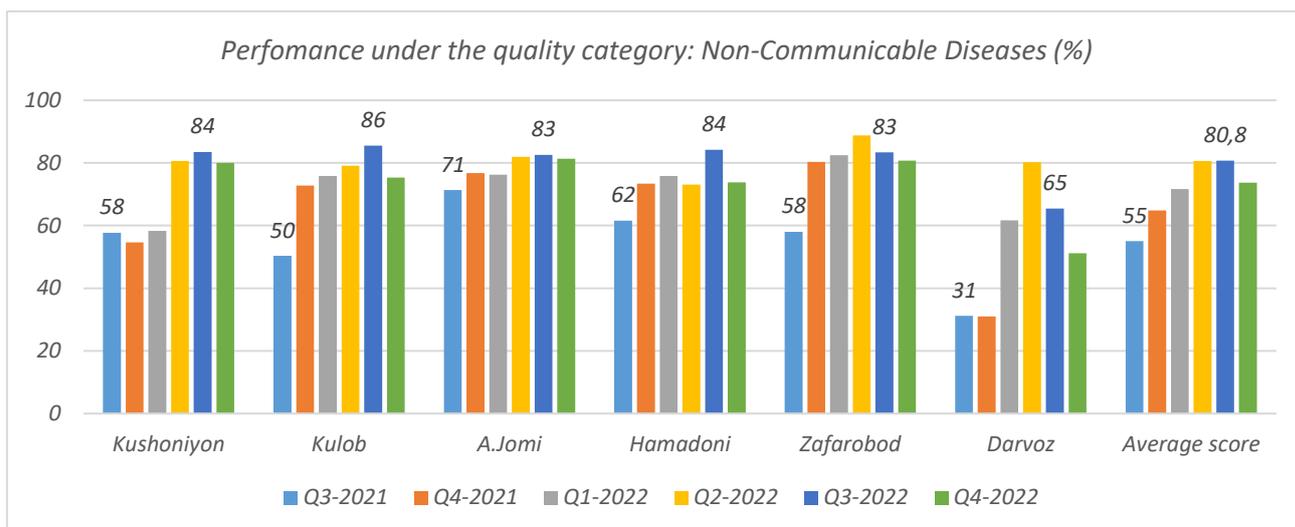
Table 23. Section’s subsections per type of health facilities

Section 3. Maternal Health	RHCs	HHs
3.1. Maintaining medical records	99,5	97,1
3.2. Quality of the first postpartum care visit at home (during the first three days after maternity hospital discharge)	95,3	86,9

Analysis of this section has shown that almost all health facilities reached high results.

Section 4. Quality of clinical care: Non-Communicable Diseases

Section 4 rates the quality of clinical care for non-communicable diseases (hypertension) in health facilities. This indicator is measured only at RHCs and includes two subsections: maintaining medical records and quality of hypertension treatment. The results of verification show that RHCs in average received 73,7%, five pilot districts received above average scores, with the exception of the Darvoz District, where the quality was rated as average. High score for quality has been received by 11% of the facilities, and 4% of facilities got low scores for quality. (Charts 67-68)



Detailed analysis of this section records positive picture in subsection *Maintaining medical records*, with rated high score of 98,9%. Average score of 72,1% is recorded under the subsection *Quality of hypertension treatment* (Table 24).

Table 24

4.2 Quality of the clinical care: <i>Non-communicable Diseases</i>	RHCs
4.1 Maintaining medical records	98,9%
4.2 Quality of hypertension treatment	72,1%

4.2 Quality of hypertension treatment

Table 25

Districts	RHCs
Kushoniyon	78,7
Kulob	73,7
A.Jomi	80,3
Hamadoni	72,1
Zafarabad	79,5
Darvoz	48,3

Analysis has shown that the quality of hypertension treatment in 5 districts is rated as over average. The exception made Darvoz District where the average scores were recorded. *Table 25*

Subsection 4.2 “Quality of hypertension treatment”, for which health facilities got low and average scores, comprises six indicators; low quality score was given for indicator *Routine (mandatory) examination (Table 26)*

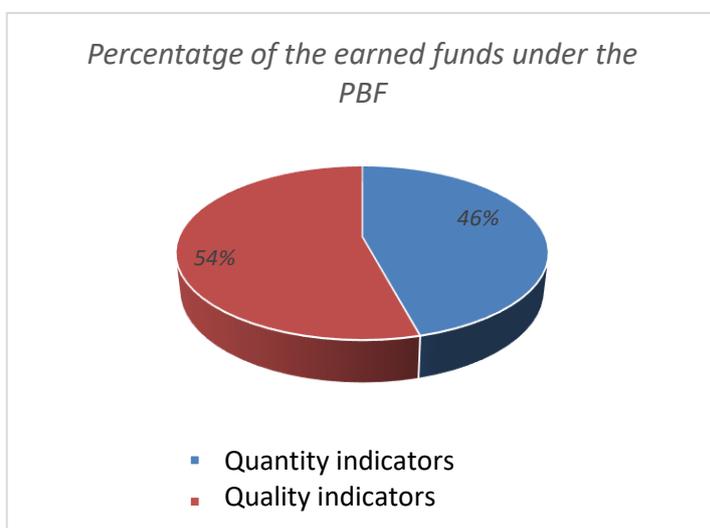
Table 26

#	Subcategory of treatment quality	RHCs
4.2.1	Medical history: (Information collected by health worker and indicated in medical record)	88,1
4.2.2	Corresponding measurements conducted and results are indicated in the medical records	86,6
4.2.3	Routine examination	30,2
4.2.4	Risk assessment	86,4
4.2.5	Treatment	91,6
4.2.6	Consultation: The patient is consulted and trained, and information on the topics of consultation is incorporated in the medical records	91,6

PBF payments

Based on the approved Performance Based Financing (PBF) Manual, the PBF scheme was launched since 2015 in 8 pilot districts of Sughd and Khatlon Region. Since 2016, the PRBF has been expanded with additional funding of the AF-1 to the Health Services Improvement Project, resulting in 10 pilot districts, including Dangara District, Khatlon Region and Faizobod District, DRS.

Chart 69



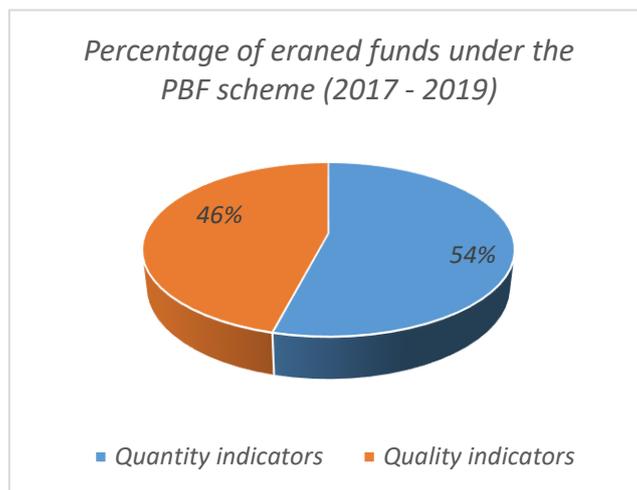
During the period of the PBF scheme implementation from 2015 to 2016 (8 rounds of Internal Verification), the total amount of the PBF funds earned amounted to 18,397,361 TJS. Health facilities in the pilot districts earned 46% of the total amount (8,430,319 TJS) for improving coverage based on quantity PBF indicators, and 56% (9,967,043 TJS) for improving the quality of care provided. *Charts 69*

This demonstrates the significant progress of health facilities in pilot districts, which have achieved improvements both in quantity and quality indicators of medical care, resulting in additional earnings under the PBF scheme. This financing approach helps to stimulate the development and efficiency of the health care system in districts, with a focus on the quality of services provided and improving accessibility of health care for the population.

In 2017, the implementation of the Performance Based Financing (PBF) scheme in the HSIP pilot districts started based on the revised PBF Manual. This Manual was updated and approved by the Order of the Ministry of Health and Social Protection of the Republic of Tajikistan based on the experience gained during the scheme implementation. According to the revised PBF Manual, health facilities of the PHC network in pilot districts started implementation of the PBF scheme based on 10 quantity indicators. The quality of services in health facilities at this stage was assessed on the basis of the revised quality assessment table, approved by the PBF Manual, as well.

Chart 70

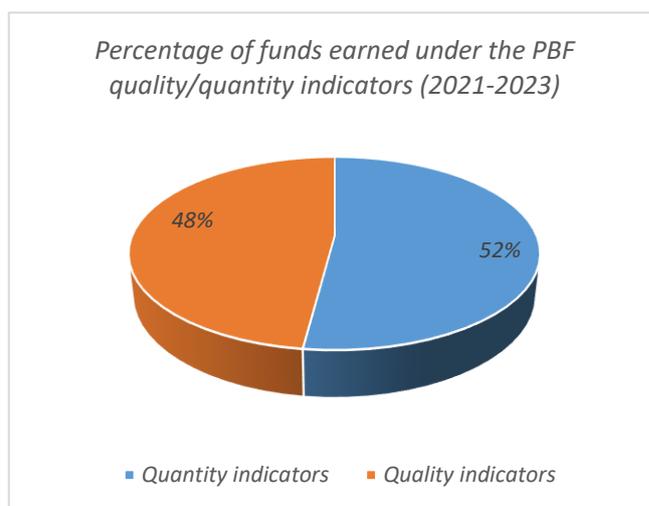
For the period 2017 - 2019, 11 rounds of Internal Verification were carried out, health facilities in 10 pilot districts of Sughd, Khatlon Regions and Faizobod District earned 67,678,690 TJS. Health facilities in the pilot districts earned 36,569,425 TJS for improving coverage based on quantity indicators under the PBF scheme. For improving the quality of services according to the PBF quality indicators performance, health facilities of the PHC network of the pilot districts earned 31,109,266 TJS. (*Chart 70*)



Under the revised PBF Manual, health facilities in the PHC network of the pilot districts had the opportunity to earn 100 percent quality bonuses in excess of the earned fund under the performance on the PBF quantity indicators.

Since the beginning of Q2 2021, the implementation of the PBF scheme under the Project has continued through Additional Financing Facility 2 (AF-2). The project districts were expanded and the PBF mechanism was implemented in 16 pilot districts of Sughd, Khatlon, GBAO (Darvoz District) and DRS (Faizobod District). The implementation of the PBF scheme was set up on the basis of the PBF Implementation Manual, which was revised (amendments made) and approved by the Ministry of Health and Social Protection of the Republic of Tajikistan.

Chart 71

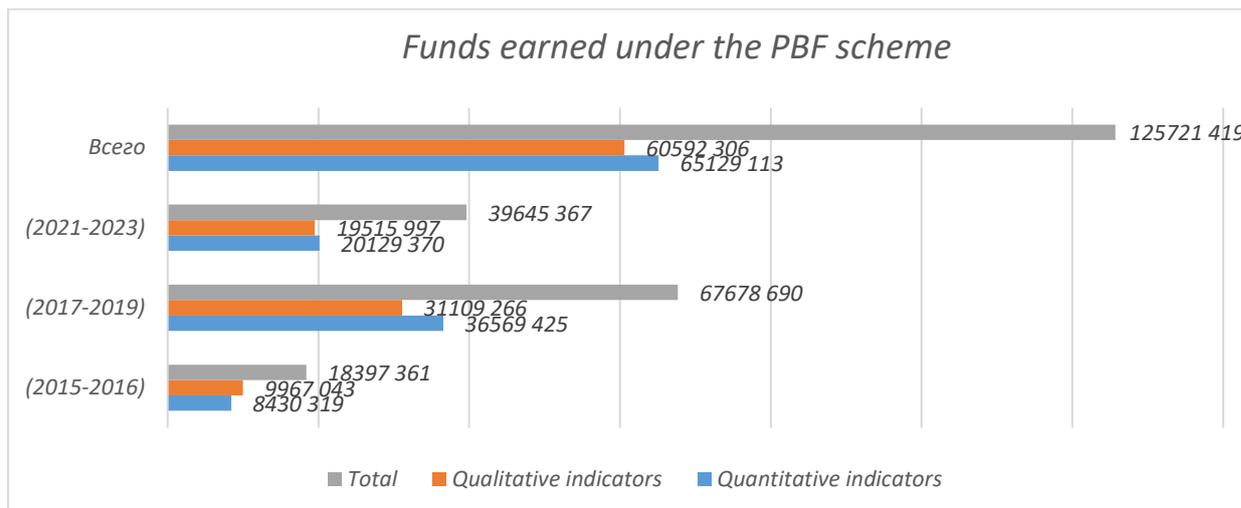


It should be noted that under the AF2, 10 existing districts started implementation of the PBF scheme from the Quarter 2 of 2021, and 6 new pilot districts started its implementation from the Quarter 3 of 2021. For the whole period of the PBF scheme implementation under the AF2, health facilities of PHC network of 16 pilot districts earned 39,645,367 TJS (total 7 rounds of Internal Verification (6 IV rounds were conducted in new districts)). Health facilities in the pilot districts earned 20,129,370 TJS for improving PHC

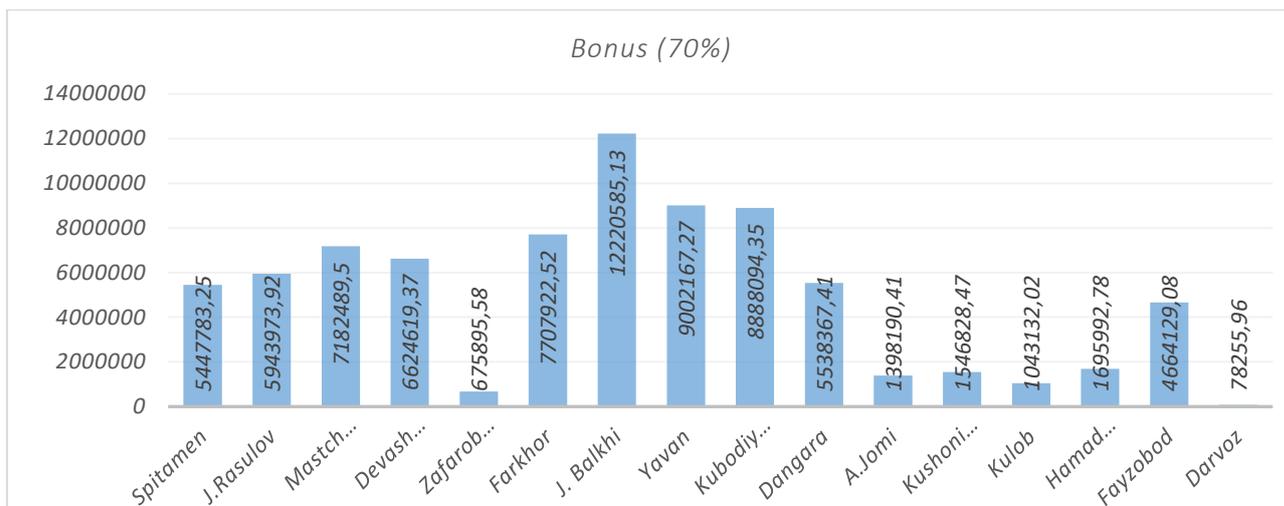
coverage based on the 7 PBF quantity indicators approved through the PBF Implementation Manual. The health facilities of the PHC network earned 9,757,999 TJS for performance of the PBF quality indicators. As a percentage, the share of funds earned for quality for the period 2021-2023 amounted to 48 percent of the total amount earned by health facilities of the pilot districts under the PBF. *Chart 71*

During the entire period of implementation of the Performance-Based Financing (PBF) scheme in pilot districts under the Health Services Improvement Project during the period from 2015 to 2023, health facilities of the PHC network of the pilot districts earned 125,721,419 TJS. (*Chart 72*)

Chart 71

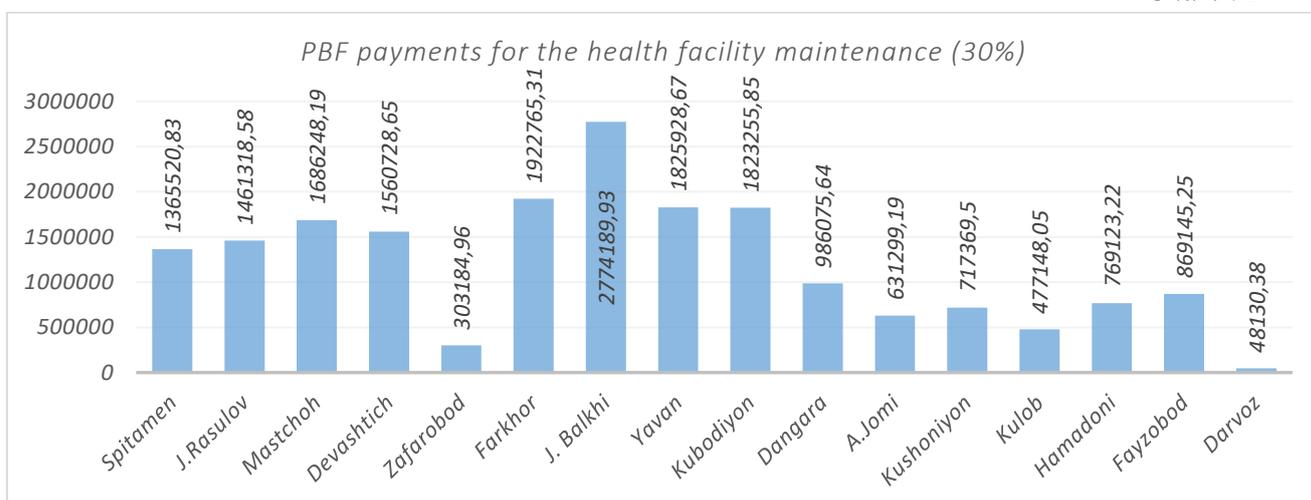


To encourage health staff, bonus payments for the whole PBF period amounted to 79,658,427 TJS. Each quarter, bonus payments were made to approximately 4,526 PHC network staff involved in the implementation of the PBF scheme in the pilot districts under the HSIP Project. This included 389 doctors, 3,128 secondary health staff and 1,009 junior health staff. The average amount of bonuses under the AF-2 amounted to 1,581 TJS per doctor, 879 TJS per one nursing staff and 273 TJS per junior health worker. As the implementation of the PBF mechanism was completed, the average bonus payments decreased, as thresholds were used for all PBF quantity indicators approved at the final stage of implementation. The Project engaged an International Consultant to develop a mechanism for bonus payments to be paid to the health staff. A spreadsheet for bonus payments to health staff was developed. Bonus payments were made using this spreadsheet based on the individual labor contribution of each health staff involved in the implementation of the PBF scheme. (*Chart 73*)

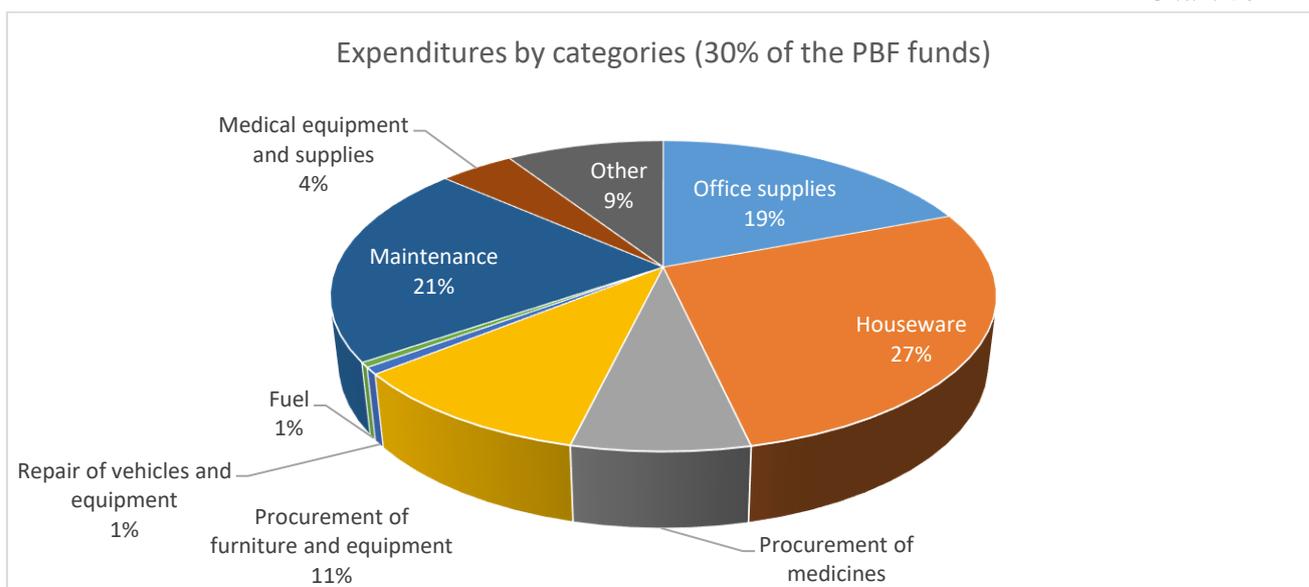


Throughout the whole period of the PBF scheme implementation, health facilities of the PHC network in the pilot districts received funds to improve the quality of care provided (30% of the PBF payments). For this purpose, bank accounts (bank plastic cards) were opened for each health facility. At the beginning of the PBF scheme implementation, to get start in the pilot districts, prepayment was made to support health facilities of the PHC network to improve the quality of services provided (30% of the PBF payments). Total prepayment amounted to 2,453,381 TJS. In the process of the PBF scheme implementation, the prepayment funds were fully recovered from the earned PBF funds by health facilities in pilot districts. For the whole period of implementation of the PBF scheme 30% of FFD payments amounted to 19,221,432 TJS in 16 pilot districts of the PHC network. (Chart 74)

Chart 71



An analysis of the use of these funds shows the following distribution: 46.5% of the funds were used for the purchase of office supplies and houseware, 7.3% for the procurement of medicines, 10.4% for the purchase of furniture and equipment, 0.7% for the repair of equipment and vehicles, 0.5% for the purchase of fuel (fuel and lubricants), 21.2% for maintenance and 13.4% for the purchase of medical equipment, medical supplies and other expenses. (Chart 75)



Difficulties in the PBF scheme implementation were related to financial administration in the health facilities of the PHC network in pilot districts. The accounting department at the District Health Centers (DHCs), which are in charge of financial management, had no corresponding previous accounting experience, which led to difficulties in the proper use of the PBF funds allocated by the project to support health facilities.

Introduction of the Per Capita Financing of the PHC health facilities of the Republic Tajikistan

In the recent years reforms of health financing and organizational issues are being conducted in the health sector of Tajikistan. The objective of the conducted reforms is to improve the financial sustainability of health care structure through major and efficient reconstruction of the hospital services system, which remained since the Soviet period to what it has been allocated the increasing volume of state resources.

Health financing reform among the other reforms includes introduction of set of defined basic health services within State Guarantee Program (SGP), introduction of co-payment/payment by the users of diagnostic and specialized services, and also introduction of per capita financing mechanism in the primary health care (PHC) facilities. Organizational reform covers introduction of methods and practice in to the base of family medicine in the PHC facilities, which is supported by quick training of PHC physicians and nurses.

The purpose of these amendments is to provide accessibility and quality of health services to the population, increase the effectiveness of healthcare system, and provision of financial sustainability of this sector.

Within the Strategy of health sector financing for 2005-2015 it has been accepted the decree of the Government of RT No.25 dated on April 03, 2006, regulating the priority of PHC. For implementation of the given decree, the Ministry of Health (MoH) together with the Ministry of finance (MoF) have signed a joint order No.609 dated on December 12, 2006 “On modification of PHC facilities financing and management system” in the pilot districts, and in 2008 given initiation have been expanded throughout the country (joint order of MoH and MoF No.300 dated on June 5, 2008). From 2007 piloting of the new financing mechanism – per capita

financing in the PHC facilities has been started with the purpose of adequate distribution of the financial resources at the level of PHC (joint order of MoH and MoF No.110, March 16, 2007). Given financing mechanism was gradually expanded in all PHC facilities of the republic (joint order of MoH and MoF No.362 dated on July 04, 2008, №68-7 dated on April 01, 2009, №374-65 dated on June 30, 2010).

However, it is necessary to note that this mechanism has been introduced partially, i.e., PHC facilities budget forming on per capita basis was applied only to unsecured items of expenditures, and the main expenses of health facilities are connected with salary of health staff 88-90% (Financial reports of MoH RT, 2007-2010), which is related to secured items of facilities expenses.

In 2013 the Ministry of health and social protection of the Republic of Tajikistan within the resolution of the Government of the Republic of Tajikistan “On introduction of new financing mechanism in the state health facilities of the Republic of Tajikistan” dated on November 2, 2011 No.536 have developed a draft methodology of calculation of per capita financing rate, and on its basis have conducted analysis in the PHC facilities of Sughd region (joint decree of MOHSP and MoF dated on February 28, 2013 No.98-25). Farther, in May 2013, in accordance to subsequent joint decree of the Ministry of health and social protection and the Ministry of finance of the Republic of Tajikistan No.237-49 dated on April 25, 2013 there has been conducted detailed analysis of all PHC facilities of Sughd region, and per capita financing had been rolled out in all PHC facilities of Sughd region in July 2013. However, per capita rate on the basis of joint decree of MoH and MoF RT dated on April 25, 2013 No. 237/49 is calculated at the district level, this allows only equal the distribution of funds within the PHC facilities of one district.

Resolution of Government dated on July 2, 2015, # 426 “On strategic plan of further reforming the financing of the health sector of the Republic of Tajikistan for 2015-2018” has been developed and approved under the grant of the World Bank allocated from the funds of Institutional Trust Fund (ITF) (P129157), which sets forth the steps of wide introduction of the per capita financing system in the PHC in details.

The Ministry of Health and Social Protection of the Republic of Tajikistan under support of the World Bank have developed a methodology of per capita implementation with taking into account all expenditures at the national level, and approved pursuant to the joint decree of the Ministry of health and social protection and the Ministry of Finance of the Republic of Tajikistan dated on July 30, 2013 No.675-321 “On introduction of per capita financing in primary health care facilities including all expenditures”.

