MINISTRY OF HEALTH
OF THE REPUBLIC OF TAJIKISTAN

National Health Strategy of the Republic of Tajikistan 2010-2020

Dushanbe-2010

Approved by Government
Resolution of RT
as of 02.08.2010, #368

National Health Strategy of the Republic of Tajikistan 2010-2020

Ҳукумати Ҷумҳурии Тоҷикистон
ҚАРОР
Правительство Республики Таджикистан
ПОСТАНОВЛЕНИЕ

аз 2 августи соли 2010 № 368
ш. Душанбе

Дар бораи тасдиқи Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020

Мутобиқи моддаи 6[1] Қонуни Ҷумҳурии Тоҷикистон «Дар бораи дурнамоҳои давлатӣ, консепсияҳо, стратегияҳо ва барномаҳои инкишофи иҷтимоию иқтисодии Ҷумҳурии Тоҷикистон», бо мақсади муайян намудани дурнамои рушди соҳаи тандурустӣ ва таъмини солимии аҳолӣ Ҳукумати Ҷумҳурии Тоҷикистон қ а р о р м е к у н а д:

1) Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020 тасдиқ карда шавад (замима мегардад);

2) Вазорати тандурустии Ҷумҳурии Тоҷикистон:

а) Нақшаи татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020»-ро барои солҳои 2010-2013 тасдиқ намояд;

б) якҷоя бо дигар вазорату идораҳои дахлдор, мақомоти иҷроияи маҳаллии ҳокимияти давлатии Вилояти Мухтори Кӯҳистони Бадахшон, вилоятҳо, шаҳри Душанбе ва шаҳру ноҳияҳо амалисозии Стратегияи мазкурро таъмин намояд.

3) Шӯрои миллии тандурустии назди Ҳукумати Ҷумҳурии Тоҷикистон ҳамоҳангсозӣ ва дастгирии техникии амалисозии Стратегияи мазкурро таъмин намояд.

4) Вазорати тандурустии Ҷумҳурии Тоҷикистон дар бораи натиҷаҳои амалисозии Стратегияи мазкур ба Ҳукумати Ҷумҳурии Тоҷикистон ҳар сол то 15 декабр маълумот пешниҳод намояд.

Раиси
Ҳукумати Ҷумҳурии
Тоҷикистон — Эмомалӣ Раҳмон

Government of the Republic of Tajikistan
DECREE

From 2nd august 2010 № 368 Dushanbe

On approval of National health strategy of the Republic of Tajikistan for period of 2010-2020

In accordance with Article 61 of the Law of the Republic Tajikistan «On state projections, concepts, strategies and programs for socio-economic development of the Republic of Tajikistan» in order to determine strategies for health development and ensuring public health, The Government of the Republic of Tajikistan decides:

1) Approve National health strategy of the Republic of Tajikistan for period 2010-2020 (attached);

2) To the Minister of health of the Republic of Tajikistan;

a) To approve the implementation plan of «National health strategy of the Republic of Tajikistan for period of2010-2020» for period of 2010-2013;

b) together with other involved ministries and departments, local executive authorities of Mountainous Badakhshan Autonomous Region, regions, the city of Dushanbe, towns and districts to ensure implementation of this Strategy;

3) National Board of Health under the Government of the Republic of Tajikistan to provide coordination and technical support for the implementation of this Strategy;

4) Ministry of Health of the Republic of Tajikistan to provide information ro the Government of the Republic of Tajikistan on the implementation of this Strategy annually before 15 December.

Chairman of the Government
of the Republic of Tajikistan — Emomali Rahmon

ВАЗОРАТИ ТАНДУРУСТИИ ҶУМҲУРИИ ТОҶИКИСТОН

734025, ш.Душанбе, к.Шевченко, 69, тел. (372) 221-18-35, факс (372) 2217525

ФАРМОИШ

аз «21» 08 соли 2010 № 494 ш. Душанбе

Оиди тасдиқи Нақшаи татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020» барои солҳои 2010-2013

Бо мақсади иҷрои банди 2 қарори Ҳукумати Ҷумҳурии Тоҷикистон аз 2 августи соли 2010 № 368 «Дар бораи тасдиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020»

Фармоиш медиҳам:

1) Нақшаи татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020» барои солҳои 2010-2013 тасдиқ карда шавад (замимаи № 1).
2) Матритсаи мониторинг ва баҳодиҳии татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020» тасдиқ карда шавад (замимаи № 2).
3) Муовини аввал ва муовинони вазир, сардорони раёсатҳо ва шӯъбаҳои дастгоҳи марказии Вазорати тандурустии Ҷумҳурии Тоҷикистон, сардорони раёсатҳои тандурустии мақомоти маҳаллии ҳокимияти давлатии ВМКБ, вилоятҳои Хатлону Суғд ва ш.Душанбе (Алиёрова П., Бузмаков Ш.М.,Тошматов Д.Х.,Темуров А.А.), сардорони шӯъба ва мудирони бахшҳои тандурустии мақомоти иҷроияи маҳаллии ҳокимияти давлатии шаҳру ноҳияҳои тобеи ҷумҳурӣ, роҳбарони муассисаҳои табобатию профилактикии ҷумҳуриявӣ ва муассисаҳои илмию таълимӣ Нақшаи татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020» барои солҳои 2010-2013 (замимаи 1) ва Матритсаи мониторинг ва баҳодиҳии татбиқи «Стратегияи миллии солимии аҳолии Ҷумҳурии Тоҷикистон барои солҳои 2010-2020»-ро ба роҳбарӣ гирифта, иҷроиши онҳоро таъмин намоянд.
4) Назорати иҷроиши фармоиши мазкурро ба зиммаи худ мегирам

Вазир **Н. Салимов**

Ministry of Health of the Republic of Tajikistan
ORDER

From 21.08.2010 № 494 Dushanbe city

On approval of the action plan for implementation «National Health Strategy of the Republic of Tajikistan for 2010-2020» for 2010-2020»

In order to implement paragraph 2 of the Government's decision of the Republic of Tajikistan on August 2,2010 № 368 «On approval of the» National Health Strategy of the Republic of Tajikistan for 2010-2020 «

I Order:

1) Approve implementation project of «National Health Strategy of the Republic of Tajikistan for 2010-2020» for 2010-2020 (attachment # 1).
2) Approve monitoring matrix and assessment implementation of «National Health Strategy of the Republic of Tajikistan for 2010-2020» (attachment #2)
3) The first deputy and deputy ministers, heads of departments and divisions of the central office of the Ministry of Health of the Republic of Tajikistan, the heads ofhealth departments of local executive authorities of Badakhshan, Khatlon andSughd and Dushanbe (Alierova P. Buzmakov Sh.M., Toshmatov D Kh., Timur AA), heads of department and heads of health departments of local executive authorities of cities and districts of republican subordination, heads of medical establishments and scientific-educational institutions of national rehabilitation and treatment agencies, as well as scientific and educational departments make their priority, implement and provide the implementation plan, « National Health Strategy of the Republic of Tajikistan for 2010-2020.» (Appendix № 1) and monitoring matrix and evaluation of implementation of the « National Health Strategy of the Republic of Tajikistan for 2010-2020.»
4) Consolidate control over the execution of the instructions to myself.

Minister N. Salimov

Coordinating Board for development of NHS of RT – N.F. Salimov (Chairman), S.Dzh. Mirsaburova, Dzh.R.Sanginov, S. Severoni, A. A. Akhmadov, G.I. Boboeva, M. M. Boboeva, K. Dean, A. M. Zoirov, S. Kurbanov, U. A. Kurbanov, B. Leverengton, E. Litman, S. Mamadyusupova, I. Miritesku, R. Mirzoyeva, Sh.Nodirova, N. Obidzhanova, N. Rakhimova, M. S. Rustamova, A.K. Saidov, U. Saleban, R. Ulmasov, N. Khasanova, A. Khojiev, R. Schoch, P. Schneider

Steering Group - M. S. Rustamova, S. Delancy, B. Mativet, A. Telyukov, G. Cherniyauskas. .

Secretariat - Z. Abdualimova, T. Ansori, Dzh.Dehkonov, S. Muminov, G. Radjabova, T. Rozikova, D.N. Sadykova

Development Partners – N.P. Artikova, Z. Akhmedova, M. Jamalova, Dzh.Kosta, V. Kolchin, L. Kurbonmamadova, M. Mahkambaeva, G. Mukhammadieva, F. Mukhamedzhanova A.Saparbekov, E. Toteva, Dzh.Hasanov

Technical Working Group and Subgroups on Health Management– S.R. Saifuddinov, S. R. Miraliyev, Z.I. Nazarova, K. Baelkin, F. Gouraud, R. M. Makhmudov, L.S. Rajabov, A. Safarov, G. Safarova, I. Sh. Sheraliyev

Technical Working Group and Subgroups on Finance – S.A. Khafizov, A. Jafarov, G.T. Bobokalonova, S. Abdujaborov, M. Ghoibov, O. Goloshapova, A. Nurov, F.K. Eghamov, M. Sheridan, Sh. d`Otirti, N. Batoni

Technical Working Group and Subgroups on Health Resource Raising - S.Dzh.Isupov, S. Nazlioglu, Dzh.Malborg, N. Sautenkova, Z. Nazhmudinova, S. H. Abdulazizov, Sh. S. Ashurova, M. Davlatov, N. Jamshedov, N. Dilshodov, H. I. Ibodov, M.A. Kamolova, Hakimi Kuwwat, S.S. Kurbanov, A. Marupov, A.M. Murodov, H. Razkavi, B. Kholnazarov

Technical Working Group and Subgroups on Service Delivery – O.I. Bobohodzhaev, J. Bandaev, G. Gottsadze, S. Evud, N. Turaev, Z. Abdurakhmonova, G.Dzh.Azimov, A.V. Vohidov, S.H. Davlatov, T.S. Dzhabborova, N. Jafarov, K.N. Dubarov, K. I. Ismailov, Sh. M. Kurbanov, D.D. Pirov, Sh.R. Rahmatulloev, U.Dzh.Uzokova, J. S. Hairov, G.M. Hodzhimorodov

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AS PRT	Agency for Statistics under the President of the Republic of Tajikistan
ART	Antiretroviral Therapy
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
GBAO	Gorno Badakhshan Autonomous Oblast
VHI	Voluntary Health Insurance
PRSP	Poverty Reduction Strategy Paper
DOTS	Directly Observed Treatment Short Course
EEC	Eurasian Economic Community
EBR WHO	Regional Office for Europe of the WHO
RO	Registry offices/Bodies registrar of civil status
IMCI	Integrated Management of Childhood Illness
STI	Sexually Transmitted Infections
HIS	Health Information System
HF	Health facility
MoH of RT	Ministry of Health of the Republic of Tajikistan
ICD-10	International Statistical Classification of Diseases and Related Health-X review
MoF of RT	Ministry of Finance of the Republic of Tajikistan
NGO	Non-governmental organization
NDS	National Development Strategy of the Republic of Tajikistan for the period up to 2015
NHA	National Health Accounts
NHS RT	National Health Strategy of the Republic of Tajikistan for the period 2010-2020
HPAU	Health Policy Analysis Unit
MHI	Mandatory Health Insurance
UN	United Nations
OPV	Oral polio(myelitis) vaccine
ARI	Acute respiratory infection
RHA	Regional Health Authority
RFO	Regional Finance Office
SGP	State Guarantees Program
PHC	Primary Health Care

UNDP	United Nations Development Programme
DHD	District Health Department
RRS	Rayons of Republican Subordination
RT	Republic of Tajikistan
DHC	District Health Centre
SRN	Sanitary rules and norms
CIS	Commonwealth of Independent States
Media	Mass Media
EDL	Essential Drugs List
MTEF	Medium-Term Expenditure Framework
AIDS	Acquired Immune Deficiency Syndrome
RHC	Rural Health Center
USA	United States of America
SES	Sanitary - Epidemiological Service
TB	Tuberculosis
TSMU	Tajik State Medical University named after Abu Ali ibn Sina
TSPU	Tajik State Pedagogical University
TPGMI	Tajik Postgraduate Medical Institute
HLC	Healthy Lifestyle Center
CCH	City Central Hospital
DCH	District Central Hospital
RHC	Reproductive Health Center
MDGs	Millennium Development Goals
SDC	Swiss Agency for Development and Cooperation
SWAp	Sector Wide Approach
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
DHIS2	Computer software for collection of health information at district level

GLOSSARY

Advocacy - a sequential and adaptive process of gathering information, its organization and formulation in form of arguments that are sent through different channels of interpersonal communication and mass media in order to mobilize resources and support a development program by political and community leaders, which in turn will contribute to adoption of this program by the society.

ART - treatment, slowing the reproduction of human immunodeficiency virus, that allows for a long time to extend the life of HIV positive, as well as delaying the development of AIDS.

Accumulation of funds - this is the level of the health budget consolidation (national, provincial, city or district).

Public servant - a citizen of the Republic of Tajikistan, occupying a paid professional position in a civil service to ensure the exercise of the powers of persons holding public office of the government and the implementation of the competence of state bodies.

Citizen – according to the constitutional right, a person belonging on a legal basis to the specific state.

Clustering of cases - a set of criteria and the process of distribution of hospital cases in the clinical groups with similar clinical characteristics and intensity of resources

Community activities on health care - joint actions aimed at strengthening public control over health determinants, thereby strengthening it.

Health determinants - a complex of individual, social, economic and environmental factors, determining a health status of individuals and contingents, or groups of population

Jamoat - administrative division, consisting of the villages and headed by a chairman, who is chosen\elected at a general meeting of delegated representatives of villages

Life skills - personal, social, cognitive and physical skills and abilities of man, through which people control and direct their lives and develop their abilities, allowing them to modify the environment and adapt themselves to its changes

Health care - a system of public and state socio-economic and medical measures to ensure a high level of protection and improvement of public health

Health - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Healthy lifestyle - typical for the socio-economic structure forms, types, ways of human life, strengthening its adaptive capacity of the body that promote full implementation of their social functions and achieve active longevity

Communication for behavior change - this is science-based consultative process, which includes knowledge, perceptions and practices by identifying, analyzing and segmenting audiences and program participants and providing them with information and motivation throughout implementation of a clearly defined strategy and use the right mix of channels of interpersonal and group communication and media, including interactive methods.