One of the main events of the sector is approval of the resolution of the Government of the Republic of Tajikistan dated on December 31, 2015, No.827 “On the issues of introduction of PHC facilities per capita financing”, which has been developed with the purpose of continuing the process of reforming health sector financing.

Introduction of per capita financing in the PHC network

The overall goal of the consulting activity under the project was provision of assistance to MOHSP on further introduction of the Per Capita Financing and improvement of PBF system by its integration into existing PHC financing system.

In accordance with the Transition Schedule per capita financing have been introduced in all cities and districts of the Republic of Tajikistan from 2016 to 2019, and currently given mechanism is introduced in 88 PHC facilities of the republic. (Table 27)

Table 27

Type of facility	Number of PHC facilities	PCF introduction			% of implementation
		2016-2017	2016-2018	2016-2019	
CHC	37	29	31	37	100%
DHC	51	37	46	51	100%
TOTAL	88	66	77	88	100%

According to the transition schedule, per capita financing was introduced in all cities and districts of the Republic of Tajikistan. At the present moment, the number health facilities, CHC and DHCs, transitioned to per capita financing in 2016-2019 makes 88 from 88 or 100%, including 37 CHCs and 51 DHCs. Introduction of PCF scheme in the PHC facilities by the regions: in Dushanbe -15, DRS - 13, Sughd Region - 24, Khatlon Region – 28 and GBAO – 8.

During this period, a range of normative and legal documents have been developed, which relate to implementation of per capita financing taking into account all items of the expenditures at the national level. These documents were approved in accordance with the resolutions of the Government of the Republic of Tajikistan and by joint decrees of the Ministry of Finance and Ministry of Health and Social Protection of the Republic of Tajikistan. These measures were undertaken to ensure effective and adequate allocation of funds in the healthcare system and improve financial sustainability of primary health care (PHC). The developed normative and legal documents contributed to introduction of per capita financing in all regions of the country and ensured sustainability of the mechanism at national level. They include:

- joint decree of MoF and MOHSP RT dated on July 30, 2015, No.675/231 – “PHC facilities financing order on the basis of per capita financing mechanism with inclusion of all expenditures” has provided ground to develop PHC facilities financing system based on per capita financing. This document used to determine the principles and order of allocating budgetary funds between PHC facilities according to the catchment population, and included all items of expenditures to provide proper medical care.
- Resolution of Government dated on July 2, 2015, # 426 “On strategic plan of further reforming the financing of the health sector of the Republic of Tajikistan for 2015-2018” set strategic goals and tasks to reform health financing, including introduction of per capita financing in primary health care. This document determined general platform to manage reforms in healthcare and provide sustainability and balanced development of healthcare system.
- “PHC facilities financing order on the basis of per capita financing mechanism with inclusion of all expenditures” was approved under the Resolution of the Government of the Republic of Tajikistan dated on December 31, 2015, No.827 “On the issues of introduction of PHC facilities per capita financing”. Per capita financing rates for city health centers (CHC) in the amount of TJS 48.82, and district health centers (DHC) in the amount of TJS 34.16 have been also approved in this resolution. In addition, this resolution approved risk adjustment coefficients during rate-based calculations. These

coefficients are linked with geographic location of the facility and other special features. As a result, per capita rates and special coefficients have been set, which contributes to more adequate allocation of funds and take into account peculiarities of different PHC facilities.

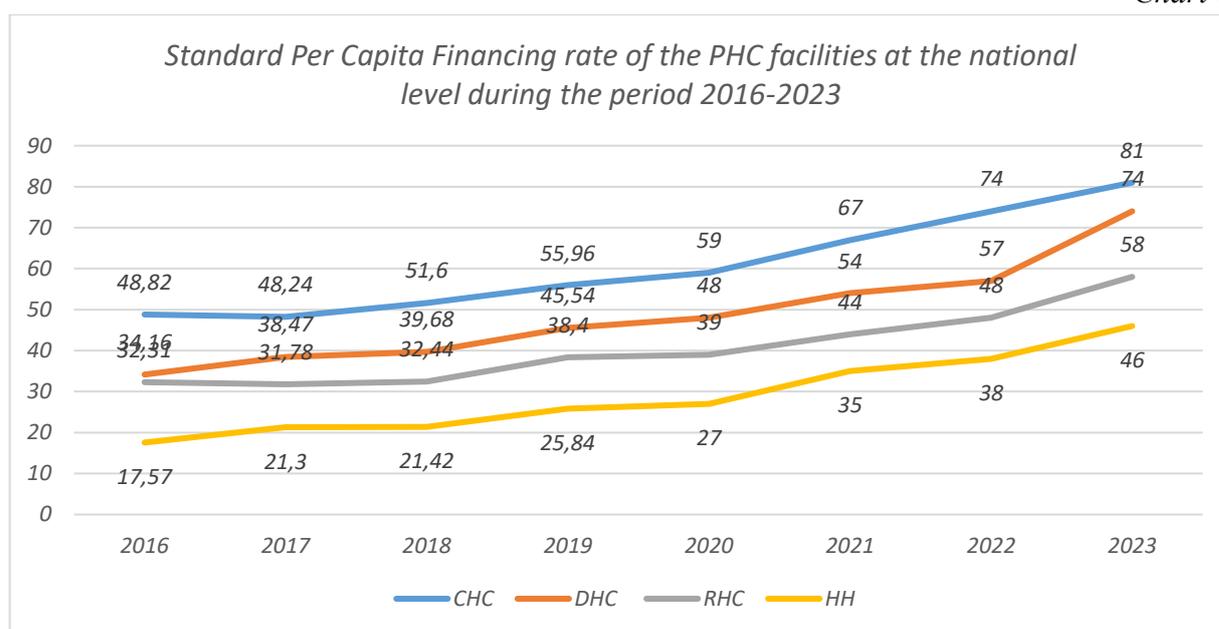
- Joint decree of MOHSP and MoF dated on January 15, 2016, No.20-10 “Transition schedule of the PHC facilities to per capita financing for 2016-2018 at the city and district levels of the Republic of Tajikistan” has been developed and approved according to the Resolution of the Government of the Republic of Tajikistan dated on December 31, 2015, No.827 “On the issues of introduction of PHC facilities per capita financing”. This decree set specific timeframes and action plan to introduce per capita financing in city and district health centers. The schedule has provided clear image of time scales on introducing the per capita financing, which contributed to more effective and smoother implementation of this initiative at the level of cities and districts of the Republic of Tajikistan.
- Decree of the MOHSP RT dated on January 15, 2016, # 40-1 provided a methodology of rated allocation of budgetary funds based on per capita financing for RHC and HH. It includes minimal recommended per capita rates for RHCs and HH with special coefficients, which were approved by the MOHSP and agreed with MoF.
- By the Resolution of the Government of RT dated January 25, 2017, No.23 “On measures for execution of the law “On State budget of the RT for 2017” MOHSP and MoF are assigned to develop the transition schedule of the PHC facilities to per capita financing. Per capita financing rates for 2017 for the city health centers (CHC) in the amount of TJS 48.24, and district health centers (DHC) in the amount of TJS 38.47 have been also approved in this resolution. In addition, this resolution approved risk adjustment coefficients during rate-based calculations. These coefficients are linked with geographic location of the facility and other special features. As a result, per capita rates and special coefficients have been set, which contributes to more adequate allocation of funds and take into account peculiarities of different PHC facilities. These coefficients allow taking into account features of different PHC facilities during allocation of funds and ensure more adequate healthcare financing at the level of cities and districts of the Republic of Tajikistan.
- The developed per capita rates and special financing coefficients for the PHC facilities for 2018 were agreed with MoF RT and approved by the Resolution of the Government of RT dated December 29, 2017, No.587 “On measures for execution of the law “On State budget of the RT for 2018”. Per capita financing rates for 2018 for the city health centers (CHC) in the amount of TJS 51.60, and district health centers (DHC) in the amount of TJS 39.68 have been also approved in this resolution. In addition, this resolution approved risk adjustment coefficients during rate-based calculations. These coefficients are linked with geographic location of the facility and other special features.
- MOHSP issues a decree # 175 in February 2018, wherein the recommended per capita financing rates were developed for the structural divisions of the CHCs/DHCs (RHCs and HHs) for 2018. Per capita financing in the amount of 32.44 for CHCs, and 21.42 for DHCs was ensured this way.

- The developed and approved per capita rates and special financing coefficients for the PHC facilities for 2019 were agreed with MoF RT and approved by the Resolution of the Government of RT dated December 29, 2018, No.594 “On measures for execution of the law “On State budget of the RT for 2019”. Per capita financing rates for 2019 for the city health centers (CHC) in the amount of TJS 55.96, and district health centers (DHC) in the amount of TJS 45.54 have been also approved in this resolution. In addition, this resolution approved risk adjustment coefficients during rate-based calculations. These coefficients are linked with geographic location of the facility and other special features.
- Budgetary funds allocation rate was developed and approved based on per capita financing principle for the structural divisions of city health centers (RHC) and district health centers (RHCs) for 2019. This rate was approved by the decree of MOHSP on February 26, 2019, #121, and agreed with the MoF RT.
- Per capita financing rates and special financing coefficients were developed and approved for the PHC facilities for 2020. These rates were approved by the Resolution of the Government of RT dated December 30, 2019, No.639 “On measures for execution of the law “On State budget of the RT for 2020”. Minimal per capita financing rates for 2020 for the city health centers (CHC) in the amount of TJS 59, and district health centers (DHC) in the amount of TJS 48 have been approved pursuant to this resolution. Special city and district coefficients were also approved to adjust PHC facilities’ per capita financing. In accordance to this, budgetary funds allocation rate was developed based on per capita financing principle for RHCs - TJS 39 and HHs - TJS 27.
- The developed and approved per capita rates and special financing coefficients for the PHC facilities for 2021 were agreed with MoF RT and approved by the Resolution of the Government of RT dated December 31, 2020, No.689 “On measures for execution of the law “On State budget of the RT for 2021”. Minimal per capita financing rates for 2021 for the city health centers (CHC) in the amount of TJS 67, and district health centers (DHC) in the amount of TJS 54 have been also approved in this resolution. In addition, this resolution approved risk adjustment coefficients during rate-based calculations. These coefficients are linked with geographic location of the facility and other special features. Budgetary funds allocation rates for structural divisions were developed as well based on per capita financing principle, which was approved by the decree of MOHSP RT on January 29, 2021, #89, and agreed with the MoF RT.
- Minimal per capita financing rates for 2022 for the city health centers (CHC) in the amount of TJS 74, and district health centers (DHC) in the amount of TJS 57 have been approved by the Resolution of the Government of RT dated December 30, 2021, No.553 “On measures for execution of the law “On State budget of the RT for 2022”. Budgetary funds allocation rates for structural divisions (RHCs and HHs) were developed based on per capita financing principle in order to implement item 19 of this resolution. This rate was approved by the decree of MOHSP RT on January 28, 2022, #60, and agreed with the MoF RT. The resolution is distributed to all PHC facilities of the republic.

- Per capita financing rates for the PHC facilities and special financing coefficients were developed and approved for the year 2023. This document has been agreed with the Ministry of Finance and approved through the GoT Resolution dated December 29, 2022. No.626 “On measures for execution of the law “On State budget of the RT for 2023”. PHC facilities data collection and analysis and compilation of a consolidated report on the PHC facilities budget execution by regions, cities and districts of the Republic of Tajikistan for 2022 was carried out to prepare the indicated document. Within the framework of above resolution, the minimum PCF rates have been approved for 2023 for the City Health Centers (CHCs), including their structural subdivisions - RHCs and HHs in the amount of 81 TJS and District Health Centers (DHCs) in the amount of 68 TJS, as well as approved risk equalization ratio for the rate-based calculations related to the geographical location of facility and other special features. Budgetary funds allocation rates for structural divisions (RHCs and HHs) were developed as well based on per capita financing principle (the decree of MOHSP RT and agreed with the MoF RT on January 30, 2023, #52)

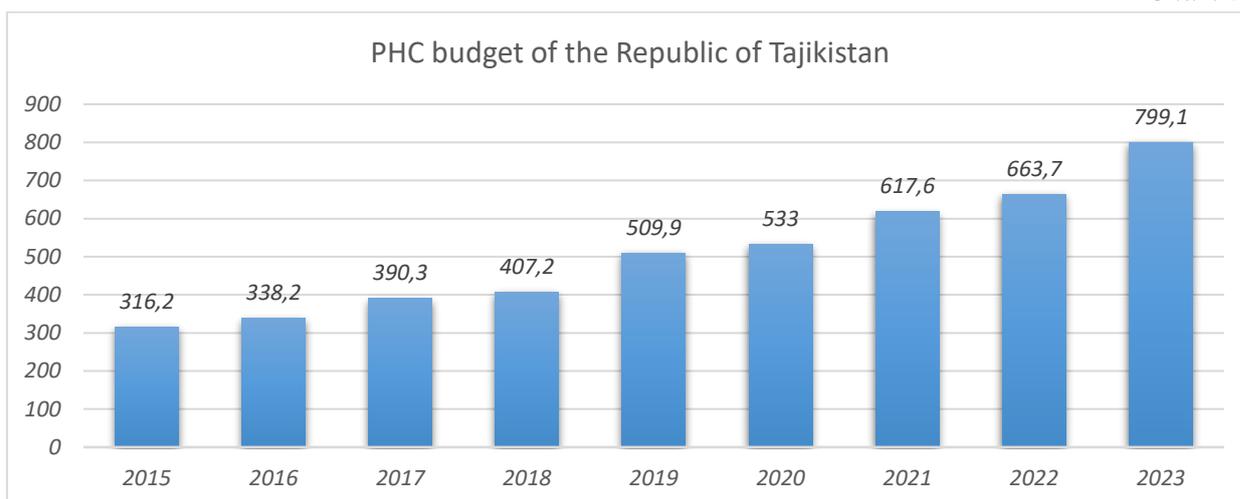
As a result of gradual introduction of per capita financing, PCF rates have increased at the level of CHC by 65.9%, DHC by 116.6%, RHC by 79.5%, and HH by 161.8% since 2016. (Chart 76)

Chart 76



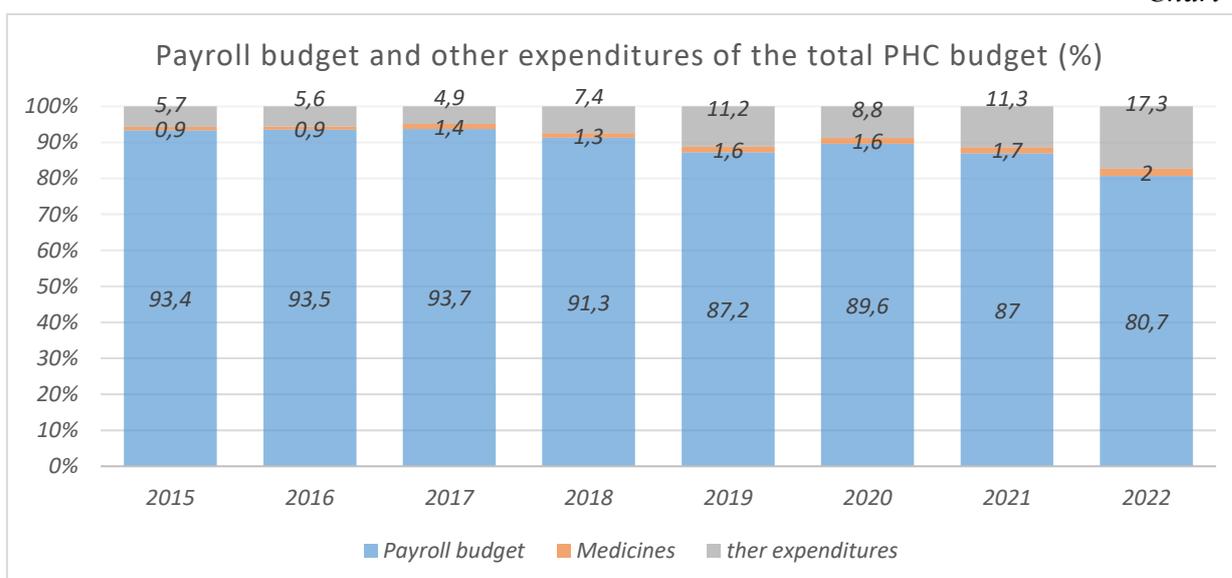
Significant increase of financing is visible in the comparison of the Republic of Tajikistan’s PHC budget for 2015 and 2023. The budget made TJS 316.2 million in 2015, while in 2023, it grew up to TJS 799.1 million. It meets the growth rate of 152%, pointing at high pace of health financing increase. Budget increase may be conditioned by the government’s intention to improve accessibility and quality of health services for the population, as well as by demand increase in healthcare sector, demographic changes, and political decisions. (Chart 77)

Chart 77



Introduction of PCF has also impacted on the items of expenditures, and specifically, the share of expenditures for the salary fund (SF) in PHC gradually decreased, falling from 93.4% in 2015 to 80.7% in 2022. At the same time, the share of other expenditures increased from 5.7% in 2015 to 17.3% in 2022. The share of expenditures for medicines remained relatively stable in the range of 0.9% - 2%. *Chart 78*

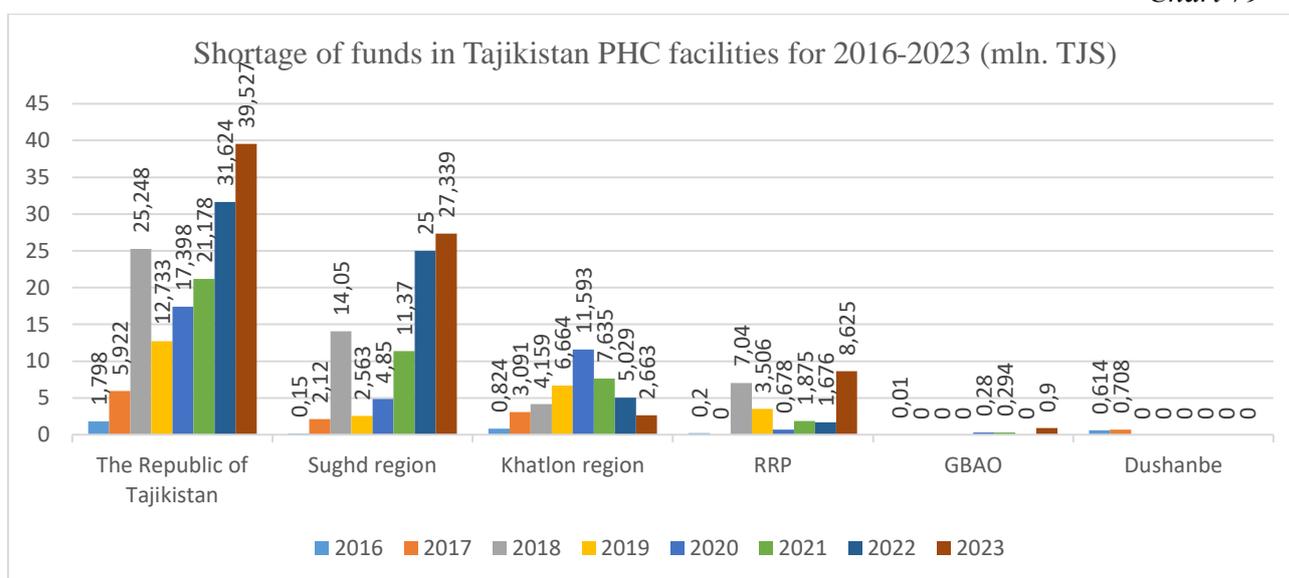
Chart 78



Monitoring and analysis of the process of PCF implementation had been conducted from the moment of introducing the per capita financing in the PHC facilities in order to execute the Resolution of the Government of the Republic of Tajikistan dated on December 31, 2015, No.827 “On the issues of introduction of PHC facilities per capita financing” and item 19 of the Resolution of the Government of the Republic of Tajikistan dated December 29, 2022. No.626 “On measures for execution of the law “On State budget of the RT for 2023”. Monitoring was conducted involving representatives of the project, MOHSP, and MoF. Analysis of the data gathered from that monitoring related to formulation of the budget of the PHC facilities for 2016-2023 displays the following:

Total shortage of funds in the PHC of the Republic of Tajikistan significantly increased from TJS 12.733 million in 2019 to TJS 39.527 million in 2023, which makes the growth by 210.5%. Based on data analysis we may say that the shortage of funds in the PHC facilities significantly increase in all regions, but Khatlon region, where in decreased from 2019 to 2023. This may point at aggravation of financial situation in healthcare in most of the country’s regions, except Khatlon region, where some measures could have been undertaken to improve financial situation of the PHC facilities. (Chart 79)

Chart 79



Main problems identified during monitoring.

- Failure to perform item 7 of the joint order of MOHSP and MoF RT (dated on July 30, 2015, #675-231) on “PHF facilities financing order based on per capita financing mechanism including all items of expenditures”, which is approved by the Resolution of the Government of the Republic of Tajikistan dated on December 31, 2015, No.827 “On the issues of introduction of PHC facilities per capita financing”;
- The volume of the budgets calculated on basis of the approved per capita rate is not allocated from the total volume of PHC budgetary funds for the planned year, and is not provided to the budget of local executive authorities in a separate item “Per capita financing”;
- The volume of the budget of PHC facilities calculated on the basis of the approved per capita rate is subject to approval by the decision of cities and districts chairman taking into account the budget of vertical centers;
- During the visit, technical assistance was provided to financial, statistic staff of the CHCs/DHCs to make calculation of the structural unit’s budgets (RHCs and HHs).

International consultant, Samvel Kharazyan was hired under per capita financing in order to provide consultations in the Republic of Tajikistan to support wide introduction of per capita financing in the PHC facilities with execution of all budget items. In this context, the consultant has developed and submitted reports comprising methodology and work plan, data analysis and

modeling PHC's per capita financing. Main steps and analysis, mentioned in the reports, comprised:

- development of the suggestions related to the volume of per capita rate and adjustment coefficients of per capita financing;
- analysis of an impact of per capita rates' calculation on all types of the PHC facilities;
- financial support for the development of per capita financing system;
- introduction of the system of free choice and electronic registration at the PHC doctors;
- researching the possibilities of applying quantity and quality indicators to calculate per capita rate under the system of incentive payments (PBF) at the district/city level;
- development of the recommendations for monitoring in order to finalize and modify per capita financing.

Action plan for implementation of the activities of the strategic plan on introduction of per capita financing mechanism of the PHC facilities of the Republic of Tajikistan for 2015-2018 was also developed, which describes the steps for introduction of per capita financing in the PHC in details. The transition schedules for PHC per capita financing for 2016-2019 at the level of cities and districts of the Republic of Tajikistan were also developed and approved under consultation activities.

In addition, with the purpose of deep expansion of per capita financing formula and integration with PBF into the existing system of PHC financing, another contract with international consultant, Samvel Kharazyan was signed. The following methodologies were developed under this contract:

1. "Improvement of Tajikistan Per Capita Financing System: how to take into account the discrepancies of demographic features", which has the following offers:
 - per capita financing improvement/revision using gender and age adjustment coefficients of basic per capita financing calculation formula for financing the PHC facilities,
 - improvement/revision of the PHC facilities' budget calculation method under per capita financing,
 - revision/increasing the calculation of the recommended per capita rate for RHCs and HHs.
2. Application of the per capita method of payment to health staff in the PHC facilities, and impact analysis during introduction, which has the following offers:
 - application of the per capita payment methods and incentive payments to the health staff of the PHC facilities;
 - analysis of the per capita payment method and impact on pilot districts.
3. Budget processes under per capita financing: Programmed budgeting and financing under a single item, which has the following offers:
 - revision/improvement of the issues of State Finance Management related to the application of a single item of PHC financing and introduction of the programmed budget.
4. Draft order of MOHSP on piloting the Patient register form at the PHC doctor (Form #P001) and an instruction on formulating an electronic patient register, as well as instruction for incentive payments for formulating the electronic patient register in the Spitamen district Health Center, which presents:

- patient register form at the PHC doctor (Form #P001);
 - instruction of filling in the registration form and keeping an electronic register of the patients in the PHC facilities for piloting,
5. Technical requirements to develop an information system for the electronic patient register in the PHC facilities, which presents:
- technical requirements to the business processes of registering a patient, system tables and catalogues;
 - suggestions on the forms of reporting, which should be received from the information system.
6. To create and implement the electronic patient register, international consultant has developed the terms of references for:
- international specialist to develop the software and information technologies architecture;
 - WEB-developer of the software and database (local specialist);
 - developer of the user's interface of a web application (local specialist).

International consultant has conducted a number of working visits (round tables) related to modification of financing system and introductions of the electronic patient register involving the MOHSP, heads of the pilot Spitamen district and authorized representatives of Sughd regions Health and Finance departments.

The following works have been conducted by the project with respect to create the electronic patient register:

- approved order of MOHSP #280 dated on 20.04.2022 regarding approval of the patient register forms, instruction for formulating the register, and instruction for incentive payments for forming the register.
- Order of Sughd region Health Department dated on 11.05.2022, #108 regarding measures for executing the abovementioned order of MOHSP.
- Contract signed with consultant to develop an architecture of the electronic patient register.

Consultant that developed the architecture of the electronic patient register submitted inception report titled "Review of the system requirements, methodology, and proposed approaches to introduce the system, as well as a calendar action plan to organize and develop the software architecture". In addition, first report was submitted, which comprises system architecture, database structure, user interface, front-end and back-end languages, as well as the terms of references for the company that would develop the ERP software.

Material and technical fitting out

Under this component, health facilities were provided with the PBF Manual, Household Engagement Manual and information materials for a total cost of US\$ 173772.05. In addition, 77 RHCs were provided with furniture at a total cost of US\$169659.03, and the supervisory teams in six pilot districts were provided with vehicles at a total cost of US\$225690.0.

In order to implement and improve the Per Capita Financing mechanism, the project procured computer equipment for the MOHSP, regional PHC financial departments and accounting

departments for a total amount of USD 98798.23. In addition, to implement the Grievance Redress Mechanism, server and computer equipment was purchased for a total amount of USD 96806.02. In addition, information materials were replicated at a total amount of US\$5019.93 and all PHC facilities were provided with mailboxes for citizens appeals at a total amount of US\$9156.99.

Furthermore, the project financed the procurement of the computer equipment at a total amount of US\$12,240.13 and two vehicles at a total amount of US\$6,3360.0 for the SHSPSS, under this component. Primary medical immunization documents were replicated at a total cost of US\$24761.06 and two refrigerated trucks were purchased for the Republican Center for Immunoprophylaxis at a total cost of US\$107484.41, as well. At the same time, the project supported the MOHSP in replicating the "Guidelines on Salary Accrual and Payment of Employees of the Tajikistan State Health System", the Guidelines on "Therapeutic Nutrition Standards in Health Care and Social Protection Facilities" and the "Collection of Diagnosis and Treatment Clinical Protocols at PHC Level" at a total cost of US\$ 142005.24. In order to improve the PBF MIS hardware and software, computer equipment was purchased at a total cost of USD 65159.41.

Component 2: Primary Health Care Strengthening

This component aims at improvement of the Primary Health Care (PHC) providers' capacity to provide quality health services.

Subcomponent 2.1. Quality Improvement

This component aims at improvement of the PHC providers' capacity to provide quality services through training the PHC workers, including: (i) six-months family medicine training course for health workers of new PBF districts; (ii) PHC Management training for the heads of PHC network of 16 pilot districts (11-month course); (iii) training the heads of RHCs of 16 pilot districts in managing statistical data and wastes utilization at the RHC level (2-weeks course); (v) support to the alumnus of medical university – doctors in the specialty of “Family Medicine” (clinical residency); and (vi) continuous medical education (based on updated clinical protocols). This sub-component supported the implementation of a collaborative quality improvement process focusing on the management of three priority areas - acute respiratory infections, childhood malnutrition and hypertension, as well.

Six-month Family Medicine Re-Training for the health staff in PBF pilot districts

The ongoing Project (AF-2) provides a six-month Family Medicine Training for nurses and doctors in the pilot districts. Under the AF-2, this approach will be applied to health staff in the new PBF-covered districts in accordance with the Capacity Building Plan, which will have a positive impact on the healthcare quality provided by these facilities. This training is organized based on the Regional Family Medicine Clinical Training Centers, MOHSP using the existing curriculum and training materials approved by the MOHSP. The curriculum of the specific FM training course includes 24 modules for doctors and 18 modules for nurses. [Annex.1](#) These modules are directly aligned with the Project goals and objectives and include such aspects as maternal and child health, antenatal care, malnutrition, hypertension and other public health issues.

In order to increase the capacity of the Primary Health Care staff in the new pilot districts and provide them with FM specialists, agreements were signed between the Ministry of Health and Social Protection of the Republic Tajikistan / Health Services Improvement Project and the Republican and Regional Family Medicine Clinical and Training Centers for conducting six-month Training Courses in the specialty "Family Medicine" for doctors and nurses.

Based on this Agreement, in accordance with the MOHSP Orders, 12 rounds of the Six-month Family Medicine Training was conducted with the involvement of 898 health staff from among doctors and nurses, including 446 persons (67 doctors and 379 nurses) in Khatlon Region, 370 persons (77 doctors and 293 nurses) in Sughd Region, 58 and 24 nurses in Faizobod and Darvoz District, respectively. At the moment, the Round II of six-month training has been completed. Of the total number of trainees, 754 (84%) are nurses and 144 (16%) are doctors. The gender ratio is dominated by women, 639 or 71,2% of the trainees completed training and the remaining 259 persons or 28,8% are men. The number of women prevails among nursing staff making 80,4%, 71,1% of the total number of doctors makes men.

Of the total number of retrained health staff, for various reasons, 149 people do not work at the same place, which is 17,0% of the total number of graduates. In terms of regions, the percentage of retrained health workers who do not work on their job in Sughd is 15,9% (59 persons) in Khatlon 17,9% (80 persons). In addition, in Darvoz District 16,7% (4 persons) and in Faizobod District – 17,2% (10 persons).

It should be noted that during the training, trainees received monthly Project scholarships and were provided with stationery, personal protective equipment and medical bags for doctors and nurses. Furthermore, in order to conduct practical sessions under the FM Training, training models and FM medical literature were purchased for the Family Medicine Training and Clinical Centers.

PHC Management training for the heads of PHC network of 16 pilot districts

For the purpose building the qualification capacity of the heads of the PHC network of pilot districts in the issues of managing healthcare system by providing necessary knowledge and practical skills (using innovative and practical training methods) in the area of management, healthcare financing, human resources management, quality, medical insurance, medical statistics and work with community, it was planned to conduct training (professional retraining) on Public Health Management with *Public Health Manager* specialization hosted by the Institute of the Postgraduate Healthcare Education of the Republic of Tajikistan with the involvement of heads / deputy heads of the PHC network from 16 pilot districts. To do this task, Agreement was signed with Post-graduate Medical Institution of the Republic of Tajikistan for organization of the training process. According to the MOHSP Order #564 dated 30.06.2021 the implementation of the 11-months training course. The training program consists of 10 modules and it is approved by the Ministry of Education and Science upon coordination with the MOHSP (on November 23, 2020). [Annex.2](#)

This training was completed in April 2023. In total, 16 PHC managers of pilot districts attended this training and received *Public Health Manager* diplomas. It should be noted that taking into account the epidemiological situation related to the spread of a new Coronavirus infection (COVID-19), the *Module 2, Healthcare Quality* was changed from full-time training to distance learning. Therefore, the Project purchased 4G/LTE modems (for trainers and trainees)

with the needed Internet traffic, as well as an annual license for the Zoom video communication platform, for distance learning.

Support to alumnus-doctors on “Family Medicine” specialty during transition to national financing

Support of alumnus-doctors on “Family Medicine” specialty during transition to national financing (clinical residency).

It should be noted that for development and strengthening family medicine institute in the country the development partners, namely Medical Education Reform Project (Sino Project) with the financial support of Swiss Agency for Cooperation had been providing support for many years in development and introducing national two-year-long post-graduate training program on “Family Medicine” specialty (also known as PUST program). At the present moment, the Swiss Agency for Cooperation completed its activity in this direction due to projects closure. In order to complete the process of transition to national financing and its management by the state, it was agreed to provide support to this course under AF2 HSIP. In this regard, the Institute of Postgraduate Healthcare Education of the Republic of Tajikistan and the Ministry of Health and Social Protection of the Republic of Tajikistan signed an Agreement on conducting 2-year Clinical Residency Training for graduates of the Tajik State Medical University with Family Medicine specialization. This training is carried out according to an approved curriculum consisting of 18 training modules for a 2-year period. [Annex.3](#) Of the 16 residents, 1 successfully completed training and hence, he was enrolled in the 2nd year of study. At the same time, according to the MOHSP Order, 2 residents were enrolled for the first year of training.

Training for the RHCs and HHs staff in pilot districts in the form of Continuous Medical Education

Continuous Medical Education (CME) includes a range of educational activities that allow Family Medicine specialists to update and improve their professional knowledge and skills throughout their professional life. CME is based on the following principles: individuality; continuity; collaboration with professional medical organizations; widespread use of distance technologies and e-learning; creation of an individual portfolio by specialists. Therefore, it is expected that the training program under this CME will include various forms and methods of training carried out both in educational institutions, at the workplace and independently. It should be noted that under of the principal financing and the Additional Financing 1 of the Project, a 4-day Continuous Medical Education Training was carried out, which allowed 3225 PHC specialists to continuously maintain PBF approach knowledge and new clinical protocols onsite. Of the total number of CME trainees, 1880 are from Khatlon Region and 1115 trainees from Sughd Region and 230 in Faizobod District. In the context of health staff, trainee composition consisted of 666 doctors and 2399 nurses. In terms of gender, women predominate among trainees- health staff, they account for 1879 retrained medical staff and the remaining 1186 are men.

As part of the second additional training round, a round table was held to discuss issues of Continuous Professional Development / Continuous Medical Education of the Family Medicine specialists of the republic with educational institutions in the field of healthcare and development partners in order to implement the *Continuous Education Concept in the Republic of Tajikistan, 2017-2023* and the *Procedure for Continuous Professional Development/Continuing Medical*

Education of Family Medicine Specialists in the Republic of Tajikistan (dated June 16, 2020 No. 444).

Based on the decision of the round table, in order to implement the procedure for Continuous Professional Development / Continuous Medical Education of FM specialists in the Republic of Tajikistan, an Interdisciplinary Working Group was created under the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan. Moreover, for the purpose of carrying out Continuous Medical Education (CME), an agreement was concluded with the Republican FM Training and Clinical. According to the approved plan, at the first stage, supervisors at the central level and facilitators at the local level were selected. Meetings were held with the heads of PHC networks and Family Medicine specialists, where information was provided on the CME goals and objectives and the CME electronic platform. A survey was also conducted regarding the choice of CME topics. As a result, 25 topics were selected for training Family Medicine specialists under the CME. Also, 116 Family Medicine specialists (32 doctors and 84 nurses) from six pilot districts were selected to attend this training.

Training was carried out on the basis of this Agreement and the Order of the Ministry of Health and Social Protection No. 592 dated August 13, 2022 regarding the CME implementation in pilot districts. Training was carried out based on the developed 8 modules on the FM relevant topics in accordance with clinical protocols for diagnosis and treatment at the PHC level. Including:

- Hypertension. Risk factors. Classification. Care
- Cardiovascular diseases
- Pregnant women and child nutrition
- Hypertension symptoms during pregnancy. Prenatal care and emergency care.
- Post-COVID-19 syndrome: as an actual Family Medicine problem and clinical practice.
- Management of the underlying medical conditions of the respiratory tract at the PHC level, from symptoms to diagnosis.
- Family planning consultations.
- Organization and providing medical care to persons physical abused

It should be noted that the modules were prepared in close cooperation with the Institute of Postgraduate Health Education of the Republic of Tajikistan and the Tajik State Medical University.

As part of the implementation of Continuous Medical Education (CME) of the Family Medicine specialists, in order to systematize, timely registration, accounting, monitoring the quality and effectiveness of educational activities, the implementing agency (RFMCTC) planned to update the CME Information System (platform). This initiative is justified by the fact that the previously developed system is non-operational, as the creators used outdated technologies capable to be updated or scaled. Therefore, a consultant was hired by RFMCTC to update the CME Information System. In addition, taking into account the weak technical capacity of the center, the RFMCTC Management addressed to HSIP to provide specialized assistance and technical support for this activity. The Health Services Improvement Project assisted in creating this information system and provided FUJITSU PRIMERGY TX120 S3p server hardware (Intel Xeon CPU E3-1230 V2 @3.30 GHz 8 GIB Memory. 2 TB hard disk), high-speed Internet connection with dedicated Project-based IP- address, for the full operation of the information system. At the design stage of a new project, it was decided to switch to newer and up-to-date technologies that allow improving development processes and speeding up the system for

customers. All of the above technologies have great potential and are easily updated to new versions.

About system:

The client side (Frontend) of the system was developed using the server side rendering method, based on the Nuxt.js framework. Styles in the system are regulated by the SASS preprocessor for fast and structured work. The client side is implemented on a modular architecture capable to be scaled. To write the client side, the JavaScript programming language was used in the wrapper of the Vue.js library. The client side is secure and functioning properly. The application programming interface (backend) is based on the Nest.js framework. An application API is a set of ways and rules allowing the client side and API to share data. The TypeScript was used as a programming language for development, in order to standardize and typify the structure of the project. For further scaling, a modular architecture was used as well, on the side of the application programming interface. The application programming interface works properly and is protected effectively. The system uses MongoDB, which is a document-oriented database of the NoSQL type. All system technologies and its data are launched on the server in the Ubuntu 20 operating system based on the Linux distribution. For the convenience of manipulating process automation of all server technologies, the Docker SW is used, which creates containers for each technology and monitors their life cycle. This information system operates on <https://rmk-tmt.tj/>

System comprises of:

- Accredited events (webinars, conferences)
- The possibility of developing the content of the site on the portal and sharing experience with colleagues
- The largest information and educational resource for medical experts
- Implementation of CME programs for the Family Medicine specialists
- Development of expertise of specialists through studying the best practices in the country and abroad
- Development of managerial skills of the health staff
- Identification and dissemination of best practices in Tajikistan
- Creation of a single information field for graduates, specialists and trainers
- Creation of boundaries of individual professional development
- Creation of a communication platform for discussing issues.

Statistical Data and Waste Management Training for RHC heads in 16 pilot districts at the RHC level

Notwithstanding the fact that the PBF scheme was introduced and successfully implemented during 5 years in project health facilities, there were some difficulties in use and management of clinical indicators by the heads of pilot rural health centers, as well as a poor understanding of the issues of managing statistical data, planning the facility activities aimed at improving the delivery of primary care services at the subnational level.

In this regard, it was decided to organize a short-term PHC Management training for the heads of RHCs in the pilot districts. To accomplish this task, the Project initiated the selection of an agency competent in the field of development of the Family Medicine institute, to develop

and approve of a short-term curriculum and training modules. The agreement was signed with the Republican Family Medicine Training and Clinical Center. The training program has been developed, coordinated with the MOHSP and approved by the Ministry of Education and Science.

The training program consists of the following modules:

1. Tajikistan Healthcare System
2. Quality of medical care
3. Business Planning
4. Knowledge Management
5. Human Resources Development
6. Infrastructure, equipment and supply management
7. Health Financing
8. Community engagement into the health issues
9. Leadership and communication
10. Fundamentals of information and communication technologies
11. Medical waste management
12. Immunization

In order to conduct *Statistical Data and Waste Management* Training for the RHC heads of 16 pilot districts, according to the MOHSP Order, a Working Group was established to review and improve the 2-week training module and training program on the Statistical Data and Waste Management Training at the RHC level, which were developed by the Republican Family Medicine Clinical and Training Center. As a result of the activities of the Working Group, the modules and the training program have been revised. [Annex.4](#)

Special Postgraduate Training for Family Medicine Specialists (USO)

As part of the principal financing and the Additional Financing 1 of the project, Special Postgraduate Training Courses for the Family Medicine Specialists (USO) were held. According to the MOHSP requirements all Family Medicine specialists should attend these courses every 5 years to improve their skills. These one-month training courses covered 13 priority PHC areas including: maternal and child health, antenatal care, nutrition, hypertension and other priority health issues. During the Project period, 236 Family Medicine specialists attended Special Postgraduate Training Courses, including 144 doctors and 122 nurses. During the training, trainees have been provided with the required information and scholarships.

Laboratory training

Training in laboratory science and medical wastes management has been conducted between health service providers of the pilot districts according to the order of the Ministry of Health and Social Protection as of May 31, 2019, No. 389 in order to improve the access to laboratory services for the rural population at PHC level. Given training was organized at the premises of the Republic Clinical and Family Medicine Training Center and its branches in Sughd and Khatlon regions. According to the plan, given trainings conducted in Khatlon and Sughd region and in Faizobod district covered 318 health workers in total. The total number of retrained health workers at the end of the trainings made 315 from total initially planned number or 99% (in Sughd – 100, in Khatlon –197, and in Faizobod district – 18 persons). From the total number of

trained health workers 314 falls on nurses and 1 (0.3%) to a doctor. Women prevail in gender breakdown, their number makes 207 (65.7%) of trained health workers, remaining 108 (34.3%) comes on men. The project provided every trainee with necessary laboratory tools for practical lessons

Methodology and tools of the training courses in laboratory analysis were developed by the Republic Clinical and Family Medicine Training Center. Main themes of the training consisted of the following:

1. Effective use of the laboratory equipment provided by the HSIP;
2. Using/application of a microscope;
3. Interpretation of the analysis results in kidney and hepatic diseases;
4. Determining blood indicators (hemoglobin, leucocytes, ESR)
5. Blood test for malaria (thick smear);
6. Determining blood sugar (express-analysis);
7. Determining sugar, acetone, and protein level in urine;
8. Stool test for helminth eggs.
9. Arranging collection and utilization of medical wastes.

Skills and knowledge assessment for the trainees of given course was conducted through testing. The results of pre-test of the trainees from the pilot districts of Sughd region made in average 46.7%, and the results of posttests made 83.2%. The results of pre-test of the trainees from the pilot districts of Khatlon region made in average 32.0%, and the results of posttests made 86.1%. The pre-test results of the trainees from Faizobod district in average made 12.9%, but the results of posttests made 63.8%, which witnesses of good preparation of the medical staff.

Collaborative Quality Improvement (CQI) mechanism

The objective of this mechanism is to review and improve the delivery of health services to meet the needs of health staff and patients, on the regular basis. It focuses on the management of three priority areas - Acute Respiratory Illnesses, Children Malnutrition and Hypertension. The following activities have been carried out to implement this mechanism:

- for effective development and implementation of given mechanism an International Consultant was hired for providing technical assistance to develop and implement the Collaborative PHC Quality Improvement (CQI) methodology in Tajikistan. He submitted proposals to support an initiative to improve the PHC quality in Tajikistan. Consultant developed the *Hypertension flowsheet, Hypertension diagnostic and classification worksheet, Children under age of 5 growth and nutrition monitoring chart, ARI worksheet, Indicator Framework, Clinical Expert Feed-back Template and Electronic Registration Database*;
- 72 health facilities selected in pilot and control districts;
- Contracts were signed with 15 trainers from Khatlon and Sughd Regions to conduct working sessions (on-site training) using the developed quality improvement tools;
- The international consultant carried out training on the effective use of the developed tools, data collection and entry into the electronic database, processing of results and development of further management approach, for trainers and health care providers of the selected health care facilities in Khatlon and Sughd Region.

- Control districts have been provided with computer equipment and Computer Literacy Training has been conducted;
- All health facilities engaged in implementation of CQI mechanism are provided with a hard copy of quality assessment tool (check-lists), such as Hypertension flowsheet, Hypertension diagnostic and classification worksheet, Children under 5 growth and nutrition flowsheet and ARI worksheet;
- CQI training sessions were held in each selected health facility. In the process of training (active sessions), trainers monitored the use of flowsheets for diagnosis and treatment of hypertension, children ARI / pneumonia and children under 5 growth and nutrition flowsheet, as well as an assessment of knowledge and skills of staff to enter patient data into the electronic database. The trainers conducted a joint work in interpretation of the received data and preparing Action Plans for CQI mechanism improvement in facilities and their execution (goal, further tactics, person in charge, and deadlines).

CQI training sessions were held in each selected health facility. In the process of training (active sessions), trainers monitored the use of flowsheets for diagnosis and treatment of hypertension, children ARI / pneumonia and children under 5 growth and nutrition flowsheet, as well as an assessment of knowledge and skills of staff to enter patient data into the electronic database.

The trainers conducted a joint work in interpretation of the received data and preparing Action Plans for CQI mechanism improvement in facilities and their execution (goal, further tactics, person in charge, and deadlines).

It should be noted that such type of a tool on collaborative quality improvement of health services provided to the population at the PHC level in the Republic of Tajikistan was developed for the first time and successfully piloted in selected health facilities. An advantage of this tool is that it was developed according to the requirements of the approved Clinical protocols (national standards) on patient diagnosis and treatment at the PHC level, is easy to use driven by certain action algorithms and comments. It is a good support for monitoring and analyzing performance of the health facilities at subnational and national level. Besides, positive feedbacks on introducing given mechanism have been received directly from health staff of the pilot health facilities. Thus, in order to achieve sustainability of implementation of given mechanism on sites, and further institutionalization, managing and introducing it at national level, the WB team and responsible officials from MOHSP have reached certain agreements on CQI tool and database handover to the Republic Clinical and Family Medicine Training Center (RCFMTC) (Aid Memoire dated June 26, 2019, No. 412, item 10).

In this context, given tool was represented by PIG specialists at a regular MOHSP collegium, that involved all the members of the collegium, heads of the ministry's units and managers of the PHC net of cities and districts of Tajikistan, in June, 2019. A MOHSP Order was issued on July 05, 2019, No. 485 "On handover of the tools of the Collaborative Quality Improvement mechanism to RCFMTC" in accordance with the decision of the collegium, with taking into account recommendations and coordination with designated persons.

Subcomponent 2.2 PHC Infrastructure Improvement

In order to improve the physical infrastructure of PHC facilities, construction and rehabilitation works were carried out in selected RHCs in pilot districts, health facilities were equipped with medical equipment, furniture, medical bags for doctors and nursing staff, computer equipment, ambulances, generators, solar panels and water heaters, under this subcomponent.

Construction works

Since the beginning of the project implementation, under the principal financing through the Grant No.8790-TJ and the Additional Financing 1 through the Loan No. 5666-TJ, 37 RHCs have been constructed in nine districts (Farkhor, Yavan, J. Balkhi, Dangara - Khatlon Region, Devashtich, J. Rasulov, Mastcho - Sughd Region, Faizobod - DRS and Ishkoshim - GBAO). RHCs were constructed based on the number of people served and are classified into three types:

- Type A – 1-story building with 153.7 m² of total area. (35 RHCs constructed)
- Type B – 1-story building with 240.77m² of total area. (Obburdon RHC, Mastcho District, Sughd Region)
- Type C – 2-story building with 430.93 m² of total area. (Mekhrobod RHC, J.Rasulov District, Sughd Region)



Type A



Type B



Type C

Design and estimates documentation (DED) of 12 RHCs under the principal financing have been developed and prepared by the design company *Sarmoya Loiha LLC*. And DEDs of 25 RHCs under the Additional Financing have been prepared by the design company *Nigora MFM LLC*, and moreover, design supervision has been carried by these companies.

Furthermore, rehabilitation works were carried out at the Clinical Family Medicine Medical Center in Khatlon Region. All construction works have been completed by the end of 2019 and the total cost was \$6,688,240.08. It should be noted that all construction works have been accepted by the Working and State Acceptance Commission.

Sughd Region

14 RHCs have been constructed in three districts in Sughd Region (1 RHC – type C, 1 RHC – type B and 12 RHCs – type A), including

Devashtich District:

In Devashtich District it has been constructed 5 RHCs: 2 RHCs at the expense of Grant H8790-TJ and 3 RHCs at the expense of the Loan No. 5666-TJ.

RHC Dalyoni Poyon – Grant H8790-TJ. One story building, Type A

The works commenced on 12 July 2016 on given site. The contractor is SANA, LLC. Contract is completed for 100%. This facility is located at an altitude of 1206 meters above sea level. Additional works at this facility included the installation of a septic tank and drilling of a drinking water well, 65 meters deep. The acceptance by the State Commission took place on August 30, 2018, the RHC opening ceremony was held with the participation of the Chairman of the Devashtich District.



RHC Khushtoiri Mukhlon – Grant H8790-TJ. One story building. Type A

Works on this site have been started on July 12, 2016. Contractor is the MUBIN LLC. The contract is 100% complete. Additional work at this facility included drilling a drinking water well 114 meters deep and a 10 kW power transmission line with the installation of a 100 kW transformer (transforming sub-station included). The acceptance by the State Commission took place on August 30, 2018, the RHC opening ceremony was held with the participation of the Chairman of the Devashtich District.





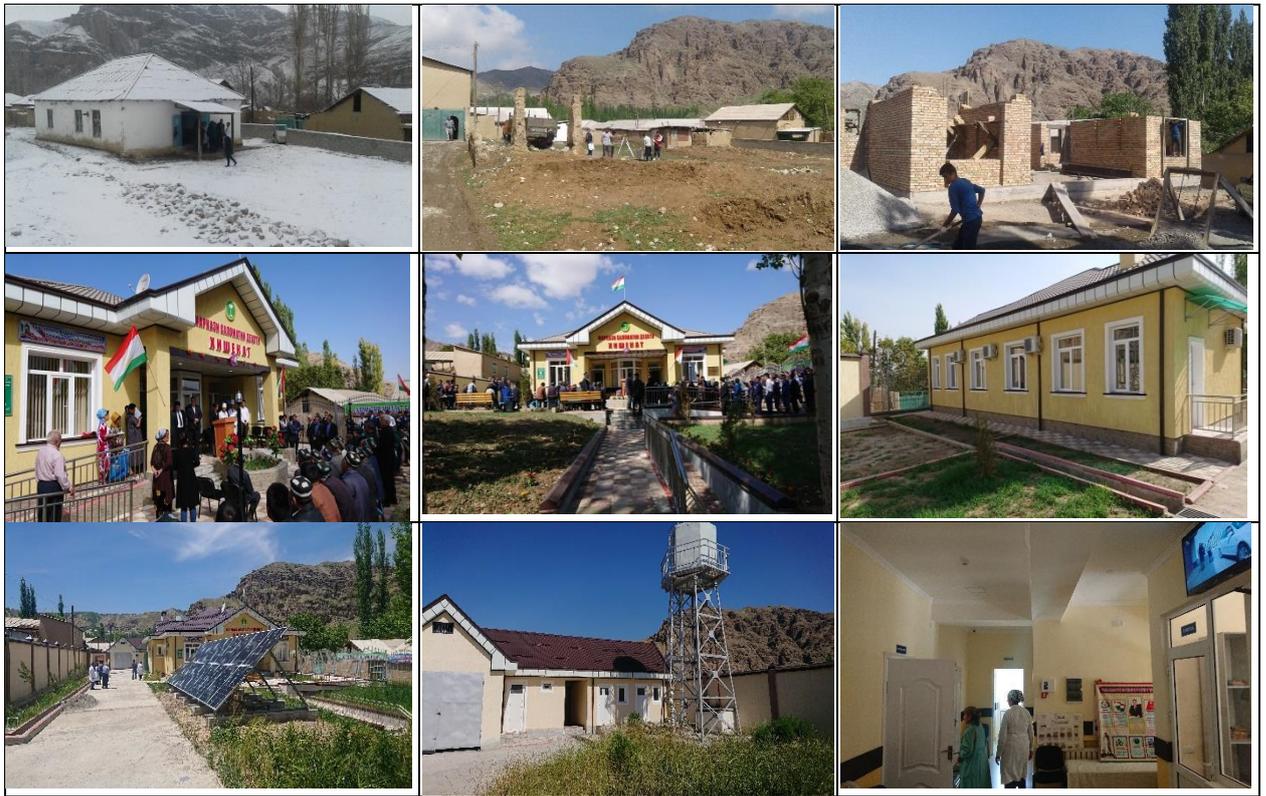
Metk RHC. Loan 5666-TJ. One story building. Type A

The works on given site started on May 4, 2017. The contractor is SAIMO, LLC. The contract is 100% completed. This facility is located at an altitude of 2045 meters above sea level. All construction, installation and finishing works were completed within 7 months (at a regular rate of 18 months). Due to the lack of space for 5 kW solar panels, it was decided to install them on the RHC’s roof (see Photo 3). The acceptance by the State Commission took place on August 30, 2018, the RHC opening ceremony was held with the participation of the Chairman of the Devashtich District.