Mentality, a mentality – pattern of thoughts, a set of mental skills, mental attitudes and cultural traditions inherent to the individual or the human community

Intersectoral actions – actions or activities due to which the cooperation of the health sector and other related sectors can achieve a common purpose, with the precise coordinated contributions of different sectors

Intersectoral collaboration means generally accepted relationship between part or parts of different layers and sectors of society, which is set for actions.

Migrant - a person performing inter-settlement territorial movement in order to change domicile, work, study, recreation, etc., either permanently or for a certain period (from 1 day to several years).

Lifestyle - a set of specific approaches for each person to use the resources and opportunities presented to him by the social conditions, traditions, and education and market relations.

Public health - the science and art of preventing disease, continuation of life and guaranteeing health through the organized efforts of society

Community - a certain group of people, often living in a certain geographic area, sharing common values, norms and cultural differences, united in one social structure, depending on connections and relationships formed in this contingent of the population in the community for some period of time.

Payment per case - pay for the actual amount of care provided

The state guarantees program - defines the types, scope and conditions of health care delivery in public health facilities free of charge and under the co-payment (participation of the population).

Primary health care (PHC) - is a key element of the health system of any country, the main service delivery of health care, built on the principle «from the periphery to the center.» PHC is an integral part of social and economic development of any country.

Purchaser of medical services – subject/party transferring accumulated health resources to providers as payment for services to specific group.

Health policy - the official, formal statement or procedure within institutions (notably government) that allows identifying priority activities and options to respond to health needs, available resources and other forms of political pressure.

Health service providers - entities providing health care services

Per capita funding - budgeting on a per capita basis according to the formula that comes from the three parameters: the district health budget, the number of the district's population and sex/age ratio

Prevention - actions aimed at reducing the likelihood of a disease or disorder, to interrupt or delay progression of disease, to preserve the ability to work.

Disease prevention - measures aimed not only to prevent disease, such as immunization, vector control or a company to control smoking, but the fact that in order to curb its development and reduce its effects after the determination of the disease.

Seasonal migration - movement of mainly working-age population to places of temporary work (harvesting, construction, etc.) and residence for time, usually several months, while preserving the ability to return to their places of permanent residence.

The health sector - consists of organized government, public and private health services (including health promotion, disease prevention, diagnostics, and treatment and care services), policy areas and activities of health departments / offices and ministry, health-related nongovernmental organizations, groups of community-based nature or level, as well as professional associations.

Family doctor - a specialist with higher medical education, who has a legal right to provide multi-disciplinary primary, continuous health care to the public or to individuals and families, regardless of age, gender and type of disease.

Social marketing - marketing, consisting in development, implementation and monitoring of social programs aimed at improving the perception of certain segments of the public of certain social ideas, movements, or actions. Typically, social marketing is used by state and public organizations.

Social mobilization - the process of combining all the potential partners and allies, representing both public and private organizations, in order to identify the tangible needs of the specific development target, bringing attention to it and increasing demand. Social mobilization involves ensuring the participation of these partners, including organizations, groups, networks and the public in identifying human and material resources, their mobilization and management, which, in turn, will strengthen the reach and promote their sustainable development.

Strategy - designed for long-term prospect, comprehensive type of activity, within which the individual events and activities are being implemented.

Labor migration (migration of the workforce) – working population's inter-settlement movements, having, as a rule, a return character after retirement/completion of work

Health promotion - a process that enables people to increase control over their health and improve it

Risk factors - factors of external and internal environment of the organism, and behavioral characteristics that contribute to increased likelihood of developing diseases, their progression and adverse outcome.

Funding - source of funding for undertaking certain activities.

Promoting a healthy lifestyle - a complex problem that requires a comprehensive approach to the study of lifestyle and health of the population, along with attention of health workers, teachers, psychologists, and depends on the specifics of macro social man's surroundings, labor, social and preventive activity.

INTRODUCTION

The National Health Strategy of the Republic of Tajikistan, henceforth referred to as the "Strategy" provides a summary statement of this nation's long-term goals in protecting the health of its people, as well as the means for achieving those goals, namely, the strategies, programs, and health sector modernization resources.

The Strategy articulates the will and interests of the sovereign Tajikistan in the field of health care. It is a vehicle for long-term planning which elaborates the future vision of this nation's leadership into a comprehensive set of planning benchmarks and evidence-based approaches. The Strategy summarizes the opinions and perspectives of the central government agencies, regional administrations, and local authorities, as well as the health care providers and the general population of Tajikistan.

The Strategy covers the decade 2010-2020. It is the tool that supports continuity and coordination. It is integral to the national policy of socio-economic development. This Strategy builds upon its predecessor 'National Health Strategy until the Year 2010', and is consistent with other national Strategies, such as the National Development Strategy of RT for the period until 2015 and the Poverty Reduction Strategy. It also guides health sector strategies relating to specific health sector systems and health care areas.

This Strategy has been designed in a collaboration of the leading experts of the Republic of Tajikistan with a corps of international advisers who represent advanced experience of systems planning in health. The Strategy is intended to facilitate the coordination of national and international plans to support the health care sector of Tajikistan. Without forgoing the national priorities of Tajikistan, the Strategy is aligned with global health goals and international best-practice approaches.

Over the last decade the Republic of Tajikistan has begun to modernize its resources, clinical base, financing system as well as the organization of health care and services. Due to economic growth and the country's leaders' constant attention to the prioritized tasks for social development and efficient support from the donor community's side there has been a positive impact on health sector development.

As a result of the last decade's efforts maternal and child mortality has decreased. There was also a decrease in the morbidity of communicable diseases, in particular vaccine-preventable diseases. Up-to-date clinical protocols and other standard routines of medical care are being developed and implemented.

Developments in delivery of health care to the population have taken a strategic turn towards an integrated Primary Health Care model based on Family Medicine. Training of family doctors and nurses has become a priority in undergraduate, postgraduate, and continuing medical education programs for health professionals. Important steps have been taken towards structural optimization of the health care and services facilities network, including reduction of under-utilized bed space capacity. The supervision of medical and pharmaceutical performance has been strengthened.

The health financing system has passed the lowest point reached during the last 20 years and has returned to a trajectory of sustainable growth. Step-by-step increases of healthcare workers' salaries during the last three years reflect the State's commitment to restore their material wellbeing as well as their professional and social status. The growth of salaries was complemented by the piloting of modern financing methods. It is generally agreed that in order to improve the quality and efficiency of health care services there needs to be a review of salaries and other financial incentives for medical workers. The orientation of health financing towards social equity is being strengthened: The Basic Benefits Package (BBP), even though it was implemented with limited resources, has increased the access to free-of-charge and co-payment medical services for vulnerable families and people in need of more expensive health care.

Continuous work on updating the health legislative framework has created the prerequisites for a continuation of reforms.

Despite success over the last decade, the health care system is still facing a number of problems that were inherited since the Soviet and transitions periods. These include:

- obsolete infrastructure and equipment and lack of investment for its timely modernization;
- uncompleted reforms in the system of doctors' and nurses' education;
- never-ending brain drain from the health sector in relation to labor migration out of Tajikistan;
- inadequate/imperfect methods and standards in the pharmaceutical supply;
- delay in the introduction of international best practice and methods for diagnosis and treatment of common diseases;
- absence of up-to-date systems of standards and quality assurance of medical care.

Health economics is not at a high level of funding. In 2009 the level of total health spending as percent of GDP amounted to 1.9%, which is significantly less than in 1991 (4.5%). This level of financing is not capable of handling the burden of problems that have accumulated over the last two decades. According to some estimates more than 70% of the country's total health spending comes from patients' out-of-pocket payments, with only some 16% from public spending and approximately 14% from Donors' contributions[1]. The patients' payments are mainly informal and therefore difficult to control. Vulnerable citizens of Tajikistan are not protected from overwhelming financial burdens in case of serious ailment. The level of payment is weakly linked with the quality of provided care. The informal patients' payments increase the incomes of medical staff, while other running costs and capital investments do not benefit at all. The structural imbalance between public spending in health is reflected in the inequitable allocation of funds throughout the regions of the country and the irregular levels of care. Healthcare workers lack material and professional incentives to perform their duties in a qualitative way in the interests of the patients.

The effectiveness of the health care and services system suffers from the predominance of services provided by out-patient specialists and hospital care instead of general/family doctors and paramedical staff.

A number of important types of institutions which would decrease the number of episodes of hospitalization and bed days are lacking.

- day care facilities;
- centers for out-patient surgery;
- nursing homes;
- services for home-based care and other services for socio-medical and rehabilitation support.

The sanitary-epidemiological wellbeing of the population highly depends on the activities and services of health institutions. Furthermore, there is no inter-sectoral cooperation required for the reduction of environmental and social health risks.

The communities, including individual families, are not utilized fully as an independent tool for the prevention, early identification, and appropriate treatment of ailments.

Rehabilitation of chronically ill patients and the disabled is an important factor for reducing the burden of diseases, but is not yet part of a system of prevention and treatment.

The above-mentioned problems, in combination with the poor socio-economic situation of large groups of the population, are obstacles for dynamic development. They are also the source of a large number of unjustified low health indicators, including life expectancy, maternal, infant and child mortality, morbidity of tuberculosis and HIV/AIDS.

Accordingly, the Government of Tajikistan has focused on providing efficient and effective social services to the poor, the rationalization of social sector spending to ensure equitable access to health services. In this respect, the UN Declaration «Achieving Millennium Development Goals by 2015.» was adopted. In particular, the health-related goal include the following targets:

- reduce by two-thirds the under-five mortality rate;
- reduce by three-quarters the maternal mortality ratio;
- have halted and begun to reverse the incidence of HIV / AIDS;

1. National Development Strategy of the Republic of Tajikistan for the period up to 2015

- have halted and begun to reverse the incidence of malaria and other major diseases..

The ideas contained in the above-mentioned policy documents are the basis for the health sector programs within the framework of the Poverty Reduction Strategy and the Health Reform Concept.

A reform model for the medical services provision includes improving access by restructuring and integrating the delivery of health care, improving the management of institutions of both levels of health care provision (PHC, hospital services and public health), the qualitative development of primary health care based on family practice model, streamlining the structure of hospital beds and hospital facilities, strengthening human resource capacity of PHC facilities, hospital services and public health, upgrading infrastructure, improvement of drug supply, changes in payroll system for health service providers differentiated at the PHC and hospital levels on per capita basis and for treated case, respectively; the introduction of scientific advances and new methods of prevention, diagnosis and treatment applying high-technology, community participation in addressing health issues, rehabilitation of sick and disabled, the organization of palliative care, improving information management base and other interventions.

This Strategy for the next decade will build upon the achievements of the previous period and aim for the efficient solution of these accumulated problems.

The goal of the Strategy is to improve the population's health and to create a healthier living environment.

The following priorities are set for the strategies successful implementation:

- health System Reform - strengthening and modernizing of the system of governance in order to create a results oriented, socially accepted, sustainable, transparent, accountable, equitable and accessible health care sector for the people of Tajikistan;
- improvement of the accessibility, quality, and efficiency of health services; and,
- development of the health system resources.

The Strategy's successful implementation will depend upon developing a comprehensive approach to resources, systems, and results of management in the health care and services sector. The systems management logic suggests that resources feed into systems, and systems function to produce results. In the strategic planning context, both the systems and the resources work for the results. Thus, it is the prediction of results – the goal setting – that stands at the helm of strategic thinking and forms the foundation of this Strategy. Consistent with this conceptual interplay, the target state of the health care and services sector of Tajikistan and pathways for transition are elaborated at three levels:

1. Results: reduction of health risks and morbidity rates for key conditions, life stages, and population groups;

2. Systems:

a) the strengthening of governance and day-to-day administration in the health care and services sector;

b) introduction of modern care and services delivery models;

c) improvement of quality controls and incentives for increased quality of medical care and services;

d) licensing and attestation of health care and services workforce;

e) accreditation of health care, medical (pharmaceutical) education and services facilities; and

f) assurance of equitable access to health sector resources.

3. Resources:

a) modernized physical conditions of health facilities and technology in health;

b) strengthened supply of state-of-the-art vaccines, pharmaceuticals, and other health commodities;

c) increased workforce output from updated programs of basic and continuing education and implementation of evidence based approaches;

d) steady inflow and efficient use of health financing resources.

All three tiers and their components are equally important and command priority attention in this Strategy. In this sense, the setting of priorities is not so much a quantitative but qualitative approach to implementation. These approaches will be step-by-step reflected in the Action Plan.

The all-encompassing priority for the ten years is to ensure a system-wide and comprehensive improvement in health sector performance. This will be achieved through a coordinated management of health care systems modernization, based on rational design, efficient use, and better resourcing. Consistent with this approach, a results-oriented, system-complete, and well-resourced health care sector of the Republic of Tajikistan will become the hallmark of the Strategy's successful implementation.

1. EXPECTED HEALTH RESULTS

Strengthened performance of the health care sector will manifest itself in a reduced disease burden on the economy and the society of Tajikistan. Disease patterns will improve primarily in areas where the burden of disease is substantial and can be reduced within the nation's economic means.

As an overall outcome of the Strategy's implementation, the aggregate morbidity rate will decline by 30%, and Tajikistan will reach the WHO/Euro B sub-regional average[2]. By referencing this Strategy to the sub-region's health status indicators, Tajikistan sets strong incentives for reducing the nation's morbidity in a perspective of 10 to 15 years.

§ 1. Strengthening Maternal, Newborn, Child and Adolescent Health.

Strengthening the health of mother, newborn, child, and youth will provide an inestimable contribution to the reduction of losses due to the burden of disease in the Republic of Tajikistan.

Through implementation of the Strategy, the antenatal, childbirth, neonatal care, as well as prevention and treatment of most common childhood diseases will be delivered by qualified providers, guaranteed free of charge to all the women, newborns and children regardless of their income status and place of residence. This will be ensured within the framework of the Basic Benefits Package (BBP).

A summary of achievements will be the:

- targeted free care entitlements;
- strengthened competencies of, and incentives for, family practitioners;
- improved transportation networks support of rural providers;
- improved diagnostic and curative capacity of rayon-level health care facilities; and
- modernized obstetric/gynecological and neonatal beds in rayon and city hospitals.

In line with the Millennium Development Goals the share of women who enter pregnancy without STIs, iron-deficiency anemia, and with 3-year intervals between pregnancies will grow substantially. Maternal mortality will decrease to 30 cases per 100,000 live births in 2015 and to 25 cases in 2020, compared to 2010 year level.

The share of newborns with low body mass (<2.500g) will decline to 8% in 2015 and 5% in 2020. Neonatal mortality (in the first 28 days of life) will be reduced by 50 percent, from 52 to 26 cases per 1,000 live births.

2. The Euro B sub-region comprises 16 countries of Europe and Central Asia with the total population of 160 million people. Most of the countries, included in this statistical aggregate, are ahead of Tajikistan by their levels of economic development.

Comprehensive pre-pregnancy, antenatal, and childbirth care and support is a health systems-wide response of the health care sector of Tajikistan to prenatal morbidity and mortality. This care model implies a holistic approach to the reproductive health of a girl and a woman from adolescence and throughout the reproductive age.

The on-going effort to educate teenagers, newlywed couples, and parents in the matters of reproductive health and family planning, safe motherhood, STIs, HIV/AIDs will become the centerpiece of health education programs managed in schools, communities, and PHC provider facilities.

Improved access to quality services for family planning will be achieved through managing contraceptive resources supply, and strengthening the role of service providers.

In the next ten years, special attention will be drawn to HIV prevention among most at-risk and vulnerable groups of the population by means of large-scale public campaigns, testing of HIV reproductive health counseling of HIV-positive women and men on reproductive health, as well as men and women living with AIDS; and prevention of mother-to-child transmission[3]. The use of Youth Friendly Services will be broadened.

The percent coverage of pregnant women with prophylactic check-ups at the primary care level will increase to match the WHO recommendations[4].

Antenatal outreach care will play an important role in remote rural areas where it will partially substitute for the facility-based visits.

Antenatal care will become more effective thanks to its increased focus on dynamic monitoring of the expectant mother's health and fetal development; an in-depth risk assessment; more accurate lab diagnostics; and expansion of the antenatal monitoring of the cardio-vascular system, respiratory tract, and nutritional status of mother and fetus. Strengthened qualifications of antenatal care providers and the family medicine physicians, improved supply of with vaccines, drugs, and nutritional supplements will provide for a modernized all-around approach to health care and support for pregnant women.

As a matter of national priority, neonatal care will be strengthened over the next decade: number of neonatal beds will increase, will be allocated more evenly across the country, and will be properly equipped to ensure vital care for newborns over the first seven days of their lives.

Concurrent implementation of the above outlined measures will result in three-fourths of pregnant women receiving a comprehensive and adequate set of antenatal care in 2020. Along with the core set of clinical services, antenatal care will be expanded to include psychosocial and legal support, dynamic monitoring of physical indexes, voluntary HIV/AIDS testing and anti-retroviral treatment; diagnostics and treatment of other STIs; fetus monitoring; immunization against maternal tetanus; administration of antihelminthic medication, micronutrients and iron supplements; and in cases of severe malnutrition (BMI<18.5) protein-calorie support [5].

An increased percentage of childbirth in maternity facilities accredited according to national standards of material and technical outfitting and staffing is among the key programmatic goals of this Strategy. In 2020, at least 90% of deliveries will be supported with qualified inpatient obstetric care, compared to 75 percent in 2009 [6].

In Tajikistan facility-based obstetric care will be provided at the following three levels:

- normal deliveries will be managed in rural health centers and obstetric departments of local hospitals (or local maternities);

- moderately-complicated deliveries will be managed in maternity wards of central rayon and urban hospitals;

3. Prevention of Mother-to-Child Transmission of HIV: Generic Training Package – Draft Trainer Manual. WHO/CDC/U.S. DHHS: January 2008: 522 pp.; Health Services Delivery for Maternal, Newborn, and Chile Health and Nutrition in Tajikistan, September 2009: 27-28

4. Essential Antenatal, Perinatal and Postpartum Care. Training Modules. WHO: Regional Office for Europe, 2002: 392 pp.: p.21

5. Health Services Delivery for Maternal, Newborn, and Chile Health and Nutrition in Tajikistan, September 2009

6. The Living Standards Measurement Survey, 2007: Indicators at a Glance. 2009, 83 pp.: 51.

- planned and emergency admission of women on specialty obstetrics and gynecology beds of general hospitals and second-level maternities will be managed by triage-based decisions with proper account of the maternal health risks, congenital pathology, and acute conditions at birth.

Access to the three levels of obstetric care should be regulated by revised referral norms to be developed and implemented over the period up until 2015. General standards for the three levels of care, including pharmaceuticals and other means of medical care, will be defined.

Since a sizeable share of the nation's population resides in rural and sparsely populated areas, up to 10% of risk-free and uncomplicated childbirths will be managed at home through mandatory home-based care of a qualified provider. Additionally, antenatal care during the second half of pregnancy will provided through home-based care.

Priority attention will be given to the support of the early start of breastfeeding and exclusive breastfeeding for the first six months of an infant's life. Breastfeeding will be encouraged as a nutritional complement until two years of age. Children of HIV-positive mothers will be provided infant formula.

Regardless of the birth management setting (be it home- or facility-based), the family, community and local authorities will become engaged in childbirth planning and facilitation, as well as post-birth support of mothers and young children. Both geographic remoteness and limited living conditions can and will be increasingly offset with carefully planned resource allocation and efficiently financed efforts of individuals and organizations to achieve a successful outcome of each pregnancy, physical and psycho-emotional recuperation of the mother, survival of her newborn, and the newborn's prompt graduation to the trajectory of normal child development.

This Strategy tasks local administrations to finance food coupons for mothers' early enrollment in pregnancy care, for each pregnancy visit to family medicine practice (within a standard number of visits) and for mother's self-referral for childbirth care to a designated provider facility. Family practitioners will be rewarded financially for positive trends in mother and child survival. Local community volunteers will be given special recognition for their community service whenever they report pregnancy and successful birth outcomes.

In the decade to come and in line with the "National Strategy on Children and Adolescence Health by 2015" the strategic focus in children's health will be shifted toward a multi-disciplinary approach and inter-sectoral coordination.

Effective prevention of childhood diseases lies primarily in parents' hands. It is pre-determined by parental supervision and control of the quality of nutrition, adequate care, competent identification of their illnesses, and prudent care seeking. Self - and mutual care in the family and community settings is viewed as a preeminent factor of caring for children and supporting their health. An important objective will be to enable ongoing support of families and communities with information, practical skills, health supplies, and psychosocial guidance for the sake of strengthening their individual and group responsibility for the health and well-being of their children. The strengthening of the family and community resources of children's health is particularly important for families with scarce means, residing in sparsely-populated rural rayons. That is where limited incomes and low education are worsened by geographic remoteness to create a 'critical mass' of socio-economic vulnerability, a precursor of poor children's health and survival rates. Impact of gender inequity will be addressed when working with women and their families.

Based on the above, the Strategy moves the concept and practice of 'community health' out of the local pilot demonstrations and into the national health reform agenda. Strengthening the community as a resource of public and personal health is a multi-prong ideology that is included in this Strategy. Yet, it is children's health that serves as a unifying idea and the main rationale for advancing community health.

The leadership of the state-governed health sector in strengthening households and communities will manifest itself in the following areas:

- health education of parents to develop their knowledge and skills in identifying the most common diseases of early childhood and remedying them with appropriate and effective response actions and also parents' skills in stimulating psychosocial development and preserving mental health in their children. Resulting from parental education (to be managed mainly by family medicine practice), 50% of families in 2015 and at least 75% of families in 2020 will be able to distinguish symptoms of respiratory infections in their children, promptly seek care, arrange home care, and complete a course of medication. Parent's ability to carry out the home-based oral rehydration therapy [7] will become the main factor of preventing children's deaths from diarrhea. In 2015, 75% of families with children of age under five years old, and by 2020, 90% of families will be trained in home-based treatment of diarrhea and provided with oral rehydration salts;

- active involvement of parents and communities when it comes to children's diseases prevention campaigns. Particularly, parental responsibility and a sense of community among related and neighboring families will be restored with respect to the timely and complete immunization of children in compliance with the National Immunization Schedule. Family practitioners will extend their health education efforts to schools, organizations, and communities in order to recruit support from businesses, government agencies, other organizations, and the entire adult population to protect children from vaccine-preventable infections;

- working with households to raise their standard of sanitation and hygiene, particularly, with respect to children's hygiene. Parents' basic literacy and their example in household matters is the most important precondition for reduction of children's mortality, prophylaxis and is the priority PHC area in this Strategy;

- working with families, schools, communities and local authorities to improve psycho-emotional status of children and teenagers, prevention and reduction of the risks and incidence of child neglect, abuse and exploitation; establishment of respectful treatment of children as personalities, changing damaging patterns of behavior and support of teenagers to find pathways to independent adult life, leadership and communication skills;

- promoting professional activism of PHC practitioners in responding to the needs of families, communities and local authorities relating to children's health and well-being will contribute to ensuring the quality of drinking water, repair sewage, functioning urban sanitation services, shutting down of dangerous pollutants, preservation of quality of vaccines and pharmaceuticals, and enforce standards of professional ethics in the provision of maternal and pediatric care.

Turning the family and the community into a stronghold of children's health care will significantly reinforce the efforts of qualified health care providers but will not substitute for those efforts. Integrated Management of Childhood Illnesses (IMCI) will provide a methodological and organizational base for the health sector of Tajikistan to advance the national children's health care agenda. A holistic management of physical and emotional health will enable an integrated and therefore more effective approach to prevention and treatment of childhood diseases along with support of the child's physical and emotional development. Under this Strategy, the integrated management of childhood illnesses will be transformed into an integral part of health care, anchored in family health practice.

The above-outlined strategic view of children's health care will guide health care providers in their daily effort of seeing children for regular check-ups, shielding them from infections, addressing malnutrition, treating them, and providing them with support at PHC level. Working in close alliance with families and communities, qualified providers of care will accomplish a reduction in infant mortality to 25 per 1,000 live births and further down to 20 in 2020. Mortality of under-five children will decrease to 38 per 1,000 live births in 2015 and to 20 in 2020.

7. The Treatment of Diarrhea: a Manual for Physicians and Other Senior Health Workers. - 4th rev., WHO: Geneva, 2006: 54 pp. (in Russian); The situation in the world of vaccines and immunization. 3rd Ed. Summary. Geneva: WHO / UNICEF / World Bank, 2009: 22 sec.: .p. 13

Priority attention will be given to developing knowledge and skills of family care practitioners, strengthening them with clinical guidelines, supplying them with pharmaceuticals, diagnostic technologies, transportation means, and cold chain equipment to enable a focus on the most widespread health risks and diseases of childhood – malnutrition, diarrhea, ARIs, and vaccine-preventable infections. Training for practitioners will include means to understand and address how social and gender inequities impact on the access to MCH services.

Priority attention will be given to supply infants and children up to 3 years with normal feeding and particularly with micro-nutrient vitamins and minerals. Exclusive breastfeeding from birth up to six months is the main strategy for infants' feeding. If a nursing mother displays symptoms of iron deficiency she will be supplied with appropriate ferrous supplements. Ferrous therapy and iodine salt will be prescribed to children from six months up to five years. Part of the acute alimentary deficiency program remains providing vitamin A for new mothers and under-five children.

Prevention and treatment of illnesses related to iodine and other micro-nutrients deficiencies among children will be one of the main tasks for the next decade, along with continuous monitoring of the implementation of the law on iodine fortified salt.

As a combined result of the above-listed measures, the prevalence of stunting will decline from 34% in 2007 [8] to 26% in 2015 and 20% in 2020. The prevalence of anemia in children below 2 years of age will decrease from 40% in 2015 and 25% in 2020. Acute malnutrition in children under five will go down to 4% and chronic malnutrition down to 30% by the end of the Strategy implementation period.

ARIs and diarrheic and parasitic diseases account for approximately 15% of the burden of disease in Tajikistan. Prevention and treatment of these conditions will be at the center of each pediatric encounter and each outreach visit to families with children under five years of age.

Following Integrated Management of Childhood Illnesses (IMCI) disease management protocols, family practitioners will attain a higher level of specificity in diagnosing ARIs and will master a differentiated approach to their treatment.

To better manage diarrheic diseases, health care providers will join in a broader program of action that will integrate disease surveillance and health education for the benefit of both communities and households. As stated earlier, the general family component in diagnosing and treating diarrhea will be accentuated. This will ensured particularly through training of adult family members to prepare and use ORS solutions. Every family medicine practice will also set a plan for acute referral to specialist care for dehydrated children. As a result of the efforts outlined in the Strategy, the incidence of diarrhea in children under 5 years will decrease by 25% in 2015 and by 50% in 2020.

The prevention and treatment of helminthes diseases, similar to other infections, will be conducted through parallel sanitary-hygiene activities. Pre-school children will be covered with a dehelminthisation/deworming program at 70% in 2015 and 90% in 2020

The previously outlined prevention and treatment strategies that target the most common childhood illnesses will be complemented with a special effort to prevent and treat HIV/AIDS. Along with children and youths being informed of the risks and mechanisms of HIV transmission, they will receive counseling and diagnostic care in order to prevent or ensure early detection of the virus. Schools and child care institutions will develop the capacity to reintegrate HIV - positive children and children living with AIDS into the learning process and extra-curricular activities. All children in the high-risk group will continue to receive HIV/AIDS voluntary counseling and testing. In the first year of Strategy implementation, definition of the children's target population group for HIV/AIDS management will be refined and their numbers verified.