Khishekat RHC. Loan 5666-TJ. One story building. Type A

The works on given site started on May 4, 2017. The contractor is Behruz Sokhtmon Trading, LLC. The contract is 100% completed. Additional work at this facility was the laying of a water supply line at a distance of 420 meters and installation of a septic tank, 5 kW solar panels installed. This facility is located at an altitude of 1680 meters above sea level. The acceptance by the State Commission took place on September 21, 2018, the RHC opening ceremony was held with the participation of the Deputy Chairman of the Devashtich District.



Dashtikon RHC. Loan 5666-TJ. One story building. Type A

The works on given site started on 17 October 2017. The contractor is SMU-1, CJSC. The contract is 100% completed. Additional work at this facility included drilling a drinking water well 98 m deep, a septic tank, access roads and a 10-kW power line with the installation of a 100-kW transformer (transforming sub-station included). Furthermore, a 15-kW generator was delivered and installed. The acceptance by the State Commission took place on September 05, 2019, the RHC opening ceremony was held on November 22, 2019 with the participation of the Deputy Chairman of the Devashtich District.



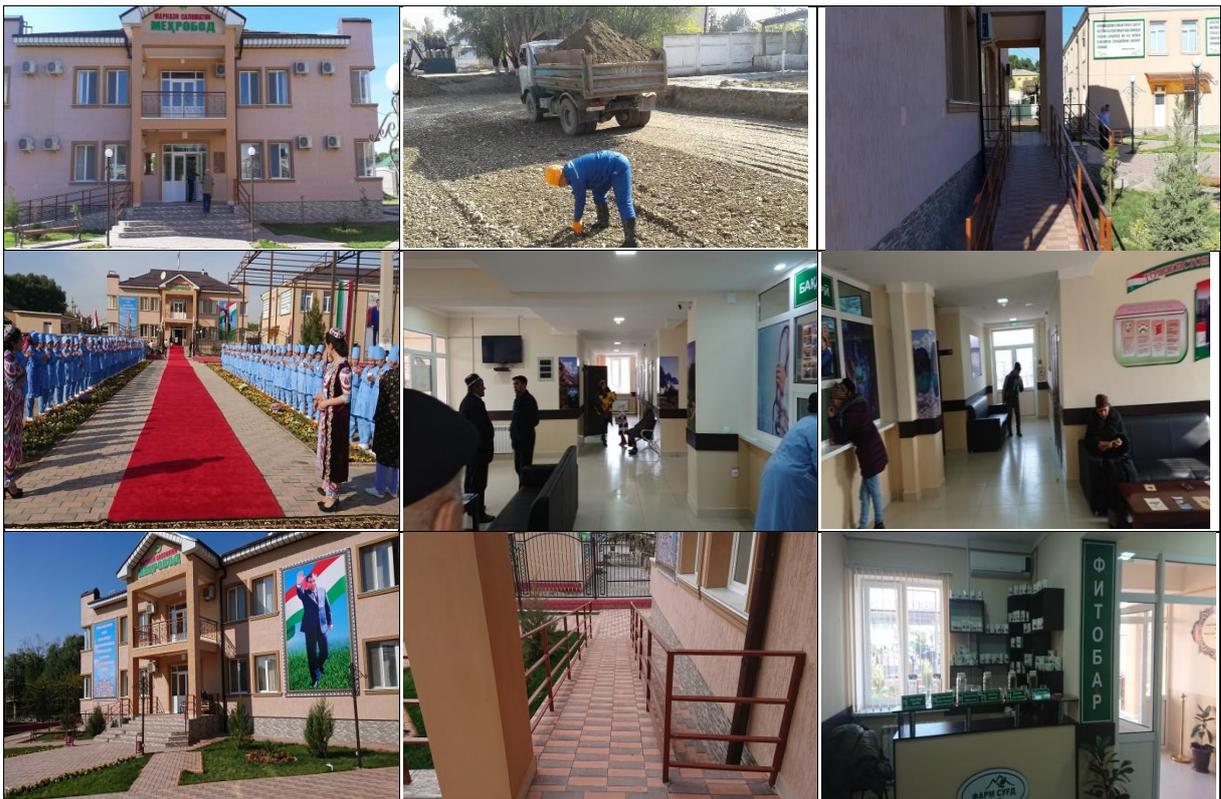


Jabbor Rasulov District:

4 RHCs have been constructed in J.Rasulov District: 2 RHCs at the expense of Grant H8790-TJ and 2 RHCs at the expense of the Loan No. 5666-TJ

Proletar RHC (Mekhrobod). Grant H8790-TJ. 2- story building. Type C

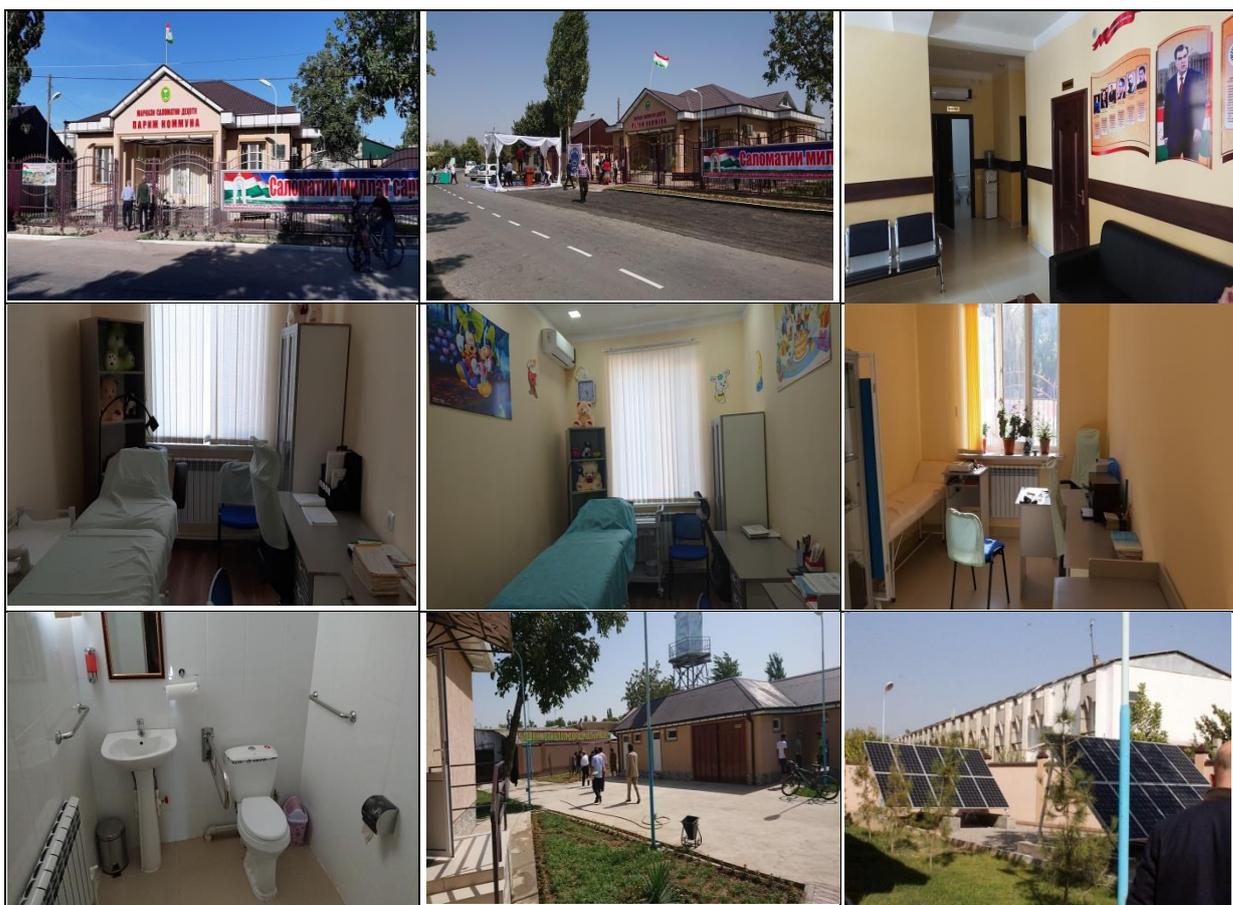
The works on given site started on October 66 2016. The contractor is Kafolat Muminobod LLC. The contract is 100% completed. Additional work at this facility included drilling a drinking water well 42 m deep, a septic tank and access roads. The acceptance by the State Commission took place on August 16, 2018, the RHC opening ceremony was held with the participation of the Leader of the Nation – President of the Republic of Tajikistan on October 22, 2018.



Paris-Communa RHC (Sino). Grant H8790-TJ. One story building. Type A

The works on this site started on 4 October 2016. The contractor is Arhstroy-2 LLC. The contract is 100% completed. Installed 5 kW solar panels. The acceptance by the State Commission took place on August 16, 2018, the RHC opening ceremony was held on

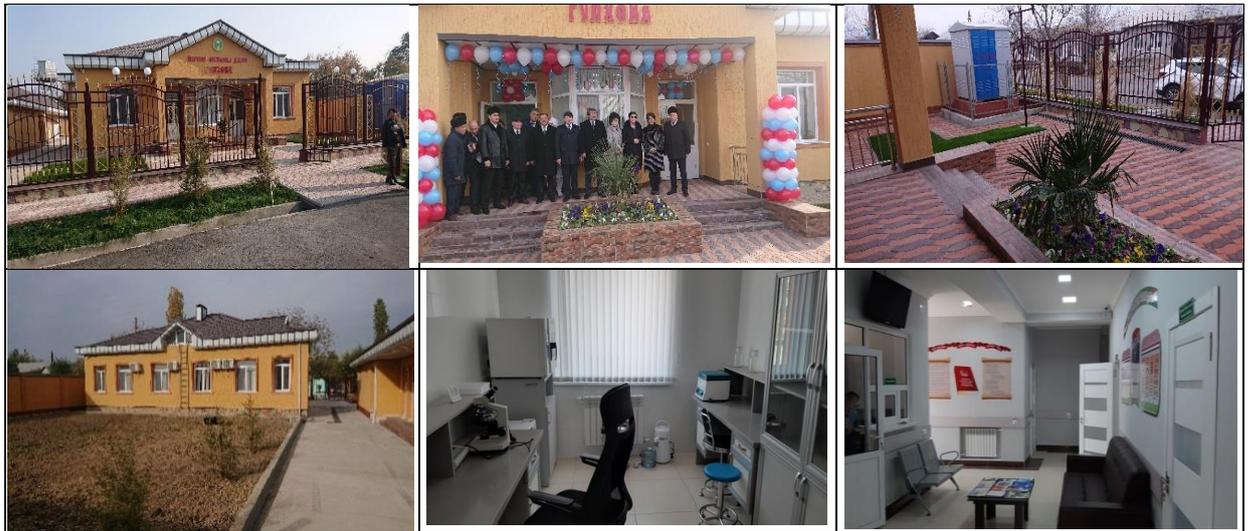
September 07, 2018 with the participation of the 1st Prime Minister of the Republic of Tajikistan, Head of the Sughd Region and Head of the District.



Gulkhona RHC. Loan 5666-TJ. One story building, Type A

The works started on July 12, 2018. The contractor is Farruhruz-1 LLC. The contract is 100% completed. Additional work at this facility included drilling a drinking water well 42 meters deep, a septic tank, access roads and a 10-kW power line with the installation of a 100 kW transformer (transforming substation included). The State Commission was held on September 19, 2019. The RHC opening ceremony was held December 07, 2019 with the participation of the 1st Deputy Minister of Health and Social Protection of the Republic of Tajikistan and Chairman of the J. Rasulov District.





Khitoykishlok RHC. Loan 5666-TJ. One-story building. Type A

The works started on July 12, 2018. The contractor is SAIMO LLC. The contract is 100% completed. Additional work at this facility was the rehabilitation work of a drinking water well, laying a water supply line at a distance of 720 meters, a septic tank, landscaping activity and a 10 kW power line with the installation of a 100 kW transformer (transforming substation included). 5 kW solar panels have been installed. The State Commission was held on September 19, 2019. The RHC opening ceremony was held December 07, 2019 with the participation of the 1st Deputy Minister of Health and Social Protection of the Republic of Tajikistan and Chairman of the J. Rasulov District.



Mastchoh district:

5 RHCs have been constructed: 2 RHCs at the expense of the Grant H8790-TJ and 3 RHCs from the funds of the Loan No.5666-TJ.

Obburdon RHC. Grant H8790-TJ. One-story building, Type B

The works started on September 28, 2016. The contractor is DSP Gas LLC. The contract is 100% completed. Additional work at this facility was the rehabilitation work of access roads, the laying of a water supply line at a distance of 380 meters, a septic tank and landscaping. 5 kW solar panels installed. The acceptance by the State Commission took place on August 31, 2018, the RHC opening ceremony was held on September 07, 2018 with the participation of the Head of the Mastchoh District.



Sardob RHC – Grant H8790-TJ. One-story building, Type A.

The works started on October 12, 2016. The contractor is Khol Sokhtmon, LLC. The contract is 100% completed. Additional work included the rehabilitation work on access roads, the laying of a water supply line at a distance of 3800 meters, a septic tank, landscaping activity and a 10 kW power line with the installation of a 100 kW transformer (transforming substation included). 5 kW solar panels were installed. The acceptance by the State Commission took place on August 17, 2018, the RHC opening ceremony was held on August 17, 2018.



Mehrobod RHC. Loan: No.5666-TJ. One-story building. Type A

The works started on February 24, 2017. The contractor is Sichiyon LLC. The contract is 100% complete. Additional work included the rehabilitation work of access roads, the laying of a water supply line at a distance of 420 meters. The acceptance by the State Commission took place on November 20, 2018, the RHC opening ceremony was held on April 13, 2019 with the participation of the Head of the Sughd Region and Chairman of the Mastchoh District.





Zarafshon RHC. Loan No. 5666-TJ. One-story building. Type A

Works started on 24 February 2017. The Contractor is Qalasozi LLC. The contract is 100% completed. Additional work included the rehabilitation work of access roads, drilling a drinking water well 98 meters deep, a septic tank and a 10 kW power line with the installation of a 100 kW transformer (transforming substation included). The acceptance by the State Commission took place on November 20, 2018, the RHC opening ceremony was held on November 20, 2018 with the participation of the Head of the Sughd Region and the Mastchoh District Chairman.



40 solagui Dilvarzin RHC. Loan No. 5666-TJ. One-story building. Type A

Works started on 17 October 2017 on this site. The contractor is Ikrom Sokhtmon LLC. The contract is 100% completed. Additional work included the rehabilitation work of access roads, drilling a drinking water well 98 meters deep, a septic tank, landscaping activity and a 10 kW power line with the installation of a 100 kW transformer (transforming substation included). The State Commission was held on September 20, 2019. The RHC opening ceremony was held December 07, 2019 with the participation of the 1st Deputy Minister of Health and Social Protection of the Republic of Tajikistan and Chairman of the Mastchoh District.



Khatlon Region

In Khatlon Region, it has been constructed 19 RHCs, type, including

Farkhor district:

Vatan RHC – Grant H8790-TJ. One-story building. Type A.

Works started on 24 August 2016. The contractor is Balkhi Safo LLC. The contract is 100% completed. Additional work included the rehabilitation work of access roads, landscaping of the surrounding area, a 10-kW power transmission line with the installation of a 100-kW transformer (transforming substation included) and drilling a drinking water well up to 40 meters deep. Acceptance by the State Commission took place on September 07, 2018, the RHC opening ceremony was held on October 30, 2018 with the participation of the Head of Farkhor District.





Darkad RHC. Grant H8790-TJ. One-story building. Type A

The works started on 24 August 2016. The contractor is Diyor LLC. The contract is 100% completed. Additional work included the drilling of drinking water wells up to 40 meters deep. Acceptance by the State Commission took place on September 07, 2018, the RHC opening ceremony was held on November 27, 2018 with the participation of the Head of Farkhor District.



Archa RHC. Loan No.5666-TJ. One-storey building. Type A

The works started on 22 February 2017. The contractor is Tolokor LLC. The contract is 100% completed. Additional work included landscaping of the surrounding area, a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included) and drilling a drinking water well up to 40 meters deep. Acceptance by the State Commission took place on September 07, 2018, the RHC opening ceremony was held on October 30, 2018 with the participation of the Head of Farkhor District.



Gayrat RHC. Loan No. 5666-TJ. One-story building. Type A

Works started on 22 February 2017. The contractor is Monalit-05 LLC. Additional work included installation of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included) and drilling a drinking water well up to 100 meters deep. Acceptance by the State Commission took place on September 04, 2019, the RHC opening ceremony was held on September 07, 2019 with the participation of the Head of Farkhor District.





Galaba RHC. Loan No.5666-TJ. One-story building. Type A

The works started on 10 August 2018. The contractor is Idorai Istekhsolii Sokhtmoni, LLC. Additional work included the rehabilitation work of access roads and laying a 10-kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on September 04, 2019, the RHC opening ceremony was held on September 07, 2019 with the participation of the Head of Farkhor District.



J. Balkhi district:

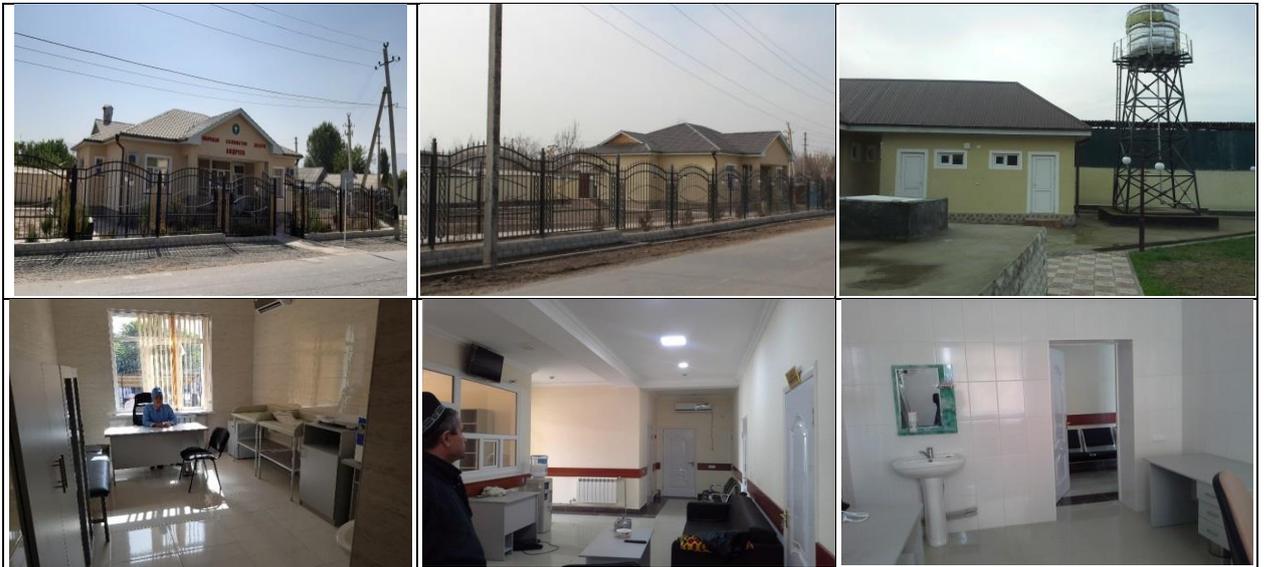
Karl Marx RHC. Grant H8790-TJ. One-story building. Type A

The works started on 23 August 2016. The contractor is Bunyodkori Somon, LLC. The contract is 100% completed. Additional work included the laying of a water supply line. Acceptance by the State Commission took place on September 08, 2018. The RHC opening ceremony was held on December 31, 2018.



Andreyev RHC. Grant H8790-TJ. One-story building. Type A

The works started on 30 September 2016. The contractor is Ramzes, LLC. The contract is 100% completed. Acceptance by the State Commission took place on December 31, 2018.





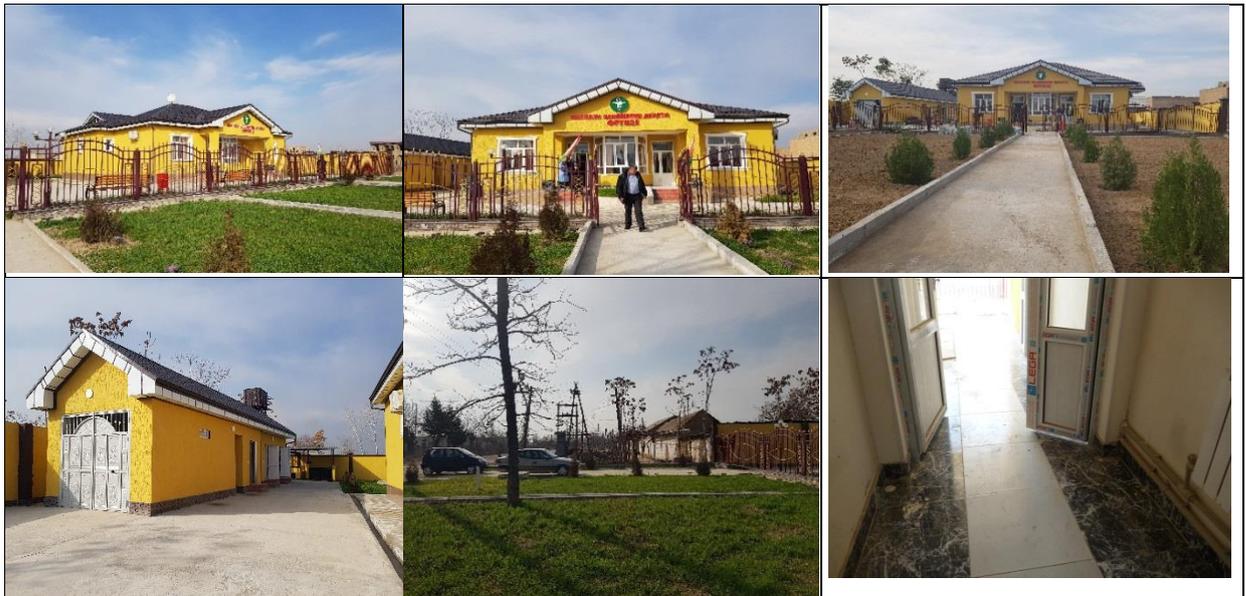
Kalinin RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on March 20, 2018. The contractor is Vakhdat LTD. Additional work included the laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on September 25, 2019, the RHC opening ceremony was held on November 06, 2019 with the participation of the Head of Khatlon Region and Chairman of J.Balkhi District.



Frunzeh RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on March 20, 2018. The contractor is Navbunyod LLC. Additional work included the rehabilitation work of access roads, foundation strengthening and laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on October 09, 2019, the RHC opening ceremony was held on November 06, 2019 with the participation of the Head of Khatlon Region and Chairman of J.Balkhi District.



Suyunobod RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on August 10, 2018. Contractor is Idorai Istekhsolii Sokhtmoni LLC. Additional work included the rehabilitation work of access roads and laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on September 25, 2019, the RHC opening ceremony was held on November 06, 2019 with the participation of the Chairman of J.Balkhi District.



Yavan district:

Kulobod RHC. Grant H8790-TJ. One-story building. Type A

The works started on November 22, 2016. The contractor is Sorbon-Service-Prokat LLC. The contract is 100% completed. Acceptance by the State Commission took place on September 06,

2018, the RHC opening ceremony was held on December 19, 2018 with the participation of the Head of Yavan District.



Dusti RHC. Grant H8790-TJ. One-story building. Type A

The works started on November 22, 2016. The contractor is Balkhi Safo LLC. The contract is 100% completed. Acceptance by the State Commission took place on September 06, 2018, the RHC opening ceremony was held on December 19, 2018 with the participation of the Head of Yavan District.





Chormagzak RHC. Loan No.5666-TJ. One-story building. Type A

The works started on July 15, 2017. The contractor is Sharq BLLC. Additional work included the rehabilitation work of access roads, drilling drinking water wells up to 60 meters deep and laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on September 06, 2019, the RHC opening ceremony was held on September 06, 2019 with the participation of the Chairman of Yavan District.



Shirinbulok RHC. Loan No.5666-TJ. One-story building. Type A

The works started on July 15, 2017. The contractor is Vakhdat LLC. Additional work included the laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on February 12, 2019, the RHC opening ceremony was held on February 12, 2019 with the participation of the Chairman of Yavan District.



Buston-2 RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on June 02, 2018. The contractor is Manora Sokhtmon LLC. Additional work included the rehabilitation work of access roads, construction of a boiler house and laying of a water supply line. Acceptance by the State Commission took place on June 13, 2019, the RHC opening ceremony was held on June 25, 2019 with the participation of the Chairman of Yavan District.