In the absence of contraindications and with parental consent, first-week immunizations will be provided for all newborns. These will include conventional vaccines (OPV, Hepatitis B, BCG), as well as newer vaccines pending their inclusion in the National Immunization Schedule.

8. The 2007 Living Standards Measurement Survey, the Republic of Tajikistan: Indicators at a Glance, 2009

Aside from timely, safe, and effective immunizations, neonatal and infant health will be supported by:

- an optimal ambient temperature and air circulation in maternity wards;
- special measures to prevent hypothermia in premature birth cases;
- an active push from physicians and outreach nurses to instill the importance of personal and residential hygiene in the parents' and family members' minds.

HIV-positive newborns will be immediately treated with a post-birth dose of ARV medications. Over the first two years of the Strategy implementation, a six-month course of ARV therapy will be administered to all newborns with mother-to-child transmitted HIV.

Concurrently with the growing number of vaccines and expanded coverage rates, the entire immunization infrastructure and production string will be strengthened to ensure safe and cost-efficient vaccinations, with the longer term goal of achieving self-financing for the immunization program for procurement of vaccines, supplies, and cold chain.

System-wide improvements will be made to enable:

- rational selection of vaccines;
- price-competitive procurement;
- quality control;
- prevention of stock-outs;
- strict inventory control;
- waste minimization based on a dependable cold chain;
- strict compliance of immunization facilities with immunization safety standards;
- health care providers trained in safe immunization management and techniques, as well as in emergency care[9] to address post-immunization complications; and
- ensuring sharp waste disposal, and accurate and credible reporting of immunization activities.

Flexible management solutions will be adopted to maximize immunization coverage rates. Vaccines will be administered during pre-planned patient-provider encounters as well as regular pediatric visits; as part of the health days held in schools and children's day care institutions; as facility-based services, vaccination mobile teams and part of an outreach activity of family medicine practice.

The Government of the Republic of Tajikistan will stay in strategic partnership with the Global Alliance for Vaccines and Immunization (GAVI) as well as with other international initiatives to sustain the financing and supply of new vaccines. Health authorities and leading health care experts of this country will closely monitor the research and development in the area of safe vaccine delivery and the creation of thermo-stable vaccines [10]. State-of-the-art technologies and solutions will be integrated in the National Immunization Program of the Republic of Tajikistan.

§ 2. Prevention and Control of Infectious Diseases

In recent years the radical socio-economic and political changes in the country have called for a fundamentally new approach in addressing sanitary-epidemiological welfare of the population. This was stated in the law on "Sanitary-epidemiological safety of the population", that reflects the current process of the relationship between legislators and the population on issues relating to regulation of sanitary epidemiological safety of the population. This includes sanitary-epidemiological requirements to ensure a safe living environment for human health, modern health risk assessment, management and communication, as well as the impact of state sanitary-epidemiological standardization on health, accreditation of controlling laboratories (centers), public health expertise, toxicological, radiological and hygiene assessments.

9. Ensuring the safety of immunization. The sanitary and epidemiological rules. SP 3.3.2342-08. Resolution of the Ministry of Health of Russian Federation № 15 as of 03.03.2008. Published: http://www.chistin.ru/default.aspx?id=50. Reviewed: 17.01.2010
10. The situation in the world of vaccines and immunization. 3rd ed. Summary. Geneva: WHO / UNICEF / World Bank, 2009: 22 sec.:.pp. 12-15

The basic principles of health system work has been and will remain focused on prevention of diseases and protection and promotion of health through: transferring the focus to: preventive interventions and services at PHC level, development and practical implementation of modern population-based public health services, including surveillance and control, and monitoring of human health and all risks of the natural, living and working environment.

The priority tasks of the Strategy are to ensure safety and protection of the population's health through: reducing the incidence of viral hepatitis and infections transmitted by water; HIV/AIDS; TB; helminthiasis; malaria and other parasitic diseases and STIs; reducing mortality and disability caused by above-mentioned diseases; improving epidemiologic control for particularly hazardous diseases; strengthening of measures to prevent their import and spread in the territory of Tajikistan; providing of donor's blood safety; expanding of voluntary donorship; strengthening of epidemiological control of hospital-acquired [nosocomial] infections.

The measures to control HIV/AIDS, outlined in the above MCH section, will be also applied to the entire population of Tajikistan. The "Program on response to the epidemic of HIV/AIDS in the Republic of Tajikistan for 2007-2010" was primarily addressed to high risk and vulnerable population groups like intravenous drug users, sex workers, men having sex with men, people living with HIV, prisoners, youth, including street children and adolescents under 17, uniformed services, migrants and their families and women. The successor program, the "National HIV/AIDS Strategy Program for 2011-2015" will be based on the principles of Universal Access to Prevention, Treatment, Care, and Support and target groups will be expanded from the high risk and vulnerable, to the entire population including children.

In the next decade, special attention will be directed to the prevention and treatment of HIV/AIDS, other STIs and tuberculosis (TB) and malaria, diseases that affect the demographic and labor potential. These diseases can be reduced with effective disease management strategies with properly integrated clinical and social tools which aim at reducing associated stigma.

Wide scale and intensive prevention measures on HIV/AIDS are aimed at stabilizing the spread of infection to 6.800 cases by 2015 and in 2020 the spread should not exceed 1% from total number of population.

HIV-positive people are at higher risk of developing clinical tuberculosis compared to HIV-negative people. In order to ensure proper medical and medico-social care for people living with HIV (PLHA) and TB it is necessary to improve the coordination mechanisms between the centers for TB treatment, the HIV centers and the PHC facilities on national, oblast and district levels and timely discovery and diagnosis of HIV-infection among TB patients.

Tajikistan is in a concentrated stage of HIV/AIDS prevalence, where the injecting drug users predominate. In the framework of the current Strategy it is planned to continue preventive measures so the entire population have universal access to prevention, treatment, care, and support on HIV/AIDS. The coverage by preventive programs, voluntary consulting and testing for HIV-high risk groups (intravenous drug users, sex workers, men having sex with men, prisoners) and other vulnerable groups of population (labor migrants, their family members and youth) are the main activities in fighting HIV infection. ARV therapy of HIV positive patients will be free of charge within the entire country. Conducting ARV therapy and treatment of opportunistic diseases will be performed in close collaboration with specialized facilities in PHC, in the framework of the current Health Care Reform. Starting in 2018 the treatment of HIV/AIDS patients will be incorporated into family medicine.

Program on training and certification of clinical psychology from the students of TSMU and PGMI be developed and implemented by 2012. Clinical psychologists are trained and certified in accordance with this program with the objective to provide effective care to HIV infected patients and their families, as well as people with mental health problems and youth with risky behavior. The specialty of clinical psychologist and consultant will be entered in the register of professions.

The strategic approach of the next decade will focus on a consistent integration of the national health sector into the Global Strategy for Prevention and Control of Sexually Transmitted Infections[11] . Promotion of reproductive health will become a mainstay of social marketing in the media, will be included in school curricula, and will define the message of family practitioners to parents and children. It is particularly important that providers of care be proactive in the early detection of STIs because of their asymptomatic nature.

By 2015, the following disease and care management skills will be developed: assurance of confidentiality of patient care information; screening for STIs, using modern express tests; population involvement in healthy life style promotion; following of family life hygiene; education and consultation of adolescents on preventive measures on STI. Care for STI will be adapted to professional, family, and individual risks, considering the migration process

The human papillomavirus (HPV) of oncogenic types has been recognized by WHO as a new threat to global health. The scientific community and health practitioners of Tajikistan will closely study the global experience of vaccine-based control of this virus. Responding to the WHO initiative, the Ministry of Health will assess the applicability of HPV vaccines in the resource-constrained health care setting of Tajikistan and will identify options for prospective implementation of an HPV vaccine to immunize childhood and adolescent girls.

In coming 10 years the activities under the strategy "STOP TB"will be continued. They will focus on quality improvement of Short Course Directly Observed Therapy (DOTS); improvement of management of TB/HIV cases; improvement of integration with PHC; introduction of practice on standard approaches on managing and treating respiratory diseases; strengthening and expanding of society's involvement (local active members, religious figures, volunteers, active involvement of TB recovered patients; leader of mahalas councils, etc.);advocacy and involvement of private health care; scaling up measures on detection and treatment of resistant TB patients and organizing scientific research works for identifying effective ways of interventions introduction and further monitoring of such interventions.

The above-mentioned measures are directed towards achievement of several main indicators: by 2015, reach a treatment success rate of at least 85% from new smear positive patients and detection rate of at least 70% of TB new cases with positive smear.

Economic growth will lead to an increased household income and improved living standards, including better residential conditions and nutrition for families. This will contribute to a reduction of poverty and social vulnerability and hence lessen the population's susceptibility to TB infection. An integrated approach with provision of material and psychological help is required for successful recovery of TB patients.

The first several years of the Strategy's implementation will include a preparatory stage of TB care reform. The reform's main effort will focus on strengthening family medicine practice as the public health and clinical base for a new model of prevention, diagnosis, and treatment of TB. For the coming period at least 80% of multidrug-resistant forms of TB are expected to be covered by treatment; at the same time palliative care for patients suffering from wide-resistant forms of TB will be organized.

By 2015 the on-going efforts in combating malaria are expected to be successfully completed in the affected regions and the country will obtain the status of a malaria-free country.

Activities to achieve the planned results will be carried out until 2020. In order to succeed it is necessary to strengthen potential; to improve the national supervision system, including prediction; early warning and response to epidemics; to increase coverage and to improve quality of early detection and timely treatment in the country; to provide cost-efficient integrated measures on disease carrier control; to organise scientific research and to increase public awareness.

To prevent transfer of waterborne diseases, the following interventions are expected to take place for the period up to 2020: decreasing pollution levels to regulated hygiene norms in water

11. Global strategy for the prevention of sexually transmitted infections and their control, 2006-2015: p. 70.

reservoirs that are used for drinking water and recreational purposes; coordination of activities of concerned services and authorities responsible for development and technical control of the water supply and disposal equipment including equipment in rural settlements; improvement of drinking water cleaning technology from water that originates from surface sources; reconstruction of cleaning devices for improvement of water cleaning processes; raising the level of professional competence and responsibility within staff that operate the systems for water supply and disposal; providing the operative laboratories with up-to-date equipment; other activities to promote the regulated sanitary standards and regulations of hygiene set of requirements for drinking water.

Flu pandemics are characterized by high incidence and significant mortality rates, and socio-economic losses. To reduce a risk and prevent introduction and spread of highly pathogenic strain of the pandemic flu H1N1and other types and subtypes of viruses that would be likely to cause pandemics in the country, the country will build its potential to fight pandemics through strengthening of the technical base and personnel and inter-sectoral coordination that will help monitor the given disease and also locate and eradicate the disease when found. Virological laboratories and related wards of infection treatment facilities will be supplied with additional equipment, preventive and acute vaccines and training of personnel. Within the Strategy implementation period a regional and international cooperation will be initiated with the participation of veterinary control services and the State Committee for Emergency Situations. In order to improve qualitative results various strategies for information dissemination will be used.

§ 3. Decreasing the Burden of Non-Communicable and Chronic Diseases

For the next decade, the main tasks in terms of improving prevention and increasing the accessibility to medical care for patients with non-communicable and chronic diseases will be as follows:

- complete vertical analysis and plan for integration of each intra-rayon specialized health care services to improve population access to specialized care;
- review the bed fund in hospitals and create day care centers and out-patient medical centers
- review the staff lists/regulations for doctors and nurses in health care facilities and identify new functions;
- elaborate new and improve existing standards and regulations (there are currently more than 500 regulatory documents regulating various activities);
- strengthen the resources of rehabilitation centers (cardiology, drug abusers, children profiled, etc.);
- strengthen the development of palliative care (PC) system for adults and children (formation of education system on PC, establishment PC departments and hospices on the bases of clinics, home care, put in order all standard-regulatory documents and etc.).
- further implementation of approved and new national sector programs (on prevention and combat diabetes, ischemic heart diseases, TB, drug abuse, oncologic diseases, development of donorship, prevention of traumas, occupational diseases, etc.);
- attract additional investments to improve the infrastructure of health care facilities;
- promote the proper use of traditional medicine by developing and providing treatments in line with WHO Traditional Medicine Strategy and the law of RT on Traditional Medicine, and international standards, technical guidelines and methodologies[12] ;
- introduce training in first-aid among drivers, state traffic police, the structures of the Committee for Emergency Situations and Civil Defense under the Government of the Republic of Tajikistan in order to ensure timely and appropriate first aid directly at the scene of the incident.

Cardiovascular diseases, particularly rheumatoid and hypertensive heart disease, and ischemic disease; respiratory diseases, primarily chronic obstructive pulmonary disease and bronchial asthma;

12. http://www.who.int/medicines/publications/traditionalpolicy/en/index.html

urinary tract diseases, mainly nephritis and nephrosis; diabetes, endocrine diseases; and psycho-neurological conditions form the list of chronic conditions resulting in the burden of disease that is high and/or significantly higher in Tajikistan than on average in the peer country group of WHO/ Euro B sub-region.

In the next 10 years, the disease management approach to the chronically ill will undergo a profound change. The professional mentality and daily activities of health care providers will focus to the management of chronic illness, centered on the prevention of disease incidence[13] . The family medicine practice will stand at the helm of this change. Sporadic patient-initiated visits will give way to a well thought-out case management plan, including a pre-established periodicity and schedule of patient contacts with the primary care physician and nurse, and for some conditions, directly with a specialist. Care will be focused to a continuous patient self-control over his/her condition and a premeditated plan for crisis avoidance and upon its occurrence. Purposeful patient education and information work on the best ways to 'peacefully coexist' with his/her ailment will take place. Long-term motivation and support will become the main focus of treatment and preventive care. It will be launched under the auspices of family care practitioners and reliance on family and household environment and the local social environment of chronically ill patients. Community Health Councils under jamoats, self-organization of the collective of people with shared health problems and interests, for example, asthma schools, clubs of diabetics and hypertensive patients, healthy lifestyle clubs at schools, self-rehabilitation clubs of alcoholics and drug addicts; retiree clubs will present important resources of health support for those with chronic diseases.