Dangara district:

Shamoldara RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on April 12, 2017. The contractor is Sokhtmoni Arzon LLC. The contract is 100% completed. Acceptance by the State Commission took place on August 28, 2018, the RHC opening ceremony was held on October 03, 2018 with the participation of the Minister of Health and Social Protection of Tajikistan and of the Head of Dangara District.



Navobod RHC. Loan No.5666-TJ. One-story building. Type A

The works started on April 12, 2017. The contractor is Navruz-01 LLC. The contract is 100% complete. Acceptance by the State Commission took place on August 28, 2018, the RHC opening ceremony was held on October 03, 2018 with the participation of the Minister of Health and Social Protection of Tajikistan and of the Head of Dangara District.



Rakhshonzamin RHC. Loan No.5666-TJ. One-story building. Type A

The works started on June 02, 2018. The contractor is Murodali LLC. Additional work included the onsite rehabilitation works and the laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on September 28, 2019, the RHC opening ceremony was held on December 18, 2019 with the participation of the Minister of Health and Social Protection of Tajikistan and of the Head of Dangara District.



Khushdilon RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on June 02, 2018. The contractor is Qalasozi, LLC. Additional work included the rehabilitation work of access roads and laying of a 10-kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on October 14, 2019, the RHC opening ceremony was held on December 18, 2019 with the participation of the Minister of Health and Social Protection of Tajikistan and of the Head of Dangara District.





GBAO

Ishkoshim district:

Vrang RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on September 09, 2017. The contractor is Sughdi SH, CJSC. On August 20, 2019, contract was terminated with Sugdi SH CJSC and a new contract was signed with Balkhi Safo-Dushanbe LLC. Additional work included the rehabilitation work of access roads and laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on October 17, 2019, the RHC opening ceremony was held on December 15, 2019 with the participation of the Head of GBAO, a Deputy Minister of Health and Social Protection of Tajikistan and Head of Ishkashim District.





Zong RHC. Loan No.5666-TJ. One-story building. Type A

The works started on September 09, 2017. The contractor is Sughdi SH, CJSC. On August 20, 2019, the contract with Sugdi SH CJSC was terminated and a new contract was signed with Balkhi Safo-Dushanbe LLC. Additional work included the rehabilitation work of access roads and laying of a water supply line. Acceptance by the State Commission took place on October 17, 2019, the RHC opening ceremony was held on December 15, 2019 with the participation of the Head of GBAO, a Deputy Minister of Health and Social Protection of Tajikistan and Head of Ishkashim District.

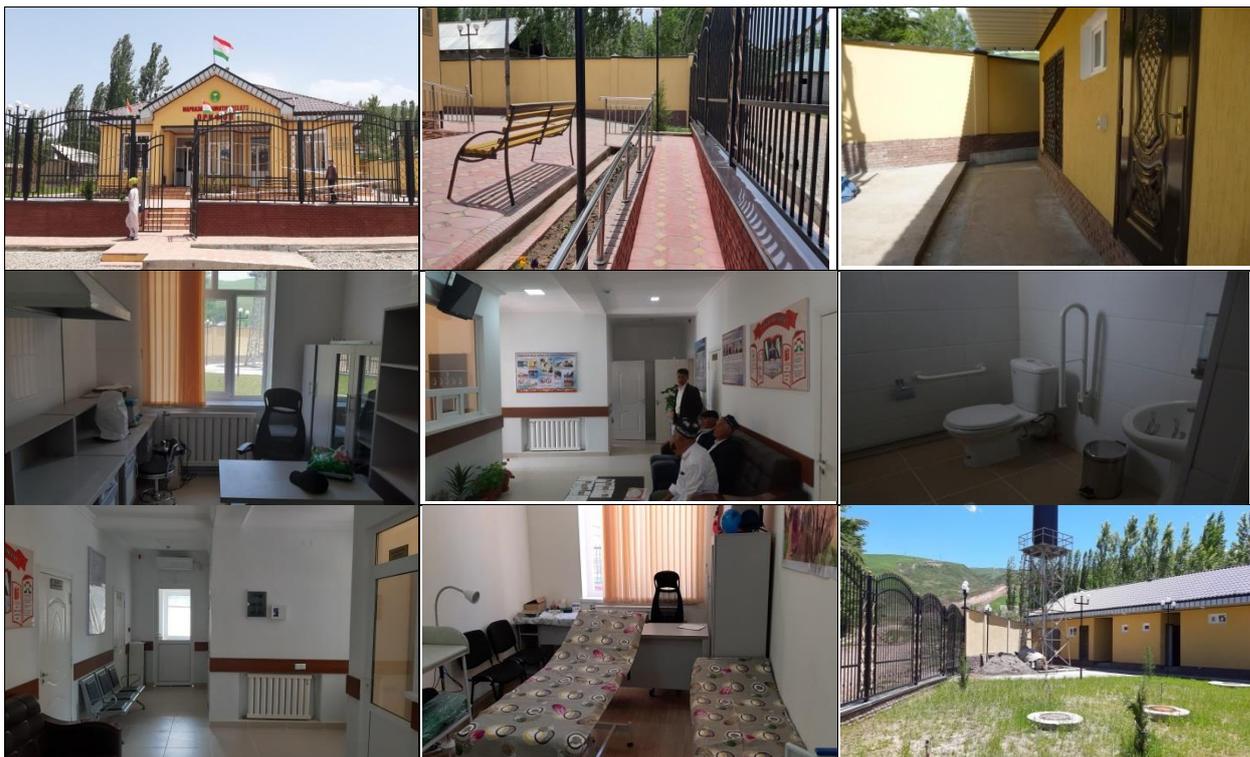


DRS

Faizobod district:

Orifon RHC. Loan No. 5666-TJ. One-story building. Type A

Works started on August 18, 2017. The contractor is Dilshod, LLC. Additional work included the rehabilitation work of access roads and laying of a 10 kW power transmission line with the installation of a 100 kW transformer (transforming substation included). Acceptance by the State Commission took place on December 20, 2018, the RHC opening ceremony was held on June 25, 2019 with the participation of the Minister of Health and Social Protection of Tajikistan and Head of Fayzobod District.



Dubeda RHC. Loan No. 5666-TJ. One-story building. Type A

The works started on August 18, 2017. The contractor is Hoji Asadullo LLC. Additional work included the rehabilitation work of access roads and laying of the water supply and power line. Acceptance by the State Commission took place on April 20, 2019, the RHC opening ceremony was held on June 25, 2019 with the participation of the 1st Deputy Minister of Health and Social Protection of Tajikistan and Head of Fayzobod District.





Rehabilitation works in the FM Training and Clinical Center in Khatlon Region. Loan No. 5666-TJ.

Works started on August 14, 2018. Contractor is Kurboniyon -1 Llc. Additional works included replacement of flooring, replacement of doors, replacement of aluminum doors and septic tank cleaning. Acceptance by the State Commission took place on July 7, 2019 and the facility was put into operation.





Rehabilitation works

Rehabilitation works were carried out in RHCs of new pilot districts such as Kushoniyon, Kulyab, Hamadoni, A.Jomi in Khatlon Region, Zafarobod in Sughd Region and Darvoz in GBAO, under the Additional Financing-2 (Grant D547-TJ). In order to carry out this activity, building structural survey of 76 RHCs was carried out in six new pilot districts to determine the need for rehabilitation work in these facilities. This survey was carried out using previously agreed standard forms. As a result of this assessment, 40 RHCs were selected where rehabilitation works should be carried out. In addition, an independent verification of the screening process and selected rural health centers for rehabilitation was carried out. It was done in order to check whether the selected facilities and proposed works meet the pre-agreed selection process and criteria. Independent verification was carried out by Mr. Pavel Funtikov, an International Consultant. As a result of this verification, 38 RHCs out of 40 selected repairs were confirmed to meet the pre-agreed criteria and selection process. Before starting rehabilitation work, building structural surveys were carried out, drawings and cost estimates for rehabilitation work were drawn up by *Korez-Loikha LLC*. As part of these works, the following tasks were performed, as needed: dismantling, installation of windows, doors and flooring, interior and exterior finishing, electric lighting, internal and external water supply and sewerage, installation of a water tank, medical waste incinerators and repair of toilets. Moreover, *Korez-Loikha LLC* carried out the designer supervision of rehabilitation work in RHCs.

Due to the SDR depreciation, which resulted in US dollar depreciation against the Tajik Somoni, the amount allocated for rehabilitation of 38 selected facilities was reduced to the amount for 36 RHCs. As a result, 24 contracts were signed for rehabilitation and restoration work in 36 RHCs. Rehabilitation work was completed at the end of June 2023 for a total cost of 1 320 937,45 USD. These works were accepted by the Commission consisted of the Project representatives, the state institution "*Capital Construction Department*" of the MOHSP and the PHC management and *Korez-Loiha*, including:

Khatlon Region

I. Kushoniyon District -13 RHCs

1. Urtabuz RHC, Grant D5470-TJ

Reconstruction work was started on February 28, 2022 and will be completed in June 28, 2022. The contractor is Arshan and K LLC. The contract is 100% completed. The amount of the contract is 399791,18 TJS.

2. K.Gulov RHC, Grant D5470-TJ

Reconstruction work was started on February 28, 2022 and will be completed in June 28, 2022. The contractor is Arshan and K LLC. The contract is 100% completed. The amount of the contract is 292774,12 TJS. Facility was put into operation.

3. Istiqlol RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 06, 2022. The contractor is *Sokhil K LLC*. The amount of the contract is 30987,5 USD. The contract is 100% completed. Facility was put into operation.

4. Doniyorkul RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 06, 2022. The contractor is *Sokhil K LLC*. The amount of the contract is 30682,42 USD. The contract is 100% completed. Facility was put into operation.

5. Navbakhor RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 06, 2022. The contractor is *Sokhil K LLC*. The amount of the contract is 34967,96 USD. The contract is 100% completed. Facility was put into operation.

6. Navkor RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 06, 2022. The contractor is *Somon Orzu LLC*. The amount of the contract is 28590,87 USD. The contract is 100% completed. Facility was put into operation.

7. Shubai-1 RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 06, 2022. The contractor is *Somon Orzu LLC*. The amount of the contract is 36793,10 USD. The contract is 100% completed. Facility was put into operation.

8. Komsomol RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 20, 2022. The contractor is *Tojikenergosystema LLC*. The amount of the contract was 21980,89 USD. The contract is 100% completed. Facility was put into operation.

9. Sarvati Istiqlol RHC, Grant D5470-TJ

Reconstruction work was started on June 06, 2022 and completed on October 20, 2022. The contractor is *Tojikenergosystema LLC*. The amount of the contract was 36130,30 USD. The contract is 100% completed. Facility was put into operation.

10. Buston-Qala RHC, Grant 5470-TJ

Reconstruction work was started on 06.06.2022 in this RHC. The expected completion date is 06.10.2022. However, the contractor *Inshot Sokhtmonsoz LLC* failed to fulfill its obligations even within the extended period due to financial difficulties. To continue these works, a contract was signed with *Kurboniyon-1 LLC*. Works started on January 30, 2023 and completed March 02, 2023. The contract amount is 44833,00 USD. The facility was put into operation.

11. Sabzavod RHC, Grant D5470-TJ

Reconstruction work was started on 06.06.2022 in this RHC. The expected completion date is 06.10.2022. However, the contractor *Inshot Sokhtmonsoz LLC* failed to fulfill its obligations even within the extended period due to financial difficulties. To continue these works, a contract was signed with *Kurboniyon-1 LLC*. Works started on January 30, 2023 and completed May 27, 2023. The contract amount is 397692,21 USD. The facility was put into operation.

12. Shubai-4 RHC, Grant D547-TJ

Reconstruction work was started on October 20, 2022 and completed on February 20, 2023. The contractor is *Vashgir LLC*. The amount of the contract was 475976,35 TJS. The contract is 100% completed. Facility was put into operation.

13. Navobod RHC, Grant D547-TJ

Reconstruction work was started on October 20, 2022 and completed on February 28, 2023. The contractor is *Vashgir LLC*. The amount of the contract was 246 154,75 TJS. The contract is 100% completed. Facility was put into operation.

II. Abdurakhmoni Jomi District (5 RHCs)

1. Gulobod RHC, Grant D4570-TJ

Reconstruction work was started on February 28, 2022 and completed on August 01, 2022. The contractor is *Asht Mohi Malikabonu LLC*. The contract is 100% completed. The amount of the contract was 335095,99 TJS. Facility was put into operation.

2. Yakkatut RHC, Grant D5470-TJ

Reconstruction work was started on February 28, 2022 and completed on August 01, 2022. The contractor is *Asht Mohi Malikabonu LLC*. The contract is 100% completed. The amount of the contract was 324952,56 TJS. Facility was put into operation.

3. Bakhor RHC, Grant D5470-TJ

Reconstruction work was started on 28.02.2022 and completed on 28.06.2022. The contractor is *Nuri Faiz LLC*. The contract is 100% completed. The amount of the contract was 351377,19 TJS. Facility was put into operation.

4. Galaba RHC, Grant D5470-TJ

Reconstruction work was started on 28.02.2022 and completed on 28.06.2022. The contractor is *Nuri Faiz LLC*. The contract is 100% completed. The amount of the contract was 320120,87 TJS. Facility was put into operation.

5. Mekhnat RHC, Grant D5470-TJ

Reconstruction work was started on 06.06.2022. The expected completion date is 06.10.2022. However, in spite of all the comments and warnings, the contractor *Amri Khamza LLC* failed to fulfill its obligations on timely manner. Therefore, the contract, the amount of which was 33,235.4 USD was terminated. The remaining scope of work was handed over to a new Contractor, *Navruz-2003 LLC*. The amount of the new contract was 408,792.62 TJS. Work recommenced on 03.11.2022 and completed on 27.04.2023. The facility was put into operation.

III. Kulob District (5 RHCs, 2 of which are excluded from the list)

1. Lagmon RHC, Grant D547-TJ

Reconstruction work was started on 22.12.2022 and completed on 22.04.2023 in this RHC. The contractor is *Somon Orzu LLC*. The contract is 100% completed. The amount of the contract was 355261,69 TJS.

2. Ziraki RHC, Grant D547-TJ

Reconstruction work was started on 19.10.2022 and completed on 05.05.2023 in this RHC. The contractor is *Dovudjon LLC*. The contract is 100% completed. The amount of the contract was 458939,54 TJS. Facility was put into operation.

3. Hakimobod RHC, Grant D547-TJ

Reconstruction work was started on 03.11.2022 and completed on 20.05.2023 in this RHC. The contractor is *Himmat LLC*. The contract was 100% completed. The amount of the contract was 478702,69 TJS. Facility was put into operation.

IV. Hamadoni District (8 RHCs where 1 RHC was excluded from the list)

1. Dusrti RHC, Grant D547-TJ

Reconstruction work was started on 03.11.2022 and completed on 15.05.2023 in this RHC. The contractor was *Obodii Dangara LLC*. The contract was 100% completed. The amount of the contract was 369957,07 TJS. Facility was put into operation.

2. Mekhnatobod RHC, Grant D547-TJ

Reconstruction work was started on 25.12.2022 and completed on 25.06.2023 in this RHC. The contractor is *Sadriddin S LLC*. The contract was 100% completed. The amount of the contract was 447909,81 TJS. Facility was put into operation.

3. Davlatobod RHC, Grant D547-TJ

Reconstruction work was started on 12.12.2022 and completed on 15.04.2023 in this RHC. The contractor is *Samand 9999 LLC*. The contract was 100% completed. The amount of the contract was 437534,90 TJS. Facility was put into operation.

4. Pushkin RHC, Grant D547-TJ

Reconstruction work was started on 20.10.2022 and completed on 17.03.2023 in this RHC. The contractor is *In Tech Tijorat LLC*. The contract was 100% completed. The amount of the contract was 427773,77 TJS. Facility was put into operation.

5. Margob RHC, Grant D547-TJ

Reconstruction work was started on 20.10.2022 and completed on 17.03.2023 in this RHC. The contractor is *In Tech Tijorat LLC*. The contract was 100% completed. The amount of the contract was 355510,74 TJS. Facility was put into operation.

6. Khojamumin RHC, Grant D547-TJ

Reconstruction work was started on 03.11.2022 and completed on 10.04.2023. The contractor is *Meros Sokhtmon LLC*. The contract was 100% completed. The amount of the contract was 456369,27 TJS. Facility was put into operation.

7. Mekhrvar RHC, Grant D547-TJ

Rehabilitation work was started on 12.12.2022 and completed on 25.06.2023. The contractor is *KSMB LLC*. The contract was 100% completed. The amount of the contract was 496082,66 TJS. Facility was put into operation.

8. Gulobod RHC Grant D547-TJ

Gulobod RHC, Grant D547-TJ Rehabilitation works in this RHC started on 27.04.2023 and completed 15.06.2023. Contractor is Samand-9999 LLC. Contract is 100% completed. Contract amount is 526284,18 TJS. Facility is put in operation.

GBAO

V. Darvoz District (3 RHCs)

1. Sagirdasht RHC, Grant D547-TJ

Reconstruction work was started on 12.07.2022 and completed on 12.11.2022. The contractor is *Vashgir LLC*. The contract was 100% completed. The amount of the contract was 41397,28 USD. Facility was put into operation.

2. Yoged RHC, Grant D547-TJ

Reconstruction work was started on 31.08.2022. The contractor is *Khizamtgor LLC*. The contract was 100% completed. The amount of the contract was 25780,72 USD. Due to weather conditions, the deadlines for completing work and putting the facility into operation have been extended until 20.01.2023. Facility was put into operation on 10.03.2023

3. Darvoz RHC, Grant D547-TJ

Rehabilitation work was started on 31.08.2022. The contractor is *Khizamtgor LLC*. The contract was 100% completed. The amount of the contract was 37693,26 USD. Due to weather conditions and power supply restrictions, the deadlines for completing work and putting the facility into operation have been extended until 20.01.2023 and completed on 10.03.2023.

Sughd Region

VI. Zafarobod District (4 RHCs)

1. Bakht RHC, Grant D547-TJ

Rehabilitation work was started on 19.08.2022 and completed on 10.05.2023. The contractor is *Murattab LLC*. The contract was 100% completed. The amount of the contract was 39477,48 USD.

2. Homid Aliev RHC, Grant D547-TJ

Rehabilitation work was started on 19.08.2022 and completed on 10.05.2023. The contractor is *Murattab LLC*. The contract was 100% completed. The amount of the contract was 48716,47 USD. Due to weather conditions and power supply restrictions, the deadlines for completing work and putting the facility into operation have been extended.

3. A.Jomi District, Grant D547-TJ

Rehabilitation work was started on 17.08.2022 and completed 10.05.2023. The contractor is *Marvoridi Sharq LLC*. The contract was 100% completed. The amount of the contract was

32503,74 USD. Due to weather conditions and power supply restrictions, the deadlines for completing work and putting the facility into operation have been extended.

4. Zarafshan RHC, Grant D547-TJ

Rehabilitation work was started on 17.08.2022 and completed on 10.05.2023. The contractor is *Marvoridi Sharq LLC*. The contract was 100% completed. The amount of the contract was 51360,00 USD. Due to weather conditions and power supply restrictions, the deadlines for completing work and putting the facility into operation have been extended.

Logistics

From the beginning of the Project implementation, in order to improve the infrastructure of PHC facilities in pilot districts, 38 contracts were signed for a total cost of 8 059 511,03 USD, under this component. As a result, 343 RHCs were equipped with basic medical equipment for a total amount of 2 510 057,89 USD, 37 RHCs with medical furniture for a total amount of 505 525,93 USD, 37 RHCs with a cold chain for the total cost of 146 735,43 USD, 36 RHCs provided with ambulance for the total amount of 1 582 631,24 USD, 17 RHCs with alternative power supply sources (solar panels) for the total cost of 417 829,82 USD, 57 RHC generators and 46 RHC solar water heaters for a total cost of 397,378.32 USD, 10 supervisory vehicles provided for a total cost of 234 520 USD, computer equipment provided to DHCs, RHCs and HHs in pilot districts with for a total cost of 684742,72 USD, providing doctors and paramedical personnel with medical bags for a total amount of 884 354,84 USD, providing PHC facilities with the FM training-medical guidelines, health service register and PBF Manual for a total amount of 193188,92 USD, 10 RHCs were equipped with a portable ultrasound machine for a total amount of 136 800.71 USD and 2 RHCs were provided with stationary x-ray machine for a total cost of 199 410.31 USD.

In addition, during the Project period, the “Collection of clinical protocols for diagnosis and treatment at the PHC level” was replicated with additions and changes in 2014- 12000 copies, in 2020 - 9760 copies and in 2023 - 5000 copies for a total cost of 166334,90 USD. Along with this, FM clinical and medical centers were equipped with training models for a total amount of 203967,26 USD. Under this component, the purchase of vehicles for engineers, consultants of regional offices and the Project computer equipment was financed for a total amount of 296 014,78 USD.

Component 3. Project Management, Coordination, Monitoring & Evaluation

Public Relations

In order to inform population on implementation and achievements of the project, we cooperated with different means of Mass Media, such as State Institution “TV Tajikistan”, “TV Safina”, and “Jahonnamo”, as well as representatives of television and radio in Sughd and Khatlon region, printed media and web-sites like National Information Agency “Khovar”, “Sughd News”, MOHSP, newspapers and websites of “Jumhuriat”, “Khatlon”, and “Sogdiyskaya Pravda”. Contracts have been signed with each of abovementioned media. In addition, Media specialists were hired in the project regional offices in Sughd and Khatlon regions for more effective work, and photo-video equipment were procured.

The Project has also supported the development and regular updating of the MOHSP's website, where project' page was opened and had regularly posted reports, articles, news and photo-reports. Specialists prepared films on project implementation on Russian, Tajik, and English on an annual basis, which were aired on republican and regional channels. Another form of cooperation with TV channels was creation of the programs in the form of infographics. This activity was successfully implemented together with "Jahonnamo" and Information Agency "Sughd News". These materials are short, understandable and memorable. Advertisement clips were also prepared for the project, which were aired several times on TV channels. The topic of the clips related to the "Role of a family doctor", "Who is a nurse?", and "Proper citizen appeal to health care facility". From the beginning of project implementation 346 TV programs and reports, 109 materials for radio, 22 films and clips, 58 articles for the printed media, and 200 information materials for soft media were prepared.

Project governance

The MOHSP is the authorized agency responsible for the preparation and implementation of the project. The Project Director (Minister of Health and Social Protection of the Republic of Tajikistan) is responsible for overall project management to ensure that project development objectives are achieved, and project resources are used efficiently.

The TSG under the MOHSP that is responsible for project preparation and implementation has been established through the MOHSP Order #571 in 2012. The latest update of the TSG composition was made in September 2020, through the MOHSP Order No. 672. The Minister heads the TSG while the First Deputy Minister is the Project Coordinator for the HSIP. The TSG consists of 28 members, who are technical experts and heads of MOHSP department/units. International consultants and local specialists having technical, fiduciary and administrative assignments support the CG. In order to support the effective project coordination and implementation, the TSG is assisted by the TSG represented by various specialists financed by the project.

International consultants and local specialists having technical, fiduciary and administrative assignments support the CG. The TSG is not an independent legal entity. In fact, it is an integral part of the MOHSP, unlike the traditional Project Implementation Unit (PIU) for the previous health sector projects. The MOHSP heads of departments/units were involved in the implementation of the HSIP.

Oversight by the World Bank

The World Bank project team conducts regular review missions during which it oversees the progress of project implementation, financial management, compliance with procurement procedures both during and off the World Bank missions.

Financial Management

The project was financed from several sources: IDA grant in the amount of 15 million USD, Health Results Innovative Trust Fund in the amount of 4.8 million USD, and contribution of the Government of the Republic of Tajikistan in kind equivalent to 3.2 million USD. First additional financing (AF-1) in the amount of 10 million USD was approved by the Board of Directors of the World Bank on June 22, 2015. It included IDA credit for 5.5 million USD and grant in the amount of 4.5 million USD. Second additional financing (AF-2) came from IDA grant in the amount of 10 million USD, and GAVI funds in the amount of 2 million USD, as well as

contribution of the Government of the Republic of Tajikistan equivalent to 502 813 USD for taxes of bonuses payments (PBF) according to the national Social Security Fund (25%). The total amount of the project according to the agreement made 45 679 272.75 USD, including the funds of the World Bank in the amount of 41 800 000.0 USD (91.5%), of which 86.8% was grant and 13.2% - credit, as well as the contribution of the Government of the Republic of Tajikistan in the amount of 3 879 272.75 USD (8.5%). At the moment, 44 416 927.24 USD is disbursed, which makes it 97.0% from the total planned funds. The funds of the World Bank are disbursed by 86.3%, contribution of the Government of the Republic of Tajikistan – by 87.6%. The reason of partially undisbursed funds is associated with the exchange differences between SDR and USD. From the disbursed funds, 18 501 617.36 USD (42%) were directed to the first project component, 19 761 841.12 USD (44%) to the second component, and 6 155 617.41 USD (14%) to the third component. Financial figures are reflected in the [annex.6](#)

Procurement Arrangements

Procurement activities under the project will be carried out by the MOHSP through its Project Implementation Group. The Procurement Unit (PU) of MOHSP is responsible for overall oversight and coordination of procurement activities under all project components. Procurement Specialist and Procurement Assistant hired under the PIG will support the MOHSP PU in implementation of project procurement activities on a daily basis.

The procurement approach, procurement risks, arrangements and procurement plan throughout the Project cycle recommended by the Borrower are provided in the Project Procurement Strategy for Development (PPSD). The PPSD and Procurement Plan have been updated during project implementation to reflect significant changes in procurement approaches and methods to meet actual project needs. Procurement under the project was governed by the World Bank Procurement Regulations for IPF Borrowers (July 2016, revised November 2017 and August 2018) and was subject to the World Bank Anti-Corruption Guidelines (July 2016).

In 2020, a full transition to the Bank's Systematic Tracking and Exchanges in Procurement (STEP) system was carried out.