Since diseases of the respiratory organs make the largest contribution to the burden of diseases, a pulmonology research center will be organized. This center will study the causes of diseases, risk factors and effective preventive measures against allergy and inflammatory diseases of the respiratory organs.

Chronic disease management that emphasizes patient self-control will increase the role of patient monitoring by a qualified health care provider, to be based on a carefully planned schedule, evidence-based clinical guidelines, and modern technology. Patient's understanding of his/her illness and patient's skills in managing will be supplemented with effective medications (e.g., in cases of diabetes and hypertension), and medical devices, provided to a patient and his/her family (e.g., in cases of asthma, diabetes and hypertension).

A transfer of a range of chronic conditions under the responsibility of family medicine practice will involve a prolonged transition during which family doctors and nurses will be working in close partnership with specialists. Their collaboration will take various shapes, including design of care coordination plans, jointly seeing patients, joint case analysis, and co-participation in patient education sessions.

Accurate reporting and self-reporting of patient condition (e.g., alternation of crises and remissions) will be set up both in a family medicine setting and in the patient's home to ensure proper control of chronic conditions.

§ 4. Health Determinants and Forming of a Healthy Life Style

Quite high levels of atmospheric air pollution continue to have a harmful impact on peoples' health, and activities aimed at the improvement of atmospheric air and building of favorable living conditions must be prioritized in the following directions: resettlement of populations living within factory buffer areas; implementation of high-performance structures for atmospheric emissions, purification and effective control of their effective exploitation; designing and construction of new industrial subjects in compliance with new technological regulations, fully or significantly excluding

13. American College of Physicians. Effective Clinical Practice – Chronic Disease Management: What Does It Take What Will It Take to Improve Care for Chronic Illness? -- On-line: http://www.acponline.org/clinical_information/ journals_publications/ecp/augsep98/cdm.htm. Accessed on Jan. 20th, 2010

atmospheric air pollution; strengthening control on execution of existing legislation in the field of environmental protection.

To reduce the level of pollution in water reservoirs used for drinking water supply and for recreation to acceptable hygienic standards, a number of measures must be taken to reduce the discharge of not dirty (polluted) and insufficiently cleaned waste waters into rivers through:

- technical re-equipment (reconstruction) of objects;
- introduction of modern high-performance waste water treatment facilities,
- paying particular attention to construction of biological purification facilities; and
- prohibition of the discharge of untreated sewage into coastal zones of the rivers used for recreation and others. It is necessary to take measures to comply with the rules of construction of sanitary facilities.

In the field of ground pollution by production waste and consumption: Preparation of legislative acts and economic incentives to business entities to develop ongoing activities, i.e. stimulation of investments into the construction of waste-treatment and waste-burning mini-factories; improvement of dumps for household rubbish and factory waste; control over the enterprises and institutions specialized in the organization, collection, temporary storage and transportation of mercurial and medical waste.

In the field of control over the quality and safety of food products and foodstuffs:

- identify the basic directions for prevention of food-borne and nutrition-related diseases and conditions, proceeding with analysis of developed and taken actions on elimination of vitamin, macro and microelements' deficiencies;
- carry out further study of the effects of genetically modified foodstuffs on people's health based on scientific data and regulatory documents governing bodies;
- conduct social and hygienic monitoring of foodstuff and food raw materials contaminated with potentially dangerous contaminants of a different nature;
- develop risk assessment methodologies for foodstuffs, assess their hazardous impact to human health
- define the most significant contaminants of food products and other commodities for human use with an estimation of exposition and dose-effective dependences, their effect on people's health and others.

To improve sanitary-and-epidemiological conditions in children's and adolescent establishments:

- approval and introduction of "National action plan on the prevention of the harmful impact of environment factors on the health of children and adolescents" as an independent plan or section of the "National action plan on environmental protection";
- development and introduction of educational programs for school children and parents on healthy life-style, prevention of smoking, drug addiction and alcoholism, hygiene, basics of healthy nutrition, prevention of nutrition related diseases;
- provision of opportunities for healthy nutrition in educational and health-improving facilities, utilization of food products with improved nutritional and biological values, and provision of enriched (with vitamins) food products.

In the field of provision of healthy working conditions:

- develop effective economic mechanisms stimulating employers to provide healthy and safe working conditions, including favorable taxation for enterprises with no traumas and accidents and encouraging automation and modernization of production and technological processes

On provision of people's health and supervision in regard to physical factors:

- creation of conditions to replace outdated technological equipment in industrial and agricultural enterprises; planning and conducting actions to protect people from excessive impact of transportation noise (motor transport and aviation).

On provision of radiation safety:

- for an overall estimation of the radiation situation it is necessary to continue the introduction of a passport system for organizations and territories and to establish radiation control over all environmental objects.

For enhancing surveillance of non-communicable diseases, it is required to identify cause-and-effect features of the spread of chronic and non-communicable diseases as well as occupational diseases. This is needed to identify the main factors influencing the appearance and spread of chronic and occupational diseases; identify the level and geographical character of the disease prevalence and causes of traumas and invalidity.

The majority of common chronic conditions have socio-economic, behavioral, and environmental determinants along with the genetic and biological origins. The socio-economic and behavioral determinants are heavily influenced by gender norms, behavior, and discrimination. Smoking, drinking, poor dietary habits, lack of physical exercise, physical exhaustion and stress, polluted environment and exposure to workplace hazards contribute to adverse living conditions that make people more susceptible to many chronic illnesses and complicate prevention and control of those illnesses. Reducing socio-economic privation is a long-term goal. Discouraging self-destructive habits and taking up a more prudent approach to daily life is a more immediate task. In some of its aspects it can and will be solved over the next decade through a shared effort of families, communities, government, and society as a whole. The MOH will have a key role in bringing these actors together in order to address multi-sectoral issues.

To improve the levels of public hygiene and sanitary culture, broaden awareness of health issues, including healthy life-style and ways to improve public health, it is proposed: to create an information system, coordinate activities of different public authorities and institutions, associations, mass media in the field of public hygiene, wide utilization of mass media to promote the healthy life-style, prevention of diseases.

Implement the 'Action Plan on Disaster Preparedness in the Health System of RT" with the aim of ensuring better medical supply, prevention, and response the emergency situations.

2. HEALTH SECTOR SYSTEMS CHANGE

Health sector systems are mechanisms that are used to develop health care objectives and support activities to achieve those objectives. This Strategy sets the course for a comprehensive modernization of the public and personal health care systems in the Republic of Tajikistan. The Strategy calls for the creation of new systems, strengthening of the pre-existing ones, and integrating both of them into a whole that can be best defined as an effective, equitable, and sustainably operating health care sector.

This Strategy promotes the mechanisms of synergistic collaboration among the stakeholders in health. It favors systems that align the private and public interests and support them both with information and other modes of incentives (financial and professional).

The presented systems work for the achievement of the following function-related objectives in the health care sector of Tajikistan:

- strengthening public governance in health;
- improving quality and universal and non-discriminating accessibility of health care;
- development of health sector resources and financing.

§ 1. Strengthening Public Governance in Health

The Government of Tajikistan, including the Ministry of Health and regional authorities will assume the following functions of public leadership in health: elaboration of basic values, governing principles, and public policy for the health care sector; establishment of modern information infrastructure and analytic frameworks for operational and strategic research on the health care

sector; modernization and improved enforcement of health legislation and regulations; strengthened alignment with advanced international experience; coordination of international aid and technical assistance; and improved current management and controls.

1) Basic Values and Guiding Principles of the National Health Policy

The following basic considerations form the foundation of the national health policy:

- attention of the national leadership to the needs and the health care sector agenda;
- a socially oriented model of economic growth; state support to the work of the health workers and state control over their competence and ethical approach to their work:

For the next ten years, this nation's health policy will be defined by a sensible, pragmatic approach to protecting and improving people's health and supporting all who contribute to health gains, whatever it is family, community or health care professionals.

Patient rights are human rights in the situation of physical, psychological, and financial vulnerability vis-à-vis an illness.

A flexible and realistic health policy implies a staged approach to implementing the ideas of goodness and equity.

The Government of Tajikistan supports the view of the WHO/Euro B member states that "it is unacceptable that people slide into poverty because of poor health" [14]. It appears to be obvious, however, that this Strategy alone cannot overcome the overall poverty trends and therefore it does not present the health care sector within an overall approach to poverty. A realistic goal of the public policy for the next decade is to shield families from a drastic reduction in their well-being due to seeking medical care.

The Government of Tajikistan supports gender equality in the "Law on State guarantees for Equality for Men and Women (2005)". Gender norms and values impact the access women have to health services and information with a clear impact on reproductive, maternal and child health. These prevailing norms and values may also keep men out of the health services and promote unhealthy lifestyles. The health sector has to be gender responsive and deal with inequities existing in society.

Within the pursuing state policy the next ten years, a system of direct budget subsidization of basic health services will protect low-income groups, while an overall increase in on-budget health financing from general tax revenue, preferably tied to the most collectable tax or taxes levied at moderately progressive rates, will increase the health financing commitment from the well-to-do citizens of Tajikistan.

The formulation of basic values and guiding principles of the national health policy requires a careful referencing of the country-specific approach to international experience. The above outlined country-level adaptation of the principles of equity, social fairness, and solidarity confirms the commitment of Tajikistan to these principles.

The WHO program documents, primarily the World Health Declaration (1998), 'Health 21: The health for all policy framework for the WHO European Region' (2005)[15] , annual global health reports, and 'The Tallinn Charter: Health Systems for Health and Wealth' , and the National Development Strategy of the Republic of Tajikistan until 2015 (2007), reflect the set of information and methodological sources that the Republic of Tajikistan drew upon in charting its health policy for the decade to come.

2) National Health Policy

The Legislative, the Executive, and the judicial are the three branches of power with distinctively important roles to play in the formulation and implementation of the health policy of the Republic

14. The Tallinn Charter: Health Systems for Health and Wealth. WHO European Ministerial Conference on Health Systems. Tallinn, Estonia, 25-27 June 2008: 5 pp.
15. Health 21: the Health for All Policy Framework for the WHO European Region

of Tajikistan. The responsibility for the implementation of the Strategy will lie on the MOH along with other concerned line ministries and authorities. The MOH functional profile will evolve to reflect the Ministry's new functions and modified traditional functions. One of the MOH's key roles will be health policy design, and to plot a strategic course of health sector development to meet the nation's current and prospective needs.

The health policy entails a process of consultation and iterative adjustment to develop solutions that enjoy broad stakeholder consent. In the decade to come, a consensus-building partnership will involve the three power branches as well as a comprehensive range of stakeholder organizations, namely, public and private health facilities, health and social care NGOs, associations of health care professionals, suppliers of goods and services for the health care sector, health financing entities; businesses as employers and sources of occupational and environmental health risks, labor unions, organizations that protect the rights of health care consumers, educational institutions, charitable foundations, international development partners, publishers of professional literature, and the media.

The health policy process will comprise the following key components: designing an 'institutional model' of the health sector, that is developing basic views on the relationship of the public and the private sectors in health financing and service delivery, paid and free health care; the degree of open competition among health care providers; pricing policy, the basic definition of provider management autonomy, the role of purchaser-provider contracts; enabling a balanced mix of centralized and decentralized approaches to health care administration and financing; setting objectives for, and developing frameworks for inter-sectoral collaboration; forming alliances of public, professional and grassroots organizations; enhancing the health care roles of the family and the community; elaborating basic approaches to setting health priorities, designing practice models, and defining quality-of-care standards; formulating basic objectives of the structural optimization of provider networks; defining health outcomes and other criteria for health sector efficacy; setting guidelines for the development of the health workforce, technologies and supply of pharmaceuticals; arranging health care administration systems to ensure their synergistic functioning in strategic alignment with the national health priorities.

At the health policy level, the above-listed complex issues will be tackled at their formative core, to ensure that subsequent technical solutions conform to the basic values, guiding principles, and pre-existing laws; and in turn provide adequate guidance for further regulatory designs. Health policy, thus, feeds directly into the legal and regulatory process. Laws and regulations will be designed or updated to transform health policy principles into specific functions of public governance in health and systems of health sector administration.

This Strategy sets out the following vision of the national health policy for the Republic of Tajikistan:

- for the next decade, health policy will be defined by the strategic priorities in health and the strategic goals of enabling equitable access to health sector resources, and modernizing the health sector's financing and resource base;

- civil society institutions are the enabling stakeholders in national health policy, while the Government of Tajikistan with its power vested in the Ministry of Health is the health policy's coordinating center. A dialogue between the government and its constituencies will serve as a vehicle for health policy updates with proper account of the nation's needs and resource capacity, as well as the accountability tool for health policy enforcement. The highlights and outputs of this dialogue will be summarized at the National Health Summit. The Summit will provide a podium for all the stakeholders to voice their opinions regarding the state of the health care system, its development objectives, progress with implementing the Health Strategy and derived health sector programs, as well as the needs for strategic correction of the policy course. Thus, the national health policy will be subject to an on-going discussion and periodic adjustment;

- a broad-based stakeholder partnership in health will entail an inter-agency collaboration within the government sector and a strategic engagement between the public and the private

sectors. A formative principle for the long term will be self-reliance of each economic sector and business entity in minimizing environmental and other health risks of their making. In a 10-year perspective, the health policy sets the following limits to this principle: Private and government-owned businesses will ensure strict compliance of new workplaces with the environmental and workplace safety standards. Carefully designed government support will enhance the employers' control of environmental and workplace health risks. The inter-sectoral and public-private collaboration in this area will begin with the environmental mapping and establishing environmental monitoring of polluting sectors and entities.

The policy of health services delivery both individual and population based will be anchored in a thoughtful analysis of health risk and disease trends, evidence-based approach to health service management, and a sensible account of consumer preferences in seeking care.

Integration of health services across levels of care and types of providers is the strategic priority under health care delivery policy.

The equity-in-health policy is focused on shielding low-income population groups from the unaffordable burden of expenses on health care services. In the medium term, household expenditure on health will decline overall, as the on-budget funding is restored to the health care sector. To the extent that user payments remain, they will be differentiated by a proxy variable of income. Long term, the health care sector will join with other social service sectors in an effort to establish a means-testing system and an integrated database to make available information about the households' material well-being.

The institutional policy in health is defined by the following features: predominantly public ownership with no barriers for the development of private health providers, government funding based on purchaser-provider contracts, with uniform quality-of-care standards and strict regulatory compliance of the providers of care -- public or private.

Health care financing policy is grounded in the following strategic approaches: Budgetary funding will be gradually restored to the main source of health financing. Public funding will be allocated in ways intended to strengthen incentives for health sector reforms, particularly, to support progressive models of health care delivery, and cost efficiency sector wide. Government contracts will encourage value-based care and provider/health facility autonomy.

Heath manpower policy will be aimed at restoring the professional and societal status of the health sector workers in Tajikistan. Step-by-step increase in provider salaries, as part of the Strategy implementation, will go hand in hand with strengthening provider legal, ethical, and financial responsibilities. Financial and professional growth incentives will be closely linked to health outcomes, patient satisfaction, provider productivity, and compliance with professional ethics standards.

Provider education programs at all levels will be geared to the new models of care and evidence-based medicine. Supportive supervision and training at the workplace (especially for newly trained Family Doctors) will be part of the providers' education programs. Attention to the education of quality managers at local levels will be given, complemented by the introduction of quality producers and routines to improve accountability.

Considerations of provider competence will take precedence over guaranteed employment. Public health professionals and later, laboratory technicians and medical engineers will join the family of occupations, in which practice entry is controlled by a renewable professional license. Credentialing of health care and public health practitioners, based on a standard licensing examination will be introduced by 2015 and extended sector-wide by the year 2020. Protection of health workers at the working place and benefit mechanisms for medical workers in contact with harmful diseases will be taken into account in this policy.

Structural optimization and investment policy in health will be shaped with a threefold consideration in mind:

- match health care practice with medical and public health technologies of the 21st century;

- achieve structural optimization of health services provider networks;
- facilitate access to capital for health care facilities and innovative projects in health.

The implementation of new technologies will be guided by strictly defined criteria of medical effectiveness and cost efficiency, and with due consideration of the fact that one-time capital investments are bound to produce a 'trail' of recurrent expenses. The latter will be planned as an inherent part of any feasibility study, preceding an investment project.

Structural change in the provider network will reflect new health priorities and health services delivery models based on the conclusions of the Health Sector Master Plan expected at the end of 2010. Prospectively it is possible to state that the majority of the fixed investment funding will be allocated to the new construction and capital renovation of rural health houses and centers – the infrastructural hub of family medicine for the larger part of the nation's population. Considering the current underutilized capacity of specialty care short- and long-stay hospitals, the supply of hospital beds will certainly have to be reduced by downsizing. In line with the Health Sector Master Plan, the Human Resources (HR) strategy and implementation plan will guide the allocation of human resources in the health sector in the country to prevent any misallocation of staff and ensure the satisfactory availability of professional staff at each level of health care delivery throughout the country.

Pharmaceutical policy of the next decade will be guided by the objective of supplying the health care sector with effective medications of guaranteed quality and their rational use. It is time to defend the pharmaceutical market of trafficking counterfeit, substandard and unregistered medicines, as well as poly pharmacy.

Health sector supply policy will focus on a steady supply of safe, effective, and efficient pharmaceuticals, miscellaneous health goods, medical equipment, and also modernized infrastructure.

Health information policy will be targeted to:

- assuring accurate and reasonably sized reporting of health status, disease and health sector performance data;
- information support for public education on healthy lifestyles and disease-specific prevention;
- information support for educating patients on their disease management strategies, treatment options, and concomitant side effects;
- enabling steady access for health sector administrators, providers of care, researchers and educators to the newest practice evidence.

In each of the outlined aspects of the national health policy, the interests of the rural health care sector will be promoted as a matter of priority.

3) Legal and Regulatory Change

As part of the Strategy implementation, the legislative and regulatory work will focus on the creation of a hierarchically ordered and internally coordinated system of laws and bylaws for the health care sector of Tajikistan. The Constitution of the Republic of Tajikistan and, prospectively, the Framework Law on the Health Protection of the Republic of Tajikistan are placed at the pinnacle of the pyramid, as they set out the vision of the health care sector, including its values and guiding principles, long-term priorities, key entitlements; and stakeholder rights and responsibilities, including those of government authorities, employers, population, and health care practitioners; as well as the basic structural elements of the laws and regulations, and references to pre-existing laws and future legislative initiatives. The Framework Health Law will stipulate amendments in the civil, family, labor, and penal codes, as well as the other basic laws, such as social insurance law and tax law. The health legislation corps will be aligned with the norms of international laws and international commitments of the Republic of Tajikistan.

In the execution of the law «On health protection in the Republic of Tajikistan» in new edition, new laws, with consecutive norms, standards and regulations, will be enacted and pre-existing laws will be amended or elaborated in the areas of environmental protection, utilities and sanitation,

chemical safety, radiation protection, communicable diseases surveillance and control, workplace safety and occupational health, safety of food and consumer products and pharmaceuticals, protection of the rights and responsibilities of the health care worker and the patient.

Judicial review and update in the areas of 'inter-sectoral' legislation pertinent to health will become another avenue of legal strengthening under this Strategy: The most pertinent pieces of legislation will be the changes and amendments to the Customs Code and the law on excise tax, as a source of financial counter-incentives for the consumption of tobacco and alcohol.

Other important areas of the government-level regulations will include the following:

- a system of inter-agency collaboration on health-relevant agendas;
- health financing mechanisms;
- health workforce education, licensing, rights, and responsibilities;
- supply of the health care sector and population with high-quality and safe medications, vaccines, and other health goods;
- a Basic Benefits Package (BBP) for free and discounted health services to the population;
- periodic update of eligibility criteria, service lists, care volumes and value amounts, as well as stakeholder responsibilities and mechanisms of control and enforcement;
- strengthening disease surveillance and epidemiological control.

In implementing the above-stated regulations, the Ministry of Health will introduce new treatment and prevention intervention models: family practice; rules and procedures for the licensing of medical practitioners; rules and procedures for the accreditation of provider facilities; health risk and disease management strategies; standard treatment schemes (clinical protocols) to provide care to pregnant women, neonates, children, patients with highly communicable and extremely hazardous infectious diseases, and patients with common chronic conditions; key methods of quality-of-care control; mechanisms for financing of health care facilities and incentive tools to reward health care practitioners; standards of health workforce education; rules and procedures for accrediting educational institutions and programs; rules and procedures for primary and summative reporting in health, including the architecture and resources of HIS; introducing clarity into statutes of health administrative agencies; and other sectoral agendas.

The outlined legislative and regulatory base will be developed along the following activity lines: inventory (judicial review) of the current laws and bylaws to identify gaps, duplication and contradictions; streamlining and reordering the body of legislative/regulatory sources by voiding the obsolete ones; merging two or several acts with concomitant sorting out of duplicative and contradictory clauses; reassigning certain regulations across hierarchical levels; and amending effective acts to update and reconcile them with the existing body of laws and regulations; adoption of new laws and bylaws to capture essential needs and processes of health sector modernization in Tajikistan.

Standards and regulatory mechanisms continue to be developed for the regulation of the private sector health facilities.

4) Health Information System and Operative Analysis

The Health Information System (HIS) will be strengthened to provide reliable and timely data needed to support the nation's objectives in public and personal health. The HIS architecture and content will be matched to the following health sector objectives:

- Early reporting of epidemic outbreaks and other sentinel events;
- service volumes and health sector resource planning, based on information about environmental, demographic and socio-economic determinants of health, morbidity trends and health care costs;
- monitoring of health status, quality of care, health outcomes, and equity in health indicators;
- daily assistance to health care providers with medical record keeping and other clinical reporting;

- population access to information about healthy lifestyles, health care entitlements, patient rights, care options, therapeutic and side effects of drug prescriptions and other medical indications; chronic disease management and home-based care;

- integration of health professionals into the global flow of information and knowledge.

To develop an integrated HIS, the six standard components of the HIS will be to strengthen:

- resources,
- indicators,
- data collection,
- data management,
- data analysis, and
- data dissemination and use.

HIS resources include legislative, regulatory and planning frameworks, human resources, financial resources and the HIS infrastructures required to ensure a fully functional HIS.

The legal regulatory framework of the HIS includes laws and bylaws that regulate the collection, management, storage, dissemination, and use of information to protect patient rights and rights for population to access health information. The legal and regulatory framework includes the Constitution of Tajikistan, the Law on State Statistics and the Law on State Registration of Acts of Civil Status.

The HIS organizational core includes the following:

- The Republican Centre for Medical Statistics and Information;
- Oblast Centers for Medical Statistics and Information;
- Centre of Medical Statistics and Information in Dushanbe City;
- Organizational and methodological offices and departments at health care institutions in cities and regions.

This structure is responsible for data collection, processing and providing the users information about the health status of the population, health resources and performance of health care facilities. The other important information is required analysis of the population health status and comes through data collected by State Statistic Agency and through Office of Vital Events Registration (social economic and demographic data), State Committee for Environment under the Government of RT (data on environmental conditions).

Priority activities are as follows:

- A HIS Strategic Plan of the Republic of Tajikistan for 2011-2015 will be developed to plan, prioritize and budget the activities needed to develop the HIS;

- The human resources for HIS include the personnel involved in HIS management, data collection, data management and analysis and data dissemination. All these expert groups will be trained and retrained;

- The financial resources for the HIS will be budgeted according to the priorities established in the HIS Strategic Plan of Tajikistan for 2011-2015.

The core health indicators will encompass the three domains of health: health status, determinants of health and health care system.

As a matter of priority for the next five years, the set of HIS primary, intermediate and output statistics will be streamlined and otherwise reordered. By year-end 2012, Health Sector Indicators of the Republic of Tajikistan will be revised and finalized. Selection of indicators for inclusion in this annotated catalogue of health sector variables will be guided strictly by consideration of their utility: indicators without pre-identified users and uses will be excluded from the primary reporting. The new and modified statistics will cover the most important health risks, morbidity and mortality trends, as well as health care quality and utilization, cost efficiency and accessibility of health services. A range of statistics that do not relate to the health sector will be expanded.

The modernization of data collection will be done by sustaining the recent trend toward the reduction of mandatory primary reporting, creating electronic forms for primary reporting, providing software data collection, processing and information use.

In the decade to come, practitioners will achieve more specific diagnostics, a more accurate registration of patient condition and medical indications, and a more skillful collection of specimen biomaterial for sending to a reference laboratory when a case of high-impact infection is suspected. Transition to ICD-10 and implementation of ICD-10.2 will be completed. Standard lists of medical and surgical procedures will be updated

The data management includes the data processing and compilation, data storage and quality data presentation. The primary data collected will be reduced and will be strictly with the indicators needed at each level.

The 'MEDSTAT' database migrates to the DHIS2. The DHIS2 is flexible open software implemented and supported internationally. Direct data transmission to DHIS2 server (DHIS2 mobile module) with handheld devices will be tested in remote (pilot) health facilities. For ensuring timely decisions, distant consultative and diagnostic system that uses telematic and telemedicine system will be deployed.

The data analysis will be strengthened, so that the data collected is converted in compelling evidence that informs local health system decision making. A key aspect of this will be the integration, synthesis, analysis, and interpretation of health information from multiple sources, examining inconsistencies, identifying and accounting for biases and summarizing health situation and trends. Such analysis will provide estimates such as risk-behavior patterns, health service coverage, trends in indicators and health system performance. These analyses will be made available for the public through user dashboards and in newsletters of arbitrary information.

New areas of operating analysis will include as follows:

- quality-of-care control at the provider level, based on external and internal review;

- trends in pharmaceutical supply, including stock-out incidence in health care provider facilities and pharmacies;

- variability of drug prices in the public and private sectors;

- distribution and flow of patients/caseloads by levels of care in the context of common diagnoses and conditions, as well as clinical and cost-based / case mix groups;

- trends in user charges, particularly, out-of-pocket expenses in annualized terms and per admission, patient-day and outpatient visit;

- financial burden on the patient population by level of care, provider facility type, and patient income level;

- performance of family practice: number of facility-based and outreach visits per provider, enrollee and by target patient population group (e.g., pregnant women, neonates, children below 5 years of age);

- health education indicators by disease prevention and disease management area;

- health risk levels determined by access to, and quality of drinking water, and personal/ residential sanitation practices.

Analytical skills of main institutions will be developed and strengthened. The Health Policy Analysis Unit (HPAU) established in the Ministry of Health will continue to address the need to strengthen health policy and analysis capacities of the MoH and its capacities will be built up to provide the expected evaluations, analyses and evidences.

By the beginning of 2013 strategic research in the health care sector will include the following new areas:

- A comprehensive disease burden (DB) analysis for Tajikistan – assessment of demographic and economic loss due to premature mortality and disability by disease and in total: The previously assessed DB indicators were predicated on the global disease trends and uniform assumptions regarding erosion of the quality of life and earnings due to premature death and disability. This

'cosmopolitan' DB model will be customized based on the demographic, epidemiological, and socio-economic statistics of Tajikistan. DB-related multi-disciplinary research will be conducted in 2011-2012 and will inform the Health Strategy Adjustment planned for 2015.

The design and periodic updates of a system of National Health Accounts (NHA) at the national and regional levels: the application of the NHA model to analyze health financing by source and use can be valuable in consideration of the following:

a) given the official and unofficial sources of health financing.

b) curate tracking of household expenditures on health, on the one hand, and provider revenues.

c) while the conceptual and methodological design of the NHA can begin immediately, the NHA implementation will have to be implemented step-by-step to allow time for establishing data collection tools and practice.

d) In future, NHA will be viewed as a supplementary tool of analysis rather than a tool of annual budget planning.