The following methods were used for procurement of goods and works under the Project

- RBF - Request for Bid
- RFQ - Request for Quotation
- NBT - National Competitive Bidding

For the procurement of consulting services, the following methods were used

- Consultant Qualifications Selection
- Direct Contract

Since the beginning of the Project implementation 284 contracts have been concluded for a total amount of 23 902 935,55 USD including:

- 28 contracts for consulting and non-consulting services (1 625 794,74 USD);
- 81 contracts for procurement of goods (10 059 415,71 USD);
- 27 contracts for construction (1 315 586,66 USD);
- 24 contracts for rehabilitation works (6 688 240,08 USD);
- 124 Contracts with Individual Consultants/Specialists (4 213 898,36 USD),

The Project's Procurement Specialists worked closely with the Project's Disbursement and Financial Management Specialists to ensure the continued operation of the internal

procurement and financial control system. The purpose of this coordination was the proper execution of the contracts being implemented, the timely implementation of the payments specified in these contracts, the registration of the delivery and acceptance of goods and services, as well as the subsequent handover of the output to certain beneficiaries in accordance with established procedures. Furthermore, procurement specialists provided all reporting information to the WB and state agencies of the Republic of Tajikistan. The procurement activity of the project was regularly checked by both the WB, state regulatory organizations and independent audits.

Audit

On an annual basis, in accordance with the terms of the Grant Agreement, the executing agency conducted an audit of the project costs. The external auditor was selected and hired by the State Investment Committee of the Republic of Tajikistan for all investment projects. The HSIP audit was carried out by independent auditors and on Terms of Reference acceptable to the World Bank and according to the International Standards on Auditing (ISA) issued by the International Auditing and Assurance Standards Board of the International Federation of Accountants (IFAC).

Project Monitoring and Evaluation

Project Monitoring and Evaluation was carried out by the World Bank, MOHSP, State Committee on Investments and MOF of the Republic of Tajikistan, on regular basis, through:

- Monthly, quarterly and semi-annual Project Progress Reports;
- Information on the implementation of recommendations reflected in the World Bank mission Aide Memoires;
- Annual and semi-annual Project Progress Reports to the World Bank;
- monthly/quarterly reports on disbursement of Project funds;
- information provided upon operational and extraordinary requests.

Moreover, annual verification of the targeted use and efficiency of the Project funds utilization was carried out by the Chamber of Accounts of the Republic of Tajikistan and the State Financial Control and Anti-Corruption Agency of the Republic of Tajikistan.

Main M&E indicators consist of Project Results Framework wherein PDOs and interim indicators are reflected. In addition, PBF quality and quantity indicators were monitored. Main data sources comprised of: PBF MIS, other sources when it's impossible to get data due to the PBF information system limitations. PDO indicators and interim indicators have been revised under AF2, as well as baseline and thresholds were adjusted given achieved results and revised actions. In particular, three PDO indicators were dropped off (*Percentage of pregnant women receiving antenatal care, Contraceptive usage, Percentage of children under 5 years old with diarrhea, who received any oral rehydration therapy*), because these actions shall no longer be motivated under Second Additional Financing. In addition, in conjunction with measurement difficulties, there have been replaced by indicators that better reflect the activity under Second Additional Financing (percentage of mothers receiving timely postnatal care, number of mothers receiving nutrition consultations). In addition, for these indicators, the Demographic and Health Survey was identified as the initial data source and the DHS provided mixed results for each Project region. Given that the DHS data reflects an average value in all districts in the region, rather than being specific to the Project districts, these values may not reflect trends in the

Project districts. In addition, due to measurement difficulties, they have been replaced by indicators that better reflect the activity under Additional Financing-2 (*Percentage of mothers receiving timely postnatal care, Number of mothers receiving nutrition consultations*). One PDO indicator was saved (*Average quality score for health service delivery*). Performance of the indicators provided in the Results Framework is not observed in the reporting period, except for indicator *Health staff receiving training*. In general, progress is being made towards the achievement of five indicators of the Project Development Objectives and 14 intermediate indicators in line with the established intermediate objectives, by the end of the Project. Exceptions were three intermediate indicators *People who received basic health, nutrition and population services, Number of immunized children and Number of women and children received basic nutrition services*. The percentage of performance against to the final goal is 97,6%, 96,6% and 96,5% respectively. [Annex.5](#)

To enhance transparency and ensure completeness of information regarding the indicators listed below, an explanatory note is provided in [Annex.9](#)

1. Explanatory note on the indicator: “Number of children aged 0-24 months whose weight and height are tracked according to the recommended schedule”

This annex presents an analysis of separate indicators for new and existing pilot districts, as well as aggregated totals for the entire project period (2017-2022). This addition eliminates data fragmentation and facilitates a more accurate interpretation of results.

2. Explanatory note on the vaccination target change

The appendix explains in detail the variance between the annual and final targets. An analysis of the impact of the 2021 restructuring and success in exceeding annual targets is presented, along with recommendations for improving future planning.

VIII. Environment and Social Safeguards Report

Introduction

The Government of the Republic of Tajikistan implemented Health Services Improvement Project. The overall objective of the Project is to improve the coverage and quality of primary health care (PHC) services provided in selected districts,

Concerning primary healthcare services, the main attention was paid to maternal and child health services (MCH), introduction of performance-based financing for the PHC facilities. The project covered 16 pilot districts including 5 in Sughd Region (Devashtich, J. Rasulov, Mastcho, Spitamen, and Zafarobod) 9 districts in Khatlon Region (Balkhi, Dangara, Farkhor, Yavan, Kubodiyon, Kulob, Hamadoni, A. Jomi, and Kushoniyon) Darvoz District in GBAO and Faizobod district of the DRS of the Republic of Tajikistan.

The project improved the coverage and quality of medical services through two main approaches: 1) performance-based financing which linked funding to the results achieved at participating primary health care facilities, and 2) investments to improve the delivery of health services, for example, improvement in the infrastructure of health facilities, purchase of medical equipment and trainings for medical personnel. More information on project components is provided in [Section IV. Project Components](#)

Environmental impacts of the Project fall under *Component 2: PHC Improvement*. to the Project in accordance with OP 4.01 “Environmental Assessment” remains as category B, and no additional safeguards to be initiated.

This component includes the construction of 37 PHC facilities in nine existing districts in different regions of Tajikistan such as Sughd Region (Devashtich, J. Rasulov, Mastcho), Khatlon Region (J. Balkhi, Dangara, Farkhor, Yavan), GBAO (Ishkoshim District) and DRS (Faizobod District). The component was also undertaking rehabilitation works in 36 RHCs (rural health centers) in new six pilot districts and providing some basic medical equipment. It was also engaged in medical waste management during the operational phase, paying attention to the environmental aspects and ensuring proper treatment and disposal of medical waste.

Environmental Category awarded to the Project in accordance with OP 4.01 “Environmental Assessment” remained as category B, and no additional safeguards have been initiated. Physical works to be supported under Second Additional financing were limited to installation of solar panels in the PHS facilities within the area of these facilities and rehabilitation works of selected PHC facilities in new pilot districts. Therefore, environmental category awarded to the project according OP 4.01 “Environmental Assessment” remained as category B and no additional safeguards have been initiated.

Safeguards Compliance Requirements

Following documents have been prepared as per the World Bank safeguard compliance requirements:

- Site map and photos
- Certificate of Land Ownership Rights
- Agreement for construction waste disposal
- Minutes of public consultation meeting on the draft ESMP
- Conclusion of seismic hazard assessment of the building

Furthermore, to comply with safeguard compliance requirements, the following laws and regulations of the Republic of Tajikistan are used, which define a legal framework applicable to project activities:

1. *Law on Production and Consumption Waste (№ 44, May 2002, updated in 2011)* The Law regulates relations arising in the process of waste generation, collection, storage, use, transportation and disposal, as well as state administration, supervision and control in the field of waste management to prevent the waste negative impact on the environment and human health, as well as the waste usage in economic and industrial turnover as an additional source of raw materials.
2. *Law "On Environmental Protection" (dated July 18, 2017, No. 1449)*, defines the legal basis for state policy in the field of environmental protection and is aimed at preventing the negative impact of economic and other activities on the environment. The law defines the process of developing standards in the field of environmental protection, including the maximum permissible concentration (MPC) standards for chemicals; standards for maximum permissible emissions (MPE) and discharges of harmful substances. Modern electronic equipment can contain harmful substances.

3. Law of RT on Licensing of Separate kinds of Activities (from 23.07.16, No. 1353), determines the types of activities subject to licensing in article 17, including:
 - activities for the collection, use, disposal, transportation and disposal of hazardous waste; the TSG must ensure that construction waste that cannot be reused is recycled or disposed of by a licensed contractor.
4. Chapter 5 of the Labor Code narrates the roles and responsibilities of employers and employees related to occupational health and labor safety. The law requires employers to be responsible for ensuring safe working conditions and safety of work at every workplace and to take measures to protect workers individually and collectively (including protective clothing and equipment) during civil or installation works.

Guided by environmental and social standards, the sub-projects have complied with environmental and social aspects throughout the project implementation cycle including

ESS-1: Assessment and management of environmental and social risks and impacts

- Environmental impacts of the construction and rehabilitation works: As part of the implementation of the Health Services Improvement Project, construction and rehabilitation works were carried out in the PHC facilities. During these works, short-term environmental impacts such as noise and gas emissions due to the use of heavy equipment occurred. However, appropriate measures were taken to limit noise to required standards and construction machinery was equipped with mufflers and other noise control devices. These measures helped to reduce the impact of noise on the environment and the population.
- Air Quality Mitigation Measures: During construction and renovation works, conditions were ensured to minimize long-distance dust transfer. This was accomplished by sprinkling water on site, which helped to quickly settle dust and reduce its impact on the environment. Trucks and heavy equipment also did not significantly disturb the topsoil, which helped prevent dust-related problems for workers and residents of nearby communities.
- Environmental Pollution Prevention: Contractors took necessary measures to prevent possible violations and complied with all state, local laws and World Bank Pollution Prevention requirements. They ensured that materials were kept in enclosed areas and covered with tarpaulins or other suitable covering to prevent airborne material. Fugitive dust emissions during material delivery and waste collection were also monitored to minimize environmental impact.
- Air Quality Management: Impacts on air quality had a short-term basis in certain locations and have not violated established standards. This is due to the use of effective methods and devices to control emissions and prevent air pollution by solid and gaseous substances.
- Environment Management Framework (EMF) and Environment Management Plans (EMPs): in order to address potential environmental impacts and social and environmental risk management the Environment Management Framework were prepared and approved. This document became a guidance document for the environmental impact assessment and the development of the site-specific Environment Management Plans (EMPs) for all constructed and rehabilitated RHCs. EMF and EMPs

enabled effective monitoring and management of socio-environmental aspects of the project at, all its stages.

Under the ESS - 2 "Working Staff and Working Conditions", steps have been taken and measures have been established to ensure occupational safety and health of the working staff engaged in construction and rehabilitation works at all sites of the Health Services Improvement Project. The following are the main measures implemented in accordance with this standard:

- **Compliance with Labor Laws:** The Labor Code of the Republic of Tajikistan, which includes rights to safe work and principles of occupational safety and health, was strictly observed during construction and rehabilitation works. Contractors used best domestic and international practices and experience implemented during construction financed by the World Bank on occupational safety and health.
- **Provision of personal protective equipment:** to ensure workers' safety, each worker was provided with free clothing, footwear and personal protective equipment (PPE) in accordance with the requirements of the workplace and construction conditions. Workers were obliged to use PPE at construction sites to prevent possible injuries and accidents.
- **Safety briefings and training:** Before the start of construction and rehabilitation works, the subcontractors conducted regular health and safety briefings among all working staff. This allowed to train workers on safe work practices and emergency response to emergencies. The trainings were conducted with the participation of local Emergency Ministry and fire department specialists, which ensured effective training and preparation for emergency situations.
- **Safety compliance monitoring:** The Environmental Specialist and engineers continuously monitored compliance with health and safety regulations. During inspections at facilities under construction and rehabilitation, continuous monitoring was carried out for:
 - Compliance with safety standards and technical regulations.
 - Equipment operating rules.
 - Sanitary and epidemiologic norms.
 - Fire safety.
 - Medical control.
 - Availability of first aid kit.
- **Protection against infectious diseases:** Specialists and workers were informed about protection measures against infectious diseases, including COVID-19 coronavirus. Regular body temperature checks of all workers were carried out before starting work. Facilities and workplaces were sanitized daily and antiseptic preparations were available for precautionary measures.
- **No injuries and accidents:** thanks to the measures taken and strict adherence to safety rules, no injuries, accidents or hospitalization of staff (Contractors' workers and engineers) in health facilities in districts of the region were recorded at all thirty-seven sites.

ESS-3: Resource Efficiency and Pollution Prevention. The information provided describes a number of measures that were taken by contractors and grantees to minimize environmental

pollution during construction and rehabilitation works. In particular, the following measures are indicated:

- Air pollution prevention:
 - Minimize dust during transportation of construction materials by water spraying and other methods.
 - Delivery of cement in dusttight bags to prevent dust emissions.
 - Prohibition of burning of construction and household waste at work sites.
- Soil and water pollution prevention:
 - Machinery servicing and refueling was conducted at remote service centers to minimize environmental impact.
 - Prohibition of washing machines near rural health centers and surface water bodies.
 - Storage of fuels and chemicals in leakproof containers to prevent negative environmental impacts.
- Waste management:
 - Waste, including medical waste was treated and disposed of in accordance with national sanitary norms and regulations as well as international requirements.
 - Waste was stockpiled and stored in special containers and medical waste was collected in special containers and disposed of in special incinerators.
- Waste Management level in Rural Health Centers:
 - Waste management in RHCs was organized at a satisfactory level.
 - Staff was trained and provided with necessary equipment for waste management.

This information demonstrates that the contractors took active care to minimize negative environmental impacts and strived for sustainable and responsible use of resources under the project. This contributes to the environmental safety and long-term sustainability of health facilities, which is important for the health and well-being of the region's residents.

Compliance with safety requirements when working with asbestos and asbestos-containing materials is of paramount importance for the preservation of the environment and human health. Asbestos is considered a hazardous material due to its toxic properties, and therefore it is necessary to strictly adhere safety precautions when handling it. As part of the Health Services Improvement Project, strong measures have been taken to ensure safety while working with asbestos:

- Prior awareness and training: All workers who were involved in the production and use of asbestos were trained about its hazardous properties and techniques for working safely with this material. This helped to raise awareness of possible risks and take necessary precautions.
- Use of personal protective equipment: Workers involved in work with asbestos-containing materials were provided with appropriate PPEs such as masks, gloves, respirators and special workwear. This helped prevent direct contact with asbestos and reduced the risk of inhaling hazardous fibers.
- Special Instructions: Workers were strictly prohibited from cutting or disturbing asbestos-containing materials to avoid dust generation. Special methods of working

with these materials were also provided to minimize dust generation and the release of hazardous substances into the environment.

- Proper transportation and storage: when transporting asbestos-containing materials to the place of disposal or storage, special precautions were applied to prevent materials from falling or being damaged. In case of destruction of asbestos-containing materials at the work site, immediate cleanup and removal of the resulting waste was carried out.
- Safe disposal: Waste asbestos-containing materials were collected in special containers and stored in sealed containers until their safe disposal. After unloading at a special landfill, the waste was tightly covered with a layer of earth to prevent the dispersion of hazardous fibers into the environment.
- Attention to environmental aspects: before removing asbestos from the site, wetting methods were applied to prevent the formation of asbestos dust and minimize its impact on the environment as much as possible.

All these measures ensured the safety of workers and the environment while working with asbestos and asbestos-containing materials. The Health Services Improvement Project adhered to high standards of environmental safety, which helped to reduce the negative impact on the environment and human health.

ESS -5: Land acquisition, restriction of land use rights and involuntary resettlement

Social safeguards issues of individuals and farms regarding resettlement, cutting of fruit-bearing and ornamental trees, demolition of retail outlets and outbuildings did not arise under this Project. It was also noted that there were no major construction works. Solar water heaters and generators have been installed in existing buildings of certain selected primary health care facilities. This allows for the utilization of renewable energy resources and improved energy efficiency, which is a positive step towards sustainable development. Therefore, no land acquisition was required for this Project and Operational Policy 4.12 *Involuntary Resettlement* was not applied, indicating that there was no need for resettlement and associated social problems.

ESS-6: Conservation of biological diversity and sustainable management of living natural resources

The project complied with the principles of biodiversity conservation and sustainable management of living natural resources. During construction and rehabilitation works and operation of facilities with environmental impacts, measures were taken to minimize negative impacts on the flora and fauna in the project area:

Flora

- Tree preservation: All trees located on the construction sites were pre-protected from damage by construction equipment. This measure allowed to preserve mature trees and prevent their accidental damage during construction works.
- Minimization of impact on flora: the impact on the surrounding vegetation was taken into account when siting facilities and carrying out construction. Construction machinery and equipment did not interfere with natural habitats, minimizing the destruction and disturbance of ecosystems.

Fauna:

- Prohibition on poaching: construction workers were prohibited from poaching, hunting edible animals and birds in the project area. This prevented illegal hunting and preserved wildlife populations in the region.
- Providing information on fauna preservation: contractors were in charge for providing workers with appropriate information regarding wildlife protection and its importance. This included instruction on how to behave in an area where wildlife is and reminders of the need for wildlife conservation.

The overall focus on biodiversity and sustainable management of living natural resources has helped to conserve ecosystems, maintain the balance of natural processes and conserve wildlife in the project area. This has had a positive impact on the environment and socio-ecological sustainability of the Project.

ESS-8 Cultural heritage

The environmental and social screening analysis showed that the RHC construction and rehabilitation works were not located in environmentally sensitive areas or near cultural heritage sites and did not involve the use or potential pollution of international waterways.

ESS - 10 Stakeholder engagement and information disclosure

Under ESS-10, measures were taken to ensure stakeholder engagement and disclosure of project information. Focus was made on the public involvement in the decision-making process, as well as providing citizens with the right to receive environmental information and participate in the development and implementation of environmental decisions.

- Local communities' outreach: Starting from the early stages of project implementation, local communities in the pilot districts were notified about the scheduled works in the rural health centers. Information about the project, its objectives and components were provided through local radio stations and newspapers. Moreover, information boards were installed with information about the timing of works at each construction and rehabilitation site.
- Public hearings: The TSG of the Ministry of Health and Social Protection of Tajikistan organized public hearings to provide information on the Project, its components, objectives, socio-environmental risks and feedback mechanism.
- Protection of local residents' interests: In order to protect citizens' rights to live in a favorable environment and prevent negative environmental impacts, measures such as limiting working hours to daytime and spraying water to prevent dust generation were taken. Blocking parking lots for construction machinery or restricting local residents' access to their property and public places was also avoided. Waste and material storage areas were clearly marked to ensure safety and prevent potential impacts on local communities.

Grievance (Applications) Redress Mechanism

Under AF-2 planned activities, which are reflected and approved in the Project Operating Manual (item 5.4), the team has developed an applications/grievance redress mechanism (ARM) of the individuals, i.e., citizens who are the beneficiaries of the HSIP in accordance with actual international norms and legislation of the Republic of Tajikistan (the Law of the RT “On applications of the individuals and legal persons” dtd 15.07.2016, #265; the Law of the RT “On information” dtd 27.11.2014, #1164; The Resolution of the Government of the RT “On the

procedure of recordkeeping and statistical accounting on the applications of the individuals and legal persons”, dtd 1.06.2017, #276; The Resolution of the Government of the RT “On State Health and Social Protection Supervision Service” dtd December 29, 2017 #597). The ARM will be publicly available to wide range of the project’s stakeholders which maybe directly or indirectly affected by the project. These include project beneficiaries, community members, project performers/contractors, civil society, Mass Media.

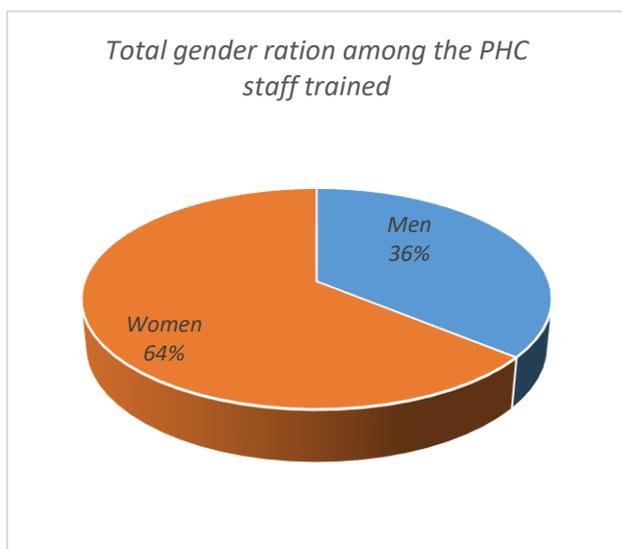
Under the Project, in order to establish the GRM, it was developed the GRM Management Information System, which is operating as grm.tj. Training was provided for employees of the Ministry of Health and Social Protection, central office of the State Health and Social Protection Supervision Service and the Main Departments of the Service for State Supervision of Health and Social Protection in GBAO, Sughd and Khatlon Region on the Management Information System of the Applications Redress Mechanism. Equipment was procured (IP-telephone, switch, telephone, NGN equipment) for launching a hotline, which serves to process citizens' appeals/complaints, at the central and regional level. For this purpose, a contract was signed with the provider Babilon-T. In order to implement the Applications Redress Mechanism, an Agreement was signed between the MOHSP and SHSPSS on the development of e-government, taking into account the existing legislation of the Republic of Tajikistan, including the Law of the Republic of Tajikistan “On appeals of individuals and Legal Entities” also for the purpose of introducing an electronic civil applications system in healthcare, which is supported by the Health Services Improvement Project. In order to inform the population about the launch of the electronic system and telephone communication under the ARM, information materials have been replicated. In addition, for the purpose of timely access for written appeal by citizens, 266 post boxes were purchased and delivered for the RHCs in pilot districts.

Under the ARM, the *Grievance Redress Mechanism* information electronic system, developed by the Project and operating as grm.tj, 136 appeals were registered, of which 80 appeals were relied, 30 appeals are at the distribution stage, 21 appeals were canceled and 4 applications are under consideration.

As for social measures, meetings were held with residents, staff of construction companies and health staff of six RHCs, as well as the PHC deputy head of Kushoniyon, A. Jomi and Zafarobod District regarding the ESMP implementation. 176 people attended these meetings, as for gender ration, women prevailed among the participants of the meetings making 126 persons or 72%, men - 50 persons or 28%. According to the designated order, each RHC has appointed specialists to supervise the ESMP implementation.

Gender aspects

The Project monitors women involvement in the training workshops and the number of women employed in companies providing services and goods under the project. Gender breakdown is provided in the [Annex.8](#).



Gender analysis of the trainees in workshops

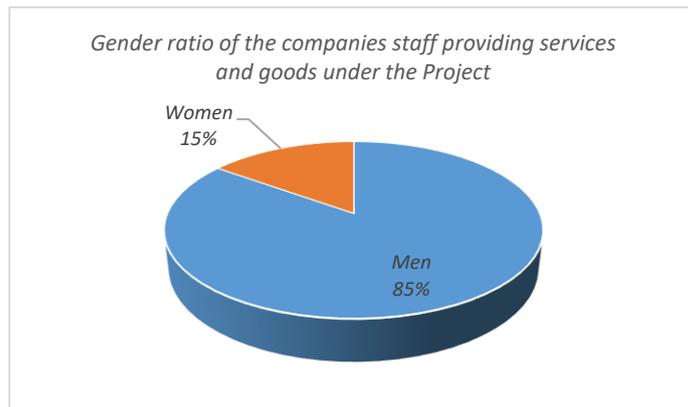
Chart 80

From the Project beginning, workshops were conducted on PBF principles and mechanism,

Computer Literacy Training, PBF Management Information System (PBF MIS), Primary Health Care Management Training for Heads of the PHC health facilities network in 16 pilot districts and the Round 1 of the six-month Family Medicine Training (Round 1 and 2) and Continuous Medical Education (CME). All these training covered 13866 PHC staff, where in gender ration, women prevailed, making 8880 persons or 64,0% of trained ones and the rest 4986 men or 36,0%. *Chart 80.*

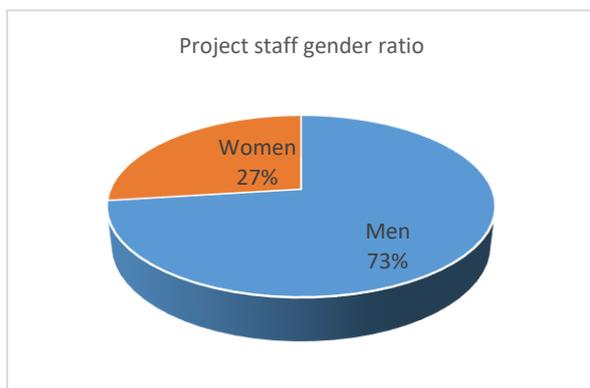
Gender breakdown of the staff of the companies providing services and goods under the project
Chart 81.