Evidence based assessment of health and clinical outcomes: Evidence-based practice guidelines will be introduced through a limited adaptation of international best-practice prototypes to the organizational and resource settings of the health sector of Tajikistan. Further and more in-depth selection and customization of care management guidelines will be based on a carefully designed clinical effectiveness/outcome research. Country-specific outcome research will prioritize practice areas where the adoption of evidence-based care is expected to overhaul the existing practice.

Health policy research: assessment of health outcomes as a corollary of care access; opinion polling regarding basic values, guiding principles, and health organization and financing tools. Health policy models of Tajikistan will draw on international values and principles and will be customized to the mindsets of the patient and provider community, and to society at large.

The outlined areas of the current analysis and strategic research will be advanced by expert teams and consultants based on their competence rather than institutional affiliation. The Ministry of Health will be initiating these studies through government contracts aimed at identifying advanced approaches to health sector administration in the Republic of Tajikistan.

The data dissemination and use will be strengthened.

Data dissemination will continue to rely on the existing platforms (i.e. compendiums or web-based solutions such as www.medstat.tj / www.tojikinfo.tj), DHIS2system, statistical yearbooks, analytical information, which will continue to be improved.

The information will be made a core part of the day-to-day management of health system planning and delivery. Institutional mechanisms and incentives to create a culture of evidence-based decision making will be further developed, based on which diverse types of users will increasingly benefit from the country health information system in line with their own needs and requirements.

A supporting environment for delivery of training for result-based and evidence based management will be developed.

Information use and demand for health information will be progressively institutionalized with more indicator-driven strategies (i.e. MDGs, NDS, PRSP, and SWAP), strategies linking data/information to actual resource allocation, improvement of the data quality (support to HIS), and production of information.

5) Inter-institutional and interdisciplinary approaches to the improvement of living conditions in the country.

In the next decade, the national leadership of the Republic of Tajikistan will engage its powers to ensure that the parliamentary committees, central ministries and agencies, regional governments and local authorities, the private business sector, non-government agencies, and individual citizens – all become involved in the nation's health agenda.

The Strategy thus puts forward the need for a broad-based partnership between the institutions of the state, national economy, and civil society with the overarching objective of achieving healthier living conditions in Tajikistan.

The first step to be taken by the Government of Tajikistan toward creating an all-out movement for improving the nation's health will be to strengthen the structure of the National Health Council (NHC) under the Government of RT, established by the governmental decree № 579 on December 29, 2003. The NHC is conceived as an independent center of public, professional, and administrative control over the epidemiological well-being of Tajikistan and the health-related performance of public authorities, business entities, provider facilities, grassroots organizations, and the people of Tajikistan.

By strengthening the NHC and transferring it into a working body for inter-sectoral management of health protection it will consolidate resources, authorities, and responsibilities of the state and private sectors, as well as community initiatives for creation of a healthier living environment for the present and future generations of Tajikistan's citizens.

6) Strategic Orientation toward International Best Practice: Coordination of International Aid and Technical Cooperation.

The decade of the Strategy's implementation will be marked by further integration of the health workers of Tajikistan with the global professional community of health care practitioners, increased intake of best-practice experience in managing common diseases, sustained collaboration with the global disease surveillance networks, secure access to procurement sources for high-quality and price-efficient pharmaceuticals and vaccines, and broadened avenues for research partnerships in the areas of health policy, regulations, management and financing.

The 'reunification' of the health sector cadre of Tajikistan both in medical and non-medical occupations with advanced international practice will begin at the level of their basic education. Education programs, curricula, teaching materials, and recommended reading lists will be increasingly reoriented toward international educational and practice standards. The sources of new knowledge will be drawn from WHO recommendations, and there will be a special focus on enhancing access to the international knowledge base. For that reason language training in English and Russian will be strengthened in medical schools and nursing colleges. Increased education standards will be sustained with modernized medical practice, health sector management systems, and infrastructure, including Information Technologies. Continuing medical education and license renewal requirements will assure that health care workers stay current with international best practice throughout their careers.

In the past 10 years, the health care sector of Tajikistan has become an arena of diverse innovations, spurred by dozens of international projects. Currently 24 international donor organizations are participating in the development process for the health sector in Tajikistan and more than 31 projects are being implemented. The total amount of foreign investment in the health sector for the period of 2004 to 2010 was US$ 267.3 million. Out of this sum US$30.78 million were provided as loans.

Donors' investments were directed to health facility infrastructure and medical equipment, training of staff, reform of the health care sector, AIDS prevention and combating, combating TB, improvement of reproductive health, mother and child health, prevention of infectious diseases as well as capacity building and supply of pharmaceuticals and other equally important problems of the health sector.

Urgent issues related to management of foreign resources and investments are as follows: presenting annual plans and quarterly reports in order to create a data base for all foreign funds directed to the health care sector; the need for annual NHA to track the flow of all funding sources through the health sector; the lack of clear regulation between the MOH and international organizations regarding organization of seminars, conferences and other large-scale events; and the

under-developed mechanisms for planning of investment projects, which decreases the efficiency of attracted funds in process of goal achieving.

The following measures are proposed for solving the above-mentioned problems: creation of a unified data base for development partners that would gather information about all flows of foreign aid directed to the health sector, for analysis and overall information of parties involved in the health sector – donors, foreign investors, international governmental and non-governmental organizations; organizing of joint project implementation monitoring; elaboration of proposals for improvement of investment project planning and mechanisms for their efficient implementation; coordination of missions of donors, international financing organizations and foreign investors during the implementation period of their projects; organization of systematic meetings with the main donors and executive international agencies for discussion of pending issues of coordination of foreign aid for the health care sector; conducting of training and conferences on current issues regarding management of foreign aid and investments.

For the next 10 years, the Ministry of Health is tasked to master a pro-active approach to identifying priorities for, and steering international participation towards the strategic goals of health sector modernization in Tajikistan. The following objectives will guide this effort: define the health sector needs for international support, whether caused by lack of domestic funding, absence of certain health goods or adequate experience in the country; improve understanding of the nuances of institutional mandates, program priorities, and cooperation tools, favored by various development partners, such as international development banks, UN agencies, international foundations with multilateral funding, bilateral donor agencies, NGOs, and private voluntary organizations; work out synergistic solutions that will target health sector priorities of Tajikistan while also matching institutional priorities and organizational and managerial models of specific development partners; develop tools to track international resources and evaluate effectiveness of joint initiatives.

The Government of Tajikistan and, primarily, the Ministry of Health together with the Ministry of Finance will assume the roles of a steering and coordinating center. This will require a more focused attention to the international collaboration agenda, an ability to identify effective solutions and stay the course in implementing them, and, not least, stakeholders' responsible approach to their commitments.

Specifically:

- Starting in 2012, the planning of health sector development and resources will be officially transferred from an annual to a three-year cycle. This shift will make the financial, physical and human resources of the health sector more predictable, and will improve the planning horizon for international development partners.

- The influx of international resources, particularly in the form of direct health budget supplementation, is bound to make the functioning of the Ministry of Health and the Ministry of Finance more complex. The success of these agencies in planning, allocating, and tracking the additional resources derived from international support of health sector reforms in Tajikistan will require strengthening of human, information, methodological, and physical assets.

- Another area of international partnerships in health care will become the country's technical cooperation.

The role of the Ministry of Health in managing international consulting will gradually increase. Preparing Terms of Reference, managing competitive procurement, evaluating proposals, short-listing best proposals and awarding contracts, establishing technical and financial controls over project implementation – all these diverse activities of managing international projects will become part and parcel of the MOH workload.

The transfer of technical cooperation under the auspices of the Ministry of Health will achieve the following three important objectives: firstly, the most competent consulting organizations will be preferred regardless of their national identity and contrary to a more restrictive approach practiced by some donor agencies; secondly, when needed, resources from multiple donor agencies will be

consolidated to support the most important and time-sensitive projects; thirdly, internationally funded projects will be used more consistently to develop the national consulting base in Tajikistan.

Shifting the center of gravity of the planning and management of international partnerships towards the Government of Tajikistan is an incremental process that will involve a tenacious effort on the part of the pertinent government agencies to develop their organizational capacity. This Strategy will be supplemented with a Capacity Strengthening Plan that will address the needs for improving the technical, management, and physical plant capacities of the Ministry of Health and the Ministry of Finance. The Plan's primary focus will be to modernize health sector administration in Tajikistan, and also to bring these agencies up to speed in their prospective roles of utilizing international financial support and managing technical cooperation. A Coordination Council for International Cooperation (CCIC) in Health will be set up under the auspices of the Ministry of Health. Along with the MOH and the Ministry of Finance, all the international development partners engaged in the financing and technical cooperation in the health care sector will be represented. Implementation of the 'Sector-wide Approach' (SWAp) will become a prominent strategic objective on the CCIC agenda.

Consolidation of the fragmented international projects, funded by multiple donors, into an integrated international partnership, to be led by the Government of Tajikistan, implies a regular and in-depth assessment of the MOH and other stakeholder agencies' preparedness to assume the planning and management of domestic and international resources to ensure the implementing agency meets the fiduciary and management requirements to manage a consolidated pool in a decentralized health system like that in Tajikistan.

It is equally important to avoid the opposite extremes – delaying the country ownership of international aid, and shifting ownership in haste. In this regard, In this regard, an important function of the Council for International Cooperation Coordination will be assessing the readiness of national actors of the international partnership to undertake strategic planning and ongoing management in a sector-wide coordination.

7) Improving Operational Management in Health.

In the next decade the functional profile of the Ministry of Health and regional health administrations will be enriched with new and modernized areas of operational management, as for example: strengthening of the operational management at central and oblast levels; annual and mid-term planning of health sector resources and budgets; tracking expenditures under the public entitlements for free health care and mechanisms of provider reimbursement; designing practice standards; basic and continuing education of health workforce; licensing and accreditation; quality-of-care control; certification; managing of prioritized programs etc.

§ 2. Raising Quality and Accessibility of Health Services.

The public governance systems, presented in the Strategy's previous section, as well as the subsequently described systems of health sector functioning will uniformly serve the two-in-one goal of providing the people of Tajikistan with more accessible and higher quality health services, both individual and public health ones.

For the decade to come, quality of health services is defined as a set of health sector performance features and results that ensure, first, that health outcomes are maximized in preventing and treating priority diseases and conditions Second, the health care system refrains from providing useless services and seeks to provide evidence-based care whenever possible; third, risks are avoided in the health care delivery process; fourth, health care is provided with due sensitivity to patient's values, needs, and preferences; fifth, health services are planned and delivered in ways that avoid waste of resources, including provider and patient's time; sixth, health care responds to considerations of equity: its accessibility steadily improves by geographic area, and patients' gender, age, and socio-economic status.

A quality-oriented health sector is one of the organizing concepts of this Strategy. The key elements of quality-oriented care will include the following: patient health management with maximum account of individual life circumstances and health risks; continuity of health services by levels of care and across the level of care; tight accountability of health care practitioners for their professional competencies; exposure to pro-quality incentives (financial and professional); provider ability to manage health care resources; attentive response of the basic and continuing education of health workers to the achievements of science: reorientation of health sector resource and budget planning.

1) Strengthening Primary Health Care based on Family Medicine Practice.

Institutionalizing the Family Medicine model as a systemic foundation for integrated PHC will present a health sector change of formative importance for the Republic of Tajikistan.

A system of professional and financial incentives will be established in line with the Government's performance-based wage system for public employees to reward family practitioners for safe and effective services that maximize health outcome in each episode of care and each key stage of a patient's life.

Consistent with PHC's organizational diversity worldwide, family medicine practice options will include the following: solo practice or as a family medicine department within health centers.

The choice of a practice setting will be made with consideration for provider qualifications, geographic location, patient population profile, health risk / disease trends, and pre-existing provider network.

All PHC providers will have equal access to government-supported basic training in, and retraining for, family medicine. Under this Strategy, the share of family medicine practice in PHC care will reach 70% in 2020.

2) Licensing and Accreditation of Health Care Practitioners.

Health practice standards will be designed to match the expectations of the patient population, health sector authorities, and professional community of health care workers. Practice standards will be the foundation of basic and continuing training of physicians and nurses. Professional licensing will be instituted as a mechanism to establish and maintain a match between health care standards on the one hand, and provider knowledge and skills, on the other.

Starting in 2016, only licensed doctors and nurses with higher and secondary medical education will be admitted to an independent medical practice. In 2014-17, mandatory licensing will be introduced for graduates of medical schools and nursing colleges, as well as for practitioners with a career record.

A system of professional licensing will be instituted by health sector authorities jointly with the provider community. Their partnership in this area will rely on their mutual interest in protecting patients and the health care sector from incompetent practitioners.

A standard examination with modular structure will become the key tool of provider licensing. A uniform core module, applicable to all clinical specialties, will be complemented with variable modules by specialty. The medical (physician) societies (and/or alternatively defined professional entities) will design an examination program, each in their practice area. The nursing association will prepare a standard licensing examination program for nurses. The Ministry of Health will articulate criteria of admission to licensing exams, application rules, examination, and rating process. As practice standards evolve, licensing criteria and examination rules will be subject to periodic review and update. Concurrently, curricula of medical and nursing basic and continuing education will be adjusted to match new licensing standards.

A Commission for conducting the licensing examination of health care staff will be established under the Ministry of Health.

The Commission for licensing of medical staff in cooperation with the Examination commission will have a special function to evaluate the compliance of national professional standards in health care practice of Tajikistan vis-à-vis those of other countries.

The MOH Commission for licensing of medical staff will be issuing a certificate to practice health care in the public, private, and not-for-profit provider facilities. Professional license will be subject to renewal every five years provided a given practitioner complied with his/her continuing education requirements and his/her practice record was not marred by any serious infraction. The current system of provider attestation will gradually get improved.

Mandatory certification will be complemented with a voluntary certification, wherever practitioners want to confirm their advanced competencies.