Gender breakdown among workers providing services and goods under the project showed that from total number of 629 workers 96 are women (15%) and 533 are men (85%). *Chart 68*



Project staff gender ratio

Chart 82



The total number of staff (TSG) during the reporting period made 39 persons, where 27 or 73% were men and the remaining 12 or 27% were women. *Chart 82.*

Table 28: Information on the rehabilitation works

#	Contract number	Name of RHC/District	Contractor	Signing Date	Approval date			Civil works		% of the reconstruction works progress	Land use certificate available	Accident Status
					ESMPs	Occupational Health and Safety Management Plan COVID-19	Emergency Response Plan	Start Date	Completion Date			
1	MOHSP/HSIP_AF 2/RFQ-W/021/001	Gulobod RHC, A. Jomi District	Asht Mokhi Malikabonu LLC	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.02.2022	01.08.2022	100%	Yes	-
2	MOHSP/HSIP_AF 2/RFQ-W/021/001	Yakkatut RHC, A. Jomi District	Asht Mokhi Malikabonu LLC	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.02.2022	01.08.2022	100%	Yes	-
3.	MOHSP/HSIP_AF 2/RFQ-W/021/002	Bakhor RHC, A. Jomi District	Nuri Faiz LLC	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.06.2022	100%	Yes	-
4.	MOHSP/HSIP_AF 2/RFQ-W/021/002	Galaba RHC, A. Jomi District	Nuri Faiz LLC	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.06.2022	100%	Yes	-
5.	MOHSP/HSIP_AF 2/RFQ-W/021/003	Urtabuz RHC, Kushoniyon District	Arshan & K LLC	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.02.2022	28.06.2022	100%	Yes	-
6.	MOHSP/HSIP_AF 2/RFQ-W/021/003	K.Gulov RHC, Kushoniyon District	Arshan & K LLC	27.04.2023	28.02.2022	28.02.2022	28.02.2022	27.04.2023	15.06.2023	100%	Yes	-
7.	MOHSP/HSIP_AF 2/RFQ-W/021/004	Shubai-4 RHC, Kushoniyon district	Vashgir LLC	20.10.2022	05.2022	05.2022	05.2022	20.10.2022	17.02.2023	100%	Yes	-

#	Contract number	Name of RHC/District	Contractor	Signing Date	Approval date			Civil works		% of the reconstruction works progress	Land use certificate available	Accident Status
					ESMPs	Occupational Health and Safety Management Plan COVID-19	Emergency Response Plan	Start Date	Completion Date			
8.	MOHSP/HSIP_AF 2/RFQ-W/021/004	Navobod RHC, Kushoniyon district	Vashgir LLC	20.10.2022	05.2022	05.2022	05.2022	20.10.2022	17.02.2023	100%	Yes	-
9.	MOHSP/HSIP_AF 2/RFQ-W/021/005	Yoged RHC Darvoz district	Khizmatgor LLC	31.08.2022	05.2022	05.2022	05.2022	31.08.2022	10.03.2023	100%	Yes	-
10.	MOHSP/HSIP_AF 2/RFQ-W/021/005	Darvoz RHC Darvoz district	Khizmatgor LLC	31.08.2022	05.2022	05.2022	05.2022	31.08.2022	10.03.2023	100%	Yes	-
11.	MOHSP/HSIP_AF 2/RFQ-W/021/006	RHC Saghirdasht Darvoz district	Vashgir LLC	12.07.2022	05.2022	05.2022	05.2022	12.07.2022	12.11.2022	100%	Yes	-
12.	MOHSP/HSIP_AF 2/RFQ-W/021/007	Bakht RHC Zafarobod district	Murattab LLC	19.08.2022	05.2022	05.2022	05.2022	19.08.2022	10.05.2023	100%	Yes	-
13.	MOHSP/HSIP_AF 2/RFQ-W/021/007	H. Aliev RHC Zafarobod district	Murattab LLC	19.08.2022	05.2022	05.2022	05.2022	19.08.2022	10.05.2023	100%	Yes	-
14.	MOHSP/HSIP_AF 2/RFQ-W/021/008	Jomi RHC Zafarobod district	Marvoriidi Shark LLC	17.08.2022	05.2022	05.2022	05.2022	17.08.2022	10.05.2023	100%	Yes	-
15.	MOHSP/HSIP_AF 2/RFQ-W/021/008	Zarafshon RHC Zafarobod district	Marvoriidi Shark LLC	17.08.2022	05.2022	05.2022	05.2022	17.08.2022	10.05.2023	100%	Yes	-

#	Contract number	Name of RHC/District	Contractor	Signing Date	Approval date			Civil works		% of the reconstruction works progress	Land use certificate available	Accident Status
					ESMPs	Occupational Health and Safety Management Plan COVID-19	Emergency Response Plan	Start Date	Completion Date			
16.	MOHSP/HSIP_AF 2/RFQ-W/022/005	Mehnatobod RHC Hamadoni district	Sadriiddin S LLC	25.12.2022	05.2022	05.2022	05.2022	25.12.2022	25.06.2023	100%	Yes	-
17.	MOHSP/HSIP_AF 2/RFQ-W/021/010	Davlatobod RHC Hamadoni district	Samand 9999 LLC	12.12.2022	05.2022	05.2022	05.2022	12.12.2022	15.04.2023	100%	Yes	-
18.	MOHSP/HSIP_AF 2/RFQ-W/021/011	Dusti RHC Hamadoni district	Obodii Dangara LLC	03.11.2022	05.2022	05.2022	05.2022	03.11.2022	03.03.2023	100%	Yes	-
19.	MOHSP/HSIP_AF 2/RFQ-W/021/009	Pushkin RHC Hamadoni district	In Tech Tijorat LLC	20.10.2022	05.2022	05.2022	05.2022	20.10.2022	17.03.2023	100%	Yes	-
20.	MOHSP/HSIP_AF 2/RFQ-W/021/009	Marghob RHC Hamadoni district	In Tech Tijorat LLC	20.10.2022	05.2022	05.2022	05.2022	20.10.2022	17.03.2023	100%	Yes	-
21.	MOHSP/HSIP_AF 2/RFQ-W/022/003	Mehrvar RHC Hamadoni district	KSMB LLC	12.12.2022	05.2022	05.2022	05.2022	12.12.2022	25.06.2023	100%	Yes	-
22.	MOHSP/HSIP_AF 2/RFQ-W/021/012	RHC Khojamumin Hamadoni District	Meros Sokhtmon LLC	03.11.2022	05.2022	05.2022	05.2022	03.11.2022	10.04.2023	100%	Yes	-
23.	MOHSP/HSIP_AF 2/RFQ-W/021/013	Hakimobod RHC Kulob District	Himmat 2017 LLC	03.11.2022	05.2022	05.2022	05.2022	03.11.2022	20.05.2023	100%	Yes	-
24.	MOHSP/HSIP_AF 2/RFQ-W/021/015	Ziraki RHC Kulob District	Dovudjon LLC	19.10.2022	05.2022	05.2022	05.2022	19.10.2022	05.05.2023	100%	Yes	-

#	Contract number	Name of RHC/District	Contractor	Signing Date	Approval date			Civil works		% of the reconstruction works progress	Land use certificate available	Accident Status
					ESMPs	Occupational Health and Safety Management Plan COVID-19	Emergency Response Plan	Start Date	Completion Date			
25.	MOHSP/HSIP_AF 2/RFQ-W/021/014	Lagmon RHC Kulob district	Somon Orzu LLC	22.12.2022	05.2022	05.2022	05.2022	22.12.2022	21.04.2023	100%	Yes	-
26.	MOHSP/HSIP_AF 2/RFQ-W/022/002	Mehnat RHC A. Jomi district	Navruz-2003 LLC	03.11.2022	05.2022	05.2022	05.2022	03.11.2022	22.04.2023	100%	Yes	-
27.	MOHSP/HSIP_AF 2/RFB-W/021/001-5	Navkor RHC, Kushoniyon District	Somon Orzu LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	10.10.2022	100%	Yes	-
28.	MOHSP/HSIP_AF 2/RFB-W/021/001-3	Istiqlol RHC, Kushoniyon District	Sokhil K LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	10.10.2022	100%	Yes	--
29.	MOHSP/HSIP_AF 2/RFB-W/021/001-3	Doniyorkul RHC, Kushoniyon District	Sokhil K LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	10.10.2022	100%	Yes	-
30.	MOHSP/HSIP_AF 2/RFB-W/021/001-3	Navbakhor RHC, Kushoniyon District	Sokhil K LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	10.10.2022	100%	Yes	-
31.	MOHSP/HSIP_AF 2/RFB-W/021/001-5	Shunbai-1 RHC, Kushoniyon District	Somon Orzu LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	10.10.2022	100%	Yes	-
32.	MOHSP/HSIP_AF 2/RFB-W/021/001-6	Komsomol RHC, Kushoniyon District	Tojikenergostem LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	20.10.2022	100%	Yes	-
33.	MOHSP/HSIP_AF 2/RFB-W/021/001-6	Sarvati Istiqlol, Kushoniyon District	Tojikenergostem LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	20.10.2022	100%	Yes	-

#	Contract number	Name of RHC/District	Contractor	Signing Date	Approval date			Civil works		% of the reconstruction works progress	Land use certificate available	Accident Status
					ESMPs	Occupational Health and Safety Management Plan COVID-19	Emergency Response Plan	Start Date	Completion Date			
34.	MOHSP/HSIP_AF 2/RFB-W/021/001-2	Busto-Qala RHC, Kushoniyon District	Kurboniyon-1 LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	02.03.2023	100%	Yes	--
35.	MOHSP/HSIP_AF 2/RFB-W/021/001-2	Sabzavod RHC, Kushoniyon District	Kurboniyon-1 LLC	06.06.2022	05.2022	05.2022	05.2022	06.06.2022	27.05.2023	100%	Yes	-
36.	MOHSP/HSIP_AF 2/RFQ-W/022/005	Gulobod RHC, Hamadoni District	Samand - 9999 LLC	27.04.2023	05.2022	05.2022	05.2022	27.04.2023	15.06.2023	100%	Yes	-

Citizen Score Cards (CSC) mechanism

This mechanism provides for the involvement of citizens living in the catchment area of health facilities in assessing the health facility performance, which contributes to improving the quality of services provided. For this purpose, 72 pilot and control districts of Sughd and Khatlon Region were selected. Questionnaires were developed with basic criteria for health facilities' quality indicators assessment. Furthermore, facilitators were hired to conduct meetings with health care providers and the attached population.

In the period from 2015 to 2019, 360 meetings were held with 7,106 participants, including 4,851 women (68.3%).

Participants of the meetings with population were residents of the village, including RHC patients, representatives of communities and local committees, society leaders and activists, and patients of pilot RHCs. All employees working at that time took part in the meetings with health staff of studied RHCs – namely doctors, nursing and junior staff of the facility.

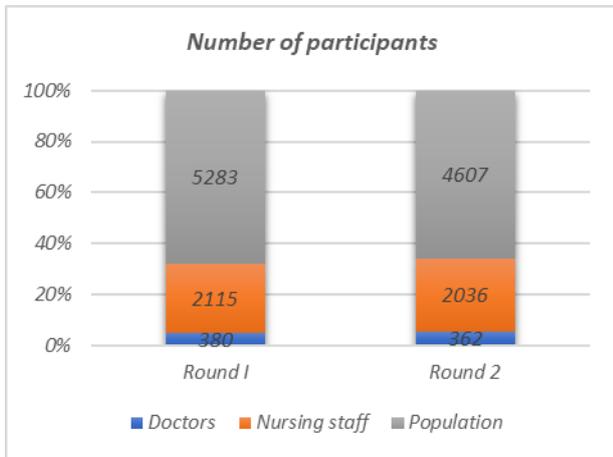
Facilitator informs the participants about project, its objectives and goals explaining why the project is implemented in pilot districts, and also explained the difference between pilot and control districts on each meeting. After that participants are familiarized with assessment procedure and tools, wherein especially marking that given format is applied for the second time in order to compare the results of previous year's assessment. Participants closely introduced with complemented "Citizen score cards" that was transmitted into A3 format in advance and posted for convenience in plain view. Facilitator explains that filling this form and giving corresponding scores the participants can share with their opinion on quality of provided health services in their village; in certain rural health center give their mark, speak out own recommendations and suggestions. Participants are warned that can express their opinions and speak openly, and it will allow to get an unbiased information.

In order to support interaction with community and increase accountability of managers and healthcare providers, the AF-2 will continue to provide support to the "Citizen Scorecards" Mechanism, included in the parent project.

In order to implement this mechanism contracts were signed with NGO "Umedbakhsh" to conduct meeting in pilot districts of Khatlon region, as well as in Darvoz and Faizobod districts, and with NGO "Subhi Tandurusti" to conduct meetings in the pilot districts of Sughd region. It should be noted that the main tools used under this mechanism were the questionnaires with basic criteria for health facilities' quality indicators assessment to hold separate meetings with the citizens, and the health staff. The Kobo Toolbox platform have been used for regular monitoring of data collection and entry. The Project has also developed an analytical database on Excel spreadsheet.

Main results of two conducted meeting rounds

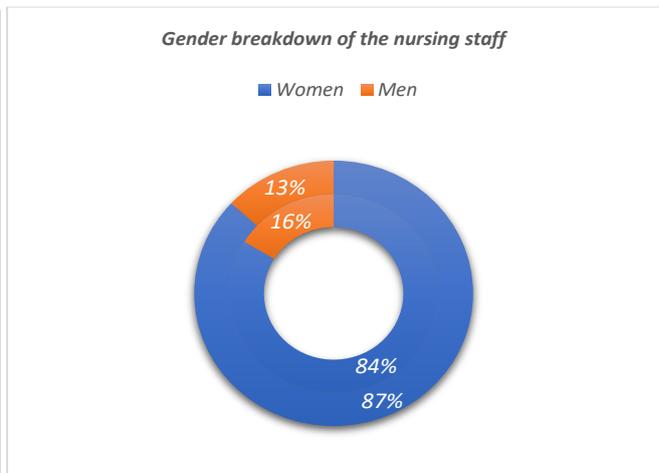
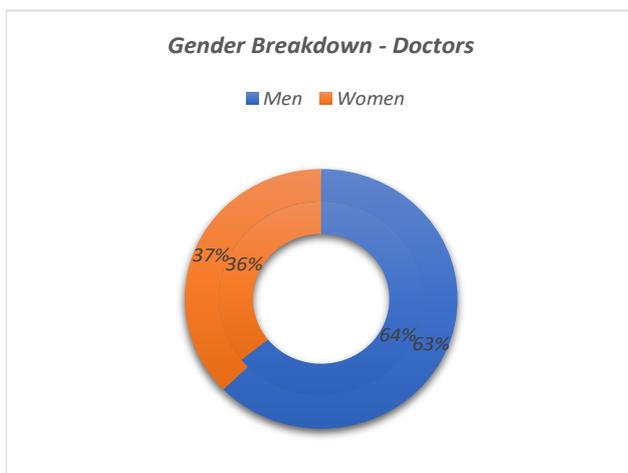
Chart 83



Two rounds of the meetings in 264 rural health centers were conducted for the reporting period covering 14783 persons, including 4893 health staff (742 doctors and 4151 nursing staff), and 9890 persons of catchment population. (Chart 83). As for the gender breakdown given two rounds of the meetings, women prevail among the participants, making 11899 or 80.5%, men were 2884 persons or 19.5%. In addition, the analysis of gender breakdown among health staff showed that women proportion also prevails and makes 78%, whereas men make it 22%. High proportion of women among health workers results from the nursing staff. Men proportion prevails in gender breakdown of the participants among the doctors, which made 63%, and women 37%, respectively. (Chart 84)

men make it 22%. High proportion of women among health workers results from the nursing staff. Men proportion prevails in gender breakdown of the participants among the doctors, which made 63%, and women 37%, respectively. (Chart 84)

Chart 84

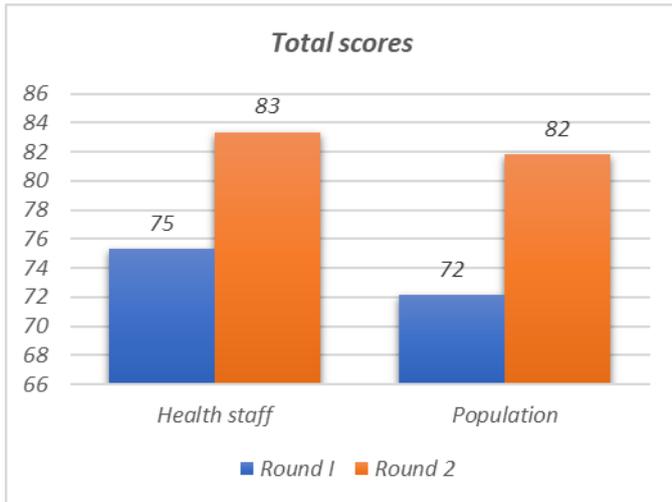


Data analysis based on the results of the questionnaires of the “Citizen Scorecard” Mechanism is provided below, where every point is marked with a score, and were the basis for determination of the proportion from the max value.

Assessment tool consists of 4 sections:

1. General conditions - 40 scores
2. Services for mother and child - 25 scores
3. Services for preventing and treatment of chronic diseases - 30 scores
4. Household visits - 5 scores

Chart 85.



In general, the total score at the level of 16 pilot districts based on two rounds of the meetings observes improvement in quality of health services both by the population by 10%, and by the health staff by 8%. See Chart 85.

Chart 86

Assessment of general conditions was conducted based on the indicators of health facilities' cleanliness, availability of medical equipment, medicines, services, state of infrastructure, availability of specialists and laboratory. In general, the "General Conditions" indicators observes progress throughout pilot districts for the quality of health services both by the health staff and population compared to the two rounds of the meetings by 10% and 13%, respectively. See Chart 86.

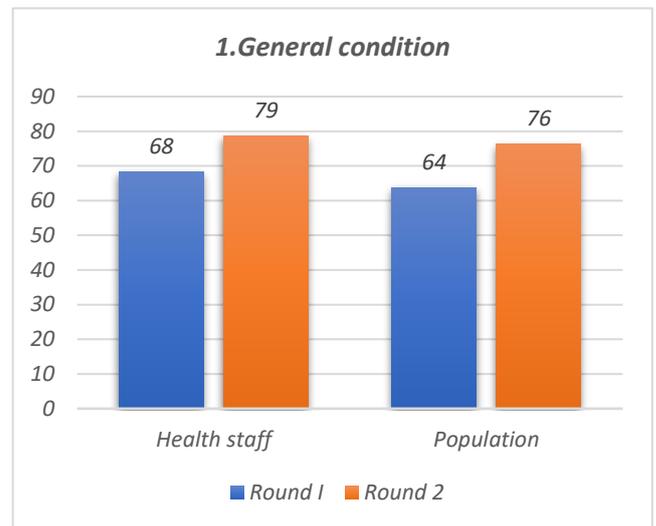
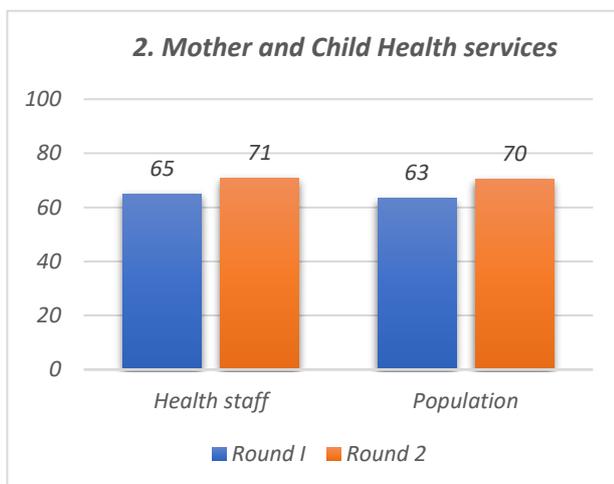


Chart 89



Analysis of "Services for mother and child" indicator, which consists of sub-indicators like "Vaccination of children aged under 1", "Monitoring of children aged under 3", and "First postnatal visit made during first three days after check out from the maternity house", has shown that, in general, all beneficiaries mark the quality of services to mother and child positively. This includes scores from the population from 65 to 71 and by the health staff from 63 to 70 scores. See (Chart 89).

The analysis of third indicator “Services for preventing and treatment of chronic deceases” has shown that the quality score for these services made 85 in the second round of the meeting by the population, and 86 by the health staff. Compared to the first round, an increase made 8 and 7 scores respectively. See (Chart 90)

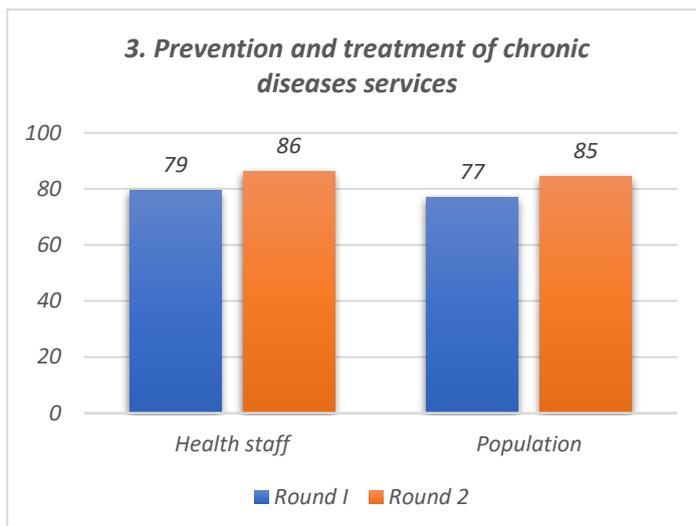
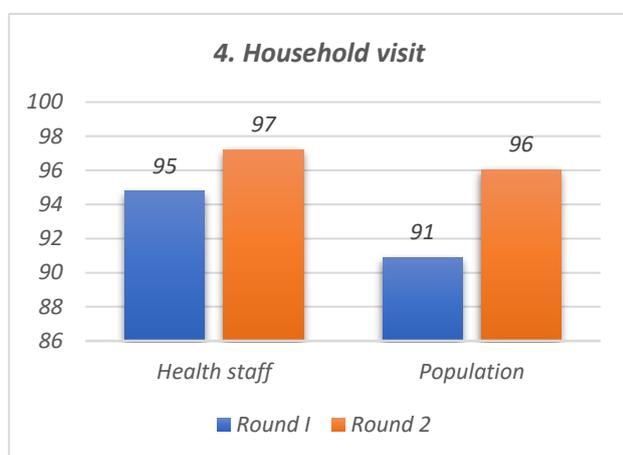


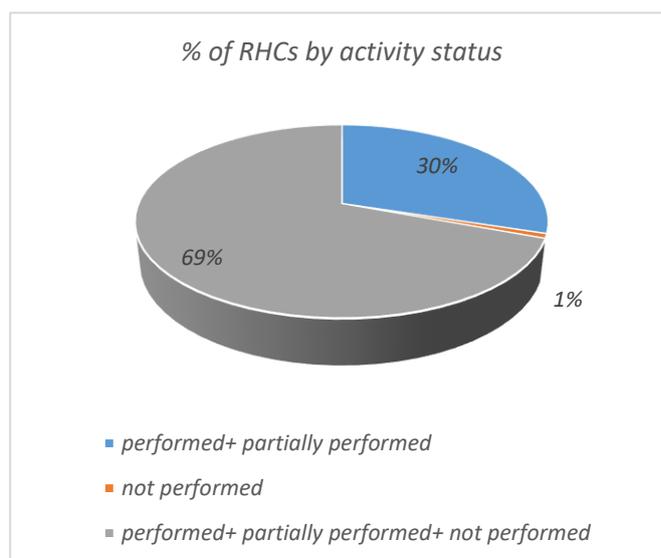
Chart 91



In addition, the quality of household visits was also assessed under this mechanism. These visits had a purpose to register and make targeted visits. Out of all 4 indicators, this one was marked over 90 scores, including population’s score of over 91 in the first round to 96 in the second, health staff’s score made from 95 to 97, respectively. (Chart 91)

Chart 92.

Action plans of the RHCs’ health staff and population were developed at the end of the meetings during the first round, which are aimed at improving the quality of health services. Implementation of these action plans was monitored before start of the second round. Corresponding analysis has shown that, in general, 99% of health facilities implemented or partially implemented the actions, and 1% did not follow the action plans. See (Chart 92)



IX. Critical Review of Actions Taken by the World Bank, Government of Tajikistan and Individuals/Organizations Providing Technical Assistance

Evaluation of the effectiveness of the Bank's actions during Project period

Commitment to the process of the health reforms and through the implementation of the necessary changes, actively supported by the World Bank, contributed to a change of the Project implementation approaches and key Project parameters, including well-coordinated and integrated with the leading MOHSP units, close interaction with donors and development partners, maintaining the principal staff and increasing the Project duration.

Evaluation of the GoT actions during the Project implementation

The Government of the Republic of Tajikistan fulfilled its commitments to provide the Project with co-financing to cover the principal part of the taxes that were levied on PBF incentive payments. This kind of initiative, where a partner co-finances a WB-funded health project, was implemented for the first time.

Evaluation of the effectiveness and quality of the relationship between the World Bank and the Government during the Project implementation

During the WB Review Missions, joint review of issues requiring the World Bank and the Government attention was carried out. Decisions were made in a timely and efficient manner.

Evaluation of the effectiveness of the actions of various organizations providing goods and services and persons/organizations providing technical assistance during the Project implementation ((comparison of costs and benefits obtained))

Given the existing mechanisms for the implementation of the Project activities, the achievement of effectiveness was ensured by harmonizing the areas and objectives of both the Project as a whole and individual Contracts, with key strategic MOHSP documents. Consultancy contracts implemented in the format of a strategic partnership demonstrated high efficiency. Long-term partnerships built with consultants under these contracts have made it possible to ensure the implementation of key strategic reforms in the context of close interaction and synthesis of international and local experience.

X. Key lessons learned

Extensive efforts of consulting companies were associated with the provision of international experience in various areas of healthcare and the subsequent development of recommendations for improving legal framework. Provision of laws and regulations and not only approaches and recommendations of developed countries, could significantly increase the effectiveness of some of the Project's activities.

As part of the Project, significant experience was gained in quick response during a pandemic, the procurement of the required medical equipment and consumables, the introduction of interactive forms of education, which made it possible to support the regions in the fight against the COVID-19 pandemic.

The uneven implementation of the Project subcomponents due to delays in the competitive procedures for the supplier's selection, a multi-level coordination process, financial losses due to exchange rate differences contributed to the fact that some project activities lost their relevance and ability to be implemented. In particular, the successfully developed *Short-Term Statistical Data Management and Disposal of Medical Waste at the RHC Level Training* and the development of the Electronic Patient Register, its implementation and training envisaged under Project became impossible due to financial losses associated with unstable exchange rate.