The effectiveness of professional licensing and certification will depend on the quality of health workforce tracking, particularly practitioners' registration in a database with frequently updated information about their professional qualifications, career growth, and prior licensing and certification results. This tracking system will be integral to the National Registry of Health Care Practitioners, a component of ISHI.

3)Accreditation of Health Care and Medical Education Facilities.

In the coming decade, in the Republic of Tajikistan it is planned to establish and develop the National system of accreditation in health care, as an independent mechanism for external evaluation of health facilities, which in recent years has been used in many countries oriented to the quality of medical services.

In accordance with generally accepted international terminology, accreditation in health care is a formal procedure by an Accreditation Body for recognition of the competence of HF to perform professional activities in compliance with the standards of accreditation (recognition of the appropriate level of medical services in compliance with the established standards). Accreditation is the key mechanism of the quality management system that provides quality assessment and continuous improvement of the quality of health services by identifying factors influencing the occurrence of defects in the provision of medical services, and recommendations to address them. One of the main tasks of accreditation, except external evaluation of HF, is the establishment of an internal facility quality management system that uses accreditation standards as a basis for the self-assessment and self-control of facility providers in their careers.

Competent actions of an individual provider in the workplace still do not guarantee the quality work of health facilities in general. Therefore, an internal quality management system is a necessary complement to control and self-control at the individual level. Given that, the accreditation of health facilities, together with the licensing of health personnel will play a key role in ensuring the quality of medical services.

Accreditation of state-owned health facilities in the Republic of Tajikistan will initially be based on the principle of obligatoriness and will be under the state control. In the future, as far as strengthening the position of market relations in the health sector, after the establishment of the system for accreditation of health care organizations, promotion of accreditation among general population of the country, the mandatory accreditation of HF can be replaced by a voluntary accreditation, regardless of ownership. Amendments to the concept of accreditation regulating legal relationships associated with the introduction of the HF accreditation system in the health care of the Republic of Tajikistan will be made to the main law regulating the health care system – "On population health protection", as well as "The Law on Health Insurance in the Republic of Tajikistan».

Activity on health care accreditation will be delegated to an independent, non-profit organization with an independent legal status – Republican Center for accreditation of health care organizations. Legal persons (Health Management Body- State Control Agency over medical activity in the Republic of Tajikistan; legal persons associations, public associations of health services consumers,

health insurance bodies, health workers unions and others) can be the founders of the Center. All of them can be represented in the Board of the Center founders.

The main method of accreditation is to evaluate the compliance of health facilities with the accreditation standards. The accreditation standards will be developed on the basis of international principles with consideration of norms and regulations of the current legislation of the Republic of Tajikistan. The accreditation standards will define norms, rules, and requirements to assess the conformity in health facilities:

- management systems, including risk and quality management;
- level of medical care safety for patients and personnel;
- quality of services provided;
- availability of necessary resources to assure professional activities.

The following will be used to develop accreditation standards:

- Normative legal acts of the Republic of Tajikistan (laws, decrees of the Government of RT, national and state programs, MOH orders, sanitary rules and standards, etc.);
- International standards;
- National accreditation standards of other countries;
- Guidelines for the treatment and diagnosis, etc.

The accreditation standards requirements will be realistically attainable taking into account the real situation in the Republic of Tajikistan. That is, given the cultural, technical, financial-economic national capabilities at the moment, the standards will provide an acceptable level of safety and quality of health services, and facilitate continuous quality improvement.

Initially, accreditation standards will be developed for obstetrics facilities (maternities having a legal person's status), then for hospitals, family medicine practice and outpatient consultative and diagnostic facilities. With the development of medical technologies, changes in approaches to health care and legal-regulatory framework, as well as economic growth, accreditation standards will be revised and updated (every three - five years).

The main directions in development of a System of accreditation in health care over the next 10 years are the following:

- Dissemination of Accreditation System to HF, starting with obstetrics facilities: development of standards, testing and approval, training of experts and users, procedures for accreditation, revision of standards - 2010 -2014;
- Dissemination of Accreditation System to hospitals: development of accreditation standards, testing and approval, training of experts and users, procedures for accreditation, revision of standards - 2015 -2017;
- Dissemination of Accreditation System to institutions of family medicine practice and outpatient consultative and diagnostic facilities: development of accreditation standards, testing, and approval, training of experts and users, procedures for accreditation, revision of standards - 2016-2020;

The second part of the accreditation agenda will focus on the assessment of resources, processes and performance results of the programs and institutions that provide basic and continuing education for health care practitioners – physicians, nurses, other health professionals; and, prospectively, administrators, planners and managers for the health sector and provider levels. Most such programs are part of the institutions of medical and nursing education, while some of the newer programs (particularly, to train health sector workers in non-health professions) would be based in the institutions with multi-disciplinary curricula of higher education. All these health sector-related programs and centers of education will be up for accreditation by the Ministry of Health in cooperation with the Ministry of Education, regardless of the form of ownership and subordination. As professional licensing becomes established in the health sector of Tajikistan, an important accreditation criterion of education and training institutions will be the pass rate on licensure exams taken by graduates.

The national standards for medical accreditation of higher education facilities will be gradually harmonized and adapted in accordance with international standards of accreditation.

4) Health Care Standards

The quality control and assurance systems devised under this Strategy – the integrated primary health care managed by family practice, licensing and certification of health care practitioners, accreditation of medical facilities and programs of education of health workforce – will be effective only if they are tied to best-practice standards of care and provider performance. Two major changes will become the hallmark of the next decade: firstly, clinical, educational, resource-related and organizational standards in health will be revamped; secondly to make a clear cut with current punitive measures, pro-quality incentives, continuous supervision and support to mechanisms of quality control and its assurance.

Quality management is viewed as a continuous, cyclical process that comprises the following stages: design and adoption of standards; on-going compliance monitoring; provider performance strengthening to improve compliance; upward revision of standards. These stages, as well as an on-going self-improvement of health care providers – ensure a consistent compliance practice between the revisions of practice standards.

The following two-tier model of quality management is propounded by this Strategy:

- at the first, strategic level, pro-quality systems are established sector-wide. All health sector systems are designed, set up, and utilized with priority attention to the quality of care. In this sense, the Health Strategy in its entirety, including its resource component presented in the next chapter, is meant to be an all-inclusive tool of quality improvement; and,
- at the second, operating level, quality-of-care management is placed under the responsibility of provider facilities and specific practitioners and is applied to the patients.

Under this strategy, the quality operational management will emphasize a comprehensive and dynamic approach to quality control, as quality should become a subject of universal concern and affect all aspects of the organization of therapeutic and preventive interventions. It will be critical to reach the specified quality standards and maintain medical and preventive work at the sustained level.

The following considerations explicate the above-outlined vision of quality management: quality and safety of health care will be provided in the patient's interests but also in the interests of his/her family, community, health care practitioners, provider facilities, health sector, and society as a whole; opinions and initiatives that originate from the patients, their relatives, social workers, provider facility managers, and the general public will be taken into consideration when designing quality control mechanisms and putting them to use; quality-of-care management will be directed at resources, processes, outputs and outcomes of health care, as well as at the organizational layout of provider facilities and the architecture of provider networks that use resources, carry out processes, and achieve results.

The quality management tools will include clinical protocols that will unify clinical practice and increase results.

In parallel, the development of new clinical protocols will take place together with the studies, organized in the country to assess the effectiveness of advanced methods of prevention, diagnosis and treatment, rehabilitation and palliative care.

Risk and Disease Management Guidelines will be a tool of practice standard setting that covers a wider range of health care activities.

Continuity and coordination of care commands special attention in a disease management guideline. Hence, up/down-referral guidelines are part of it and so is the approach to involving social services and initiating patient-provider contacts at patient's initiative. Risk and disease management guidelines will be a second set of tools for quality standardization and management as a complement to the clinical protocols.

In the health care setting of Tajikistan, risk and disease management guidelines will be created or updated for common chronic conditions, such as asthma, diabetes, hypertension, and congestive heart disease, as well as for high-risk patient groups, for example comprehensive management of antenatal, childbirth and post-partum care; office-based and outreach care for neonates and infants; integrated management of childhood illnesses; care and support of teenage students with psycho-behavioral disorders; social-medical rehabilitation of the elderly with differentiation for urban and rural conditions.

In the next decade, job descriptions by provider category and care range by provider facility will be revised to reflect the following changes: firstly, new approaches to practice management, secondly, structural change in health care provider networks. Particularly, transition to the integrated PHC based on family medicine practice will imply a significant increase in the range of care competencies and professional responsibilities of primary care physicians and nurses both within a PHC-based episode of care and in care coordination across levels of service, as well as in health risk management, disease prevention, and population health improvement in the practice catchment area. Based on the above, the 2003 Guidelines for PHC Provider Management will be revised. Similar to PHC, the expected integration of specialty inpatient care into general hospitals and development of hospital-substituting care will warrant revisions in provider job descriptions and provider facility functional profile in the hospital sector of Tajikistan. A new classification of provider facilities and their redefined functions will be elaborated in 2012.

In 2012-2015, provider job descriptions and facility functions will be aligned with clinical protocols, disease and risk management protocols, and practice scope. The Coordination Council for Clinical Practice will be at the helm of these activities.

The outlined quality-of-care tools will be enhanced by improved monitoring and enforcement. The first-line evidence and controls will be provided by provider licensure and certification. The second-line evidence and controls will be enabled by a thorough review of provider systems and performance; and also by tracking household health indicators through sample-based surveys. An additional set of quality management tools will be provided with the implementation of clinical audits and patient surveys.

Clinical audit will take the shape of a periodic sample-based review of health care practice for congruence between provider actions, patient conditions, and pertinent clinical protocols and disease management guidelines. A secondary task of the clinical audit will be to analyze the links between disease course and utilization patterns. This will create an important evidence base for further adaptation of clinical guidelines, and the planning of health sector resources and financing.

Along with the outlined tools for quality control, search light services will be rehabilitated and a commission for investigation of causes of deaths will be re-activated. This will significantly increase the quality of medical services.

5) Improving Access to Health Care

In addition to saving human lives and improving people's health, medical services ought to be provided in socially just ways. The health sector of Tajikistan must deliver on the twofold expectation of clinical and social effectiveness.

Under this strategic framework, an equal access of all people residing in the country to health sector resources is set out as the determinant of equity in health. This implies legal, spatial and socio-economic equality of access. This Strategy sets limits and defines mechanisms for the application of all the three criteria of equity in health for the next ten years.

Legal equality of access to health services is guaranteed by the Constitution and applies to all citizens of the Republic of Tajikistan as well as foreign citizens registered for temporary residence in the country. As to the individuals who are neither citizens nor legal residents of Tajikistan, their right to access health care is not legally restricted yet is not backed by publicly stated guarantees either.

Spatial (geographic) equality of access will be improved in the following four ways:

- Active development of health care provider networks in sparsely populated, remote areas: Primary health care will remain the main medium of health care proximity for most Tajikistanis. In the next decade, PHC will be modernized on the conceptual and organizational platform of family practice. As the practice scope of family medicine practice grows, any small geographic area covered, will improve its access to health services. The task, thus, will be to promote rural health houses to the sparsely populated and remote rayons grounded on the forthcoming results of the 2010 Master Plan.

Four modalities of rural health houses and three modalities of rural health centers have been identified as the hub of family practice, based on a modeling exercise conducted in 2009. Specific modalities will be selected for small, medium, and large localities, based on the population size. For the 'very small' localities, a family medicine practice modality will be established according to the locality's population size or the catchment area size if it includes several localities, plus the combined population of those localities. The staffing schedule of a family medicine practice will be flexibly matched to the size and density of the local population: instead of a previously adopted uniform provider/population ratio, a 'pluralistic' approach will prevail whereby a family medicine practice staff can include several of the following: a family physician, PHC 'specialists' and a nurse. The presence and numbers of each personnel category will be determined with regard to the catchment area and enrolled population.

After the 2010 population census data for the Republic of Tajikistan become available, the final calculations for «a differentiated model" to optimize the locations of general practices will be done, based on the conclusion of the 2010 Master Plan. Starting in 2013, PHC investments, workforce, supplies, and financing will be geared to:

- the refined map of family medicine practice locations;
- strengthening resources of self-care at the household and community levels: access to health care will improve dramatically as the line of the health sector will be redrawn. The patient, his/her family, and their community will be placed at the core of health care activities;
- a thoughtful approach to structural optimization of health care provider networks: Closing health care facilities solely on account of low capacity utilization reflects a simplistic approach that puts considerations of cost-efficiency at odds with considerations of social effectiveness (equity). Early in the Strategy implementation, this conflict will be resolved on a case-by-case basis: frequently, rural provider facilities without a substitute will be kept despite their low utilization and, concurrently, increased unit costs. Rather than eliminating them, preferred solutions will include improved resource levels, change of care profile, diversification of services and other forms of rehabilitation that may make them more attractive to the local population. In the event of a facility closure, careful planning will be done to accommodate displaced staff and improve mobility of the local population so they could access health care from more distant providers. Additionally, a contingency reserve of provider capacity will be established. In 2011-12, a system-wide analysis will be conducted to ascertain health care access levels under alternatively configured provider networks. The findings will be summarized in several master scenarios of the transformation of local provider networks and specific provider facilities to enable a trade-off between equity and cost efficiency. Thus, the 'master-planning' of structural optimization in the health sector of Tajikistan will correct the lately observed bend toward a schematic approach and this approach will provide a more productive contribution to improving access to health care for the country's entire population;
- equalizing resource levels across health care providers nationwide: The geographic access to services depends greatly, but not solely, on the availability of provider facilities within daily access (walking or driving) range.

Special attention will be given to the availability of improved emergency medical services, to ensure effective universal access to emergency care for all, especially emphasizing the crucial role of these services in the occurrence of a disaster.

Socio-economic equality of access (Patients' Rights) will be achieved by following means: д:

- protection of patients' rights and interests: denial of care, blunt or tacit (in violation of accessibility and quality standards), will be viewed as discrimination. Other forms of patients' rights violation