Special Drawing Rights towards the US Dollar. The limited financial capabilities of health facilities did not allow the implementation of best practices that required investments.

Difficulties in the PBF scheme implementation were related to financial administration in the health facilities of the PHC network in pilot districts. The accounting department at the District Health Centers (DHCs), which are in charge of financial management, had no corresponding previous accounting experience, which led to difficulties in the proper use of the PBF funds allocated by the project to support health facilities.

The project encountered difficulties in the PCF implementation, including the following aspects: non-finalized processes for restructuring the PHC system, instability of human resources at the level of the PHC network (staff leakage, low wages, etc.), imperfection of the existing system of planning and allocation of financial resources, lack of the state budget funds and of the automated financial reporting and analysis system based on primary data.

As part of the environmental management, during the rehabilitation works in most RHC, there were no land use right certificate. To solve this problem, the project sent an official appeal to the local Khukumats with a request for assistance in obtaining these certificates. As a result of all efforts, all RHC received certificates for the right to use land plots.

Furthermore, despite the results achieved, there were problems in the category "Hygiene and Sanitation", in some health facilities, in particular, the sterilization of instruments by staff in accordance with the standards and the pit availability for non-infected stuff in HH. To address this situation, the project has repeatedly carried out all kinds of educational activities to raise awareness and improve the knowledge of the staff of pilot health facilities on sanitary safety and medical waste management. Of course, it was not possible to cover the entire working staff of facility, but through the Project efforts, we have achieved significant positive results compared to previous years.

It should be noted that with the HSIP technical support, a Medical Waste Management Training was developed and approved for the RHC heads, at the level of responsible units. Training was scheduled under the CME framework (national medical organization), organized by the Republican Family Medicine Clinical and Training Center. In addition, further support for this training course and similar events is expected under the new Millati Salim Project.

XI. Sustainability of investments provided under the Project

During the Project implementation, assistance was provided in the physical equipment of healthcare facilities in pilot districts, which will ease the burden on the republican budget while strengthening the infrastructure of healthcare facilities to create better conditions for the provision of health services to the population. In addition, a number of laws and regulations, mechanisms and strategies have been developed for the further healthcare development in Tajikistan. The project was a logical continuation of previous healthcare projects financed by the World Bank and was aimed to support

the PHC network reform, improving the population's access to quality healthcare services. The main results indicating the sustainability of the Project are as follows:

Capacity building of the MOHSP employees, other government agencies, as well as health staff in the health care system. For the entire Project period, various forms of training (clinical residency (residency), CME, USO, FM retraining (specialization), Postgraduate Healthcare System Management Training for heads of the PHC network in districts, Computer Literacy Training and the PBF Approach for the health staff in pilot districts, participation in international conferences, study tours, workshops, round tables, etc.), more than 13,866 persons were covered.

Introduction of the Project results into laws and regulations. Most of the achievements of the Project have been integrated into the existing legislation, thereby strengthening the regulation of the health care system in Tajikistan to the best international experience.

The introduction of strategic partnerships with the universally recognized medical universities will strengthen the healthcare staff training system, which responds to the changing needs of the labor market, and create conditions for the training of qualified and competitive personnel.

PHC Focus. The implementation of such activities as: introduction of the Quality Assessment Checklists, the development and implementation of clinical protocols, approaches to motivate health staff, the physical infrastructure improvement of the PHC network health facilities, etc., will create an effective and sustainable PHC service.

Mechanisms for ensuring the healthcare quality. Accreditation, the introduction of evidence-based medicine, the assessment of medical technologies, the quality management system is a continuous and cyclical process covering all levels of medical care. Retaining the achieved Project results and their improvement is possible only under the condition of continuous improvement of these mechanisms.

Structural reforms focus. A number of activities started as a piloting (new Performance-Based Financing model, integrated model of medical education, quality management system, commitment to the accreditation process, Continuous Medical Education, etc.) and subsequently, using lessons learned, changes in practice and thinking of medical workers, the nation-wide possibility of implementation. The fact that the MOHSP RT and medical workers have experience in conducting and participating in pilot projects will allow to develop prudent approaches to policy development and introduce step-by-step changes, in future.

Commitment to scheduled reforms. Further promotion and implementation of the measures provided under the Project – Performance Based Financing (motivation of medical workers at the PHC level), Per Capita Financing of the PHC network, improvement of the quality management system at the PHC level, continuous staff capacity building, will contribute to the achievement of long-term health development goals.

Cooperation with international organizations. Membership of the Ministry of Health and Social Protection of the Republic of Tajikistan in designated international associations is one of the most

important sources of acquiring new knowledge, a way to harmonize national policy with international best practices, as well as a tool to enhance the image of the Republic of Tajikistan on the world stage. Cooperation with foreign leading universities contributes to the entry of the country's medical educational institutions into the international educational space and to be recognized in the international professional community.

XII. Conclusion

Project activities evidence its importance and significance for the development of the healthcare system in Tajikistan. The project was successfully implemented and had a significant impact on various healthcare aspects in the country. Important findings of the project activities include:

1. Improving the access and quality of medical care: Project contributed to the strengthening of the physical infrastructure of the health facilities and the improvement of the health staff qualification, which improved the availability and quality of medical services for the population.

2. Implementation of Structural Reforms: The project has successfully implemented pilot projects and introduced new approaches and models in the health system, which contributed to the formation of a more efficient and sustainable PHC system.

3. Partnership and Collaboration: Collaboration with the World Bank and other international organizations, as well as partnerships with the world's leading medical universities, made it possible to use best practices and resources for the successful Project implementation.

4. Sustainability and integration: Majority of the Project's achievements have been integrated into legislation and become part of the strategic plans for health development, which ensures their long-term sustainability and continuation.

5. Response to the COVID-19 Pandemic: The project has successfully met the challenges of the pandemic by providing crisis response, staff training and support to health facilities.

6. Need for further development: The project has shown that many achievements are steps towards further health care improvement in the country. To achieve long-term health development goals, it is necessary to continue reforms and strengthen the health system.

Under this Project, a strategic partnership and interaction between educational institutions of the country was established. New mutual educational programs were introduced into the educational process. Based on international experience, recommendations were provided on the CME implementation in Tajikistan for the FM experts.

A wide range of medical equipment procured under the Project will also allow further improvement of the quality and accessibility of medical care to the population in the regions.

Activities carried out under the Project on the Health Staff Capacity Building will make it possible to continue systemic changes in the healthcare sector in Tajikistan, in the future.

In general, Project contributed to the improvement of health care in Tajikistan, however, challenges and tasks remain for the further development of the health care system in the country. Continued cooperation with international partners and sustainable implementation of reforms will help ensure long-term improvements in medical care and public health of Tajikistan.

Annex

Annex 1. Syllabus of the Specific Training for the training of General Practitioners (family doctors)

#	List of modules	Duration	Number of academic hours
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		(days)	total	lectures	workshops	practical sessions
1.	Introduction. Family Medicine Concept	2	16	8	-	8
2.	Public health and population health	3	24	12	1	11
3.	Interpersonal communication	2	16	4	4	8
4.	Gender issues in the family doctor practice	1	8	4		4
5.	Geriatrics	2	16	4	6	6
6.	Medical psychology in the family specialists' practice	1	8	4	1	3
7.	Integrated Management of Childhood Illness	6	48	10	15	23
8.	Emergencies	3	24	6	8	10
9.	Laboratory science	3	24	4	10	10
10.	Computer literacy	2	16	-	8	8
11.	Application of clinical protocols. Rational use of drugs	3	24	10	4	10
12.	Adults prevention measures	2	16	4	4	8
13.	Child monitoring and care. Adolescent medicine	18	144	40	40	64
14.	Obstetrics-gynecology, Family Planning	18	144	40	40	64
15.	Common acute and chronic diseases of internal organs	24	192	50	62	80
16.	Outpatient surgery and traumatology. Burst abdomen	12	96	30	12	54
17.	Infectious diseases	6	48	19	8	21
18.	Neurology	4	32	11	7	14
19.	Tuberculosis	4	32	10	6	16
20.	Common skin diseases. STD. HIV AIDS	4	32	12	4	16
21.	Pharynx inflammatory diseases and sinusitis. Ear pain and hearing loss syndrome	4	32	12	4	16
22.	Oculistics	4	32	8	8	16
23.	Mental health and illness. Acedia and Anxiety Disorders	2	16	8	2	6
24.	Palliative Care	2	16	4	4	8
	Exam	2	16			
	Total	134	1072	314	258	484

Annex 2. Curriculum Public Health Management Training

#	Module	Number of academic hours						Total
		Lectures	Works hops	Practical sessions	Onsite training	Individual work	Knowledge rating	
1.	Health System of the Republic of Tajikistan	24	16	8	30	90	4	172
2.	Healthcare quality	24	4	20	30	90	4	172
3.	Management in practice; business planning and other performance assessments at the level of PHC facilities	24	12	12	30	90	4	172
4.	Knowledge management	24	12	12	30	90	4	172
5.	Human Resources Development	12	24	12	30	90	4	172
6.	Infrastructure, equipment and supply management	12	16	20	30	90	4	172
7.	Health Financing	18	12	18	30	90	4	172
8.	Public involvement in healthcare issues	24	12	12	30	90	4	172
9.	Leadership and communication	12	12	24	30	90	4	172
10.	Health Information System	20	6	22	24	74	4	150
Consultations							18	18
Total		194	126	160	294	884	58	1716

Annex 3. Curriculum Clinical residency on the Family Medicine Specialization

#	Module	Number of academic hours				Total
		Lectures	Practical sessions	Workshops	Knowledge rating	
1.	Internal illnesses	28	434	22	8	492
2.	Childhood diseases	34	524	34	8	600
3.	Obstetrics and gynecology	28	436	28	8	500
4.	Surgery, trauma and rejection	24	410	26	8	468
5.	Infectious diseases and tuberculosis	8	130	8	8	154
6.	Neurological diseases	8	130	8	8	154
7.	Skin and venereal diseases, HIV/AIDS	8	130	8	8	154
8.	Psychiatry	8	130	8	8	154
9.	Ocular diseases	8	130	8	8	154
10.	Otorhinolaryngologic diseases	8	130	8	8	154
11.	Cancer medicine	4	62	4	4	74
12.	Laboratory diagnostics Лабораторная диагностика	4	62	4	4	74
13.	Introduction to Family Medicine	16	60	4	-	80
14.	Hemadenology	2	26	4	4	36

15.	Geriatrics	2	26	4	2	34
16.	Fundamentals of pharmacology	2	26	4	2	34
17.	Emergency	4	26	2	4	36
18.	Public Health	16	56	4	4	80
Examination		-	-	-	100	-
Total		212	2928	188	104	3432

Annex 4. Curriculum PHC Facility Management

#	Module	Number of academic hours				Total
		Lectures	Practical session	Workshops	Knowledge rating	
1.	Health System of the Republic of Tajikistan	1	2	1	0,5	4,5
2.	Healthcare quality	2	8	2	0,5	12,5
3.	Management in practice; business planning and other performance assessments at the level of PHC facilities	2	2	-	0,5	4,5
4.	Knowledge management	2	-	2	0,5	4,5
5.	Human Resources Development	4	-	-	0,5	4,5
6.	Infrastructure, equipment and supply management	2	-	2	0,5	4,5
7.	Health Financing	8	8	2	0,5	18,5
8.	Public involvement in healthcare issues	-	2	-	0,5	2,5
9.	Leadership and communication	2	-	-	0,5	2,5
10.	Health Information System	2	-	2	0,5	4,5
11.	Prevention of infection. Medical waste management	3	-	1	0,5	4,5
12.	Community engagement in immunization issues	2	-	-	0,5	2,5
Consultations						2
Total		30	22	12	6	72

Annex 5: Results Framework

Results Framework													
COUNTRY: Tajikistan													
Second Additional Financing to the Tajikistan Health Services Improvement Project													
Project Development Objective(s)													
The revised PDO is to contribute to the improvement of the coverage and quality of basic primary health care (PHC) services in selected districts.													
Project Development Objective Indicators by Objectives/ Outcomes													
Coverage of basic Primary Health Care (PHC) services in targeted (separate) districts													
№	Indicator Name	Baseline	Results		Intermediate Targets			End Target	Definition/Description	Frequency	Data source	Methodology for Data Collection	Responsibility for Data Collection
			1 st year	2 nd year	1 st year	2 nd year	3d year						
Coverage of basic Primary Health Care (PHC) services in selected districts													
1	Mothers receiving timely postnatal counselling in existing districts (Percentage)	90,0	99,15	99,7%	92,0	93,0	94,0	95,0	Percentage of mothers in project districts who received first postnatal patronage visit at home within the first three days after discharge from the Maternity House	Every six months	Project Data	Project Data	MOHSP PCG, Oblast and District Health Departments.
2	Mothers receiving timely postnatal counselling in new districts (Percentage)	60,0	96,94	99,4%	90,0	91,0	92,0	93,0	Percentage of mothers in project districts who received first postnatal patronage visit at home within the first three days after discharge from the Maternity House	Every 6 months	Project data	Project data	MOHSP PCG, Oblast and District Health Departments.
3	Number of mothers counseled on nutrition (Number)	182 452,0	225 053,0	326 730	213 911	266 419,0	281 319	290 512	Number of mothers in project districts who received nutrition counselling. To be expressed also in percentage by calendar year.	Every six months	Verified project data	Verified project data	PCG, Oblast health departments, and rayon authorities.

Quality of basic Primary Health Care (PHC) services in selected districts													
4	Average Health Facility Quality of Care Score in existing project districts (percentage)	60% - CЦ3 50.6%-Д3	87,9%CЦ3 86,3%Д3	91,3% CЦ3 91,2 %Д3	80%CЦ3 80%Д3	83% CЦ3 73%Д3	85%CЦ3 84%Д3	88%CЦ3 86%Д3	Composite Health Facility Quality Score covering key domains of the quality checklist.	Annually	PBF verified data	PBF MIS	MOHSP Coordination Group, Oblast and District Health Departments
5	Average Health Facility Quality of Care Score in new project districts (percentage)	55% -CЦ3 50% - Д3	65,5%CЦ3 58,8%Д3	83,8 %CЦ3 80,5%Д3	60%CЦ3 55%Д3	63% CЦ3 55%Д3	63%CЦ3 55%Д3	65%CЦ3 55%Д3					
Intermediate Results Indicators by Components													
№	Indicator Name	Baseline	Results		Intermediate Targets			End Target	Definition/Description	Frequency	Data source	Methodology for Data Collection	Responsibility for Data Collection
			1 st year	2 nd year	1 st year	2nd year	3d year						
Component 1: Performance Based Financing (<i>Action: This Component has been Revised</i>)													
1	Number of eligible health facilities in which PBF is initiated (Number)	449	721	720	720	720		720	Number of Rural Health Centers and Health Houses that have received first PBF payment	Annually	Project data (PBF MIS database).		MOHSP PCG, Oblast and District Health Departments.
2	Percentage of Primary Health Care facilities eligible for PBF payments who received timely PBF payments in the preceding quarter (Percentage)	100%	100%	100%	100%	100%	100%	100%	Numerator: Number of Rural Health Centers and Health Houses in project districts who received quarterly PBF payment within [TBD] days of quarter ending in the most recently completed quarter Denominator: Number of Rural Health Centers and Health Houses in project districts who were eligible for payment based on first verification report (ex-ante verification) To be disaggregated for Sughd, Khatlon & RRS.	Annually	Project data (PBF MIS database).		MoHSP Coordination Group, Oblast and District Health Departments.

3	Number of independent verification visits completed per schedule (Number)	10	11	14	11	12		14	Number of independent verification reports completed by third party verification agency as scheduled, i.e., one report per rayon every six months.	Annually	Independent verification reports		MOHSP Coordination Group, Oblast and District Health Departments.
4	Percentage of hypertension patient charts with treatment according to protocol in existing districts (Text)	80%	98,3	98,0%	97%	97%	97%	98%	Numerator: Number of charts of adult hypertensive patients with treatment according to protocol reviewed during internal verification. Denominator: Total number of charts of adult hypertensive patients screened during internal verification	Annually	PBF Verification Records		MoHSP PCG, Oblast and District Health Departments.
5	Percentage of hypertension patient charts with treatment according to protocol in new districts (Text)	20%	89,09	98,9%	88%	88%		89%	Numerator: Number of charts of adult hypertensive patients with treatment according to protocol reviewed during internal verification. Denominator: Total number of charts of adult hypertensive patients screened during internal verification	Yearly	PBF verification records		MoHSP PCG, Oblast and District Health Departments.
6	Number of citizen scorecard exercises/sessions conducted in the project districts. (Number)	288	-	816	288	522	816	816		Annually	MOHSP CG reports		MOHSP Coordination Group, Oblast and District Health Departments.

7	Average proportion of women attending citizen scorecard exercises (Percentage)	0,0	-	80,5%	10,0	20,0	23,0	25,0	Numerator = number of community members who are women attending citizen scorecard exercise. Denominator = number of community members attending citizen scorecard exercise. Averaged across all community scorecard exercises for preceding six months.	Semi-annual	PCG administrative data		MOHSP PCG
8	Percentage of PHC facilities that act on community action plans (Percentage)	0,0	-	99,2%	5,0	15,0	18,0	20,0	Number of rural health centers (and associated health houses) in project districts that develop and implement an action plan to improve services in response to feedback received during citizen score card discussions.	Annually	MOHSP PCG reports		MOHSP PCG, Oblast and District Health Departments.
9	People who have received essential health, nutrition, and population (HNP) services (CRI, Number)	1 102 806,0	1 503 067,0	2 176 204,0	1 506 237,0	2 037 047	2 083 056,0	2 230 685,00		Semi-annually	Project data	Project reports	MoHSP PCG.
10	People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)	1 166 908	1 383 868,0	1 651 910,0	1 268 382,0	1 337 508,0	1 343 508,0	1 364 483,0		Semi-annually	Project data	Project reports	MoHSP Coordination Group.
11	Number of children immunized (CRI, Number)	163 699	207 445,0	262 577,0	07 636,0	54 255,0	262 256,0	271 695,0		Semi-annually	Project data	Project reports	MoHSP Project Coordination Group.
12	Number of women and children who have received basic nutrition services (CRI, Number)	939 107,0	1 257 983,0	1 814 084,0	1 276 601,0	1 720 792,0	1 750 800,0	1 878 990,0		Semi-annually	Project data	Project reports	MoHSP Project Coordination Group.
13	Number of deliveries attended by skilled health personnel (CRI, Number)	0,0		82 800,0	22 000,0	22000,0	70 000,0	80 000,0		Semi-annually	Project data	Project reports	MoHSP Coordination Group.

			37 639,00										
14	Percentage of PBF facilities completing household engagement exercise (Percentage)	0,0	51,6	97,1	30,0	35,0	40,0	45,0	Numerator: Number of PBF facilities completing household engagement exercise. Denominator: Number of PBF facilities	Every six months	PBF MIS data		MOHSP PCG, Oblast health departments
Component 2: Primary Health Care Strengthening													
15	Health personnel receiving training (Number)	10289	13614	13 867	12800	13000	13500	13700	This indicator measures the cumulative number of health personnel receiving training to include (i) PBF principles and computer literacy training; (ii) Training on PCF, PBF and registry principles; (iii) 6-month family medicine training, (iv) primary care management training, (v) family medicine specialty training.	Annually	Project data (PBF MIS database), official medical statistics		MOHSP PCG, Oblast and District Health Departments.
16	Health facilities rehabilitated and/or equipped (Number)	403	403	481	403	419		425	Cumulative number of primary care facilities (rural health centers and health houses) in project districts rehabilitated or equipped.	Annually	Project data (PBF MIS database).		MoHSP PCG, Oblast and District Health Departments
Component 3: Project Management, Coordination, and Monitoring & Evaluation													
17	Number of new project districts in which PBF MIS is operational (Number)	0,0	6,0	6,0	6,0	6,0	6,0	6,0	Number of districts where the PBF MIS is used to transmit PBF data in soft copy from districts to MOHSP PCG	Annually	Project data (PBF Progress reports).		MoHSP PCG, Oblast and District Health Departments.

Annex. 6 Financial Performance

Disbursement of funds under the USD Project

Development by years	Total USD	World Bank USD	Government USD	Other /Tender proceeds USD	Exchange difference USD
2013	-	-	-	-	-
2014	1 677 953,80	1 671 485,63	-	-	6 468,17
2015	3 252 562,78	3 084 536,00	130 595,36	142,56	37 288,86
2016	4 668 274,65	4 421 902,52	256 670,73	2 567,22	- 12 865,82
2017	6 217 806,07	5 956 973,19	256 869,48	1 630,45	2 332,95
2018	8 661 002,06	6 976 333,15	1 688 875,18	1 670,96	- 5 877,23
2019	7 041 901,14	6 452 609,98	596 465,07	18 622,07	- 25 795,98
2020	517 306,83	517 298,59	-	18,88	- 10,64
2021	3 673 323,89	3 513 517,76	160 042,04	-	- 235,91
2022	6 411 216,51	6 229 903,44	182 876,95	-	- 1 563,88
2023	2 295 579,51	2 172 968,45	124 265,73	-	- 1 654,67
Total	44 416 927,24	40 997 528,71	3 396 660,54	24 652,14	- 1 914,15

Project cost by components (USD)

Component	Plan	Fact	Deviation
Component 1. Performance Based Financing	19 186 630,01	18 501 617,36	685 012,65
Component 2: Primary Health Care Strengthening	19 550 429,77	19 762 684,63	-212 254,86
Subcomponent 2.1. Quality Improvement	3 439 578,74	3 228 913,40	210 665,34
Subcomponent 2.2 PHC Infrastructure Improvement	16 110 851,03	16 533 771,23	-422 920,20
Component 3. Project Management, Coordination, Monitoring & Evaluation	7 067 792,84	6 154 773,90	913 018,94
Exchange difference	0,00	-2 148,65	
Total	45 804 852,62	44 416 927,24	1 385 776,73

Annex. 7 Number of beneficiaries trained

#	Type of training	Men	Women	Total
1.	PBF Principles and Mechanism Training	2183	4191	6374
2.	Computer Literacy	408	513	921
3.	PBF Management Informational System Training (PBF MIS)	495	973	1468
4.	Six-month Family Medicine Re-Training for the health staff in PBF pilot districts	260	638	898
5.	PHC Management training for the heads of PHC network of 16 pilot districts	14	2	16
6.	Training for the RHCs and HHs staff in pilot districts in the form of Continuous Medical Education	1324	2314	3638
7.	Special Postgraduate Training for Family Medicine Specialists (USO)	95	141	236

8.	Laboratory training	207	108	315
	Total	4986	8880	13866

Annex 8: Gender distribution

Indicators	Total	Men		Women	
		Number	%	Number	%
Number of trainees	13866	4986	36%	8880	64%
The number of employees of companies providing services and goods under the Project	629	533	85%	96	15%
Number of Project staff	39	27	69%	12	31%
Number of beneficiaries (population)	2 181 252	1 105 092	51%	1 076 160	49%

Annex 9: Explanatory Note on Indicator

Explanatory Note on Indicator: "Number of Children Aged 0-24 Months Whose Weight and Height Are Tracked According to the Recommended Schedule"

Context and identified problem

In the process of analyzing the results for this indicator, there was a need to clarify the data. The final report provides a separate description of indicators for **existing and new pilot areas**:

- *Diagram No2 on page 22* – data for existing pilot districts.
- *Diagram No13 on page 27* — data for new pilot districts.

Despite the correct separate presentation of data, the total amount of services provided for this indicator for the entire period **2017–2022** was not aggregated in the main text. As a result, there was an impression of fragmentation of data, which could affect the perception of the scale of the results achieved.

Data analysis and interpretation

For this indicator, which assesses the monitoring of the weight and height of children aged 0-24 months with the provision of counseling to parents, the total number of services provided is **1,596,653**. This indicator includes services in **existing pilot districts** as well as **in new ones**.

The main challenge was that the data for the new and existing pilot areas were presented separately, and the report did not include an aggregate value on the initial reading. However, summing up the data from **Chart No2 (page 22)** and **Chart No13 (page 27)** confirms the correctness of the total value of **1,596,653 services**.

Inference

This note is attached to ensure transparency and to confirm the correctness of the data presented in the report. The aggregate value of **1,596,653 services** is the final result of the work on this indicator for the entire period **2017-2022**, including both existing and new pilot districts.

Explanatory Note on Change in Vaccination Target

Context and description

In the process of analyzing the results of the vaccination indicator, a discrepancy in the target indicators was revealed:

1. For the **last year of the project (2022)**, the target was set at **262,256 services**.
2. For the **entire project period**, the final target was **271,695 services**.

This discrepancy created a difference in the perception of the implementation of the plan:

- **In 2022**, the project successfully exceeded the annual target by **321 services** (262,577 services **were actually provided**).
- However, despite the success in the last year, **the final target of the project** was not achieved: **9,118 services were missing** (the total number of services provided during the project period was **262,577** against the target value of **271,695**).

Analysis and explanation of the discrepancy

The target of **262,256 services** was set exclusively for the **last year** of the project and reflected the expected workload for that period. At the same time, **the total of 271,695 services** represented the total target result that the project had to achieve over the entire period of its implementation. Thus, in practice, the project faced two different targets:

- **The annual target for 2022** (262,256 services) was met and exceeded by **321 services**.
- **The final target** (271,695 services) was not reached: **9,118 services** were missing.

Impact of the 2021 restructuring

The restructuring carried out in 2021 did not include changes in target values for either the annual or the final indicator. This confirms that the discrepancy between the annual and final targets is not the result of restructuring, but is due to different approaches to setting goals for individual periods and the project as a whole.

Conclusion

Despite the project fell short **of the final target** of 9,118 services, **the annual target for 2022 was exceeded by 321 services**, which is a positive result. This demonstrates that the project has shown strong results in its last year, although it has not reached the overall target for the entire implementation period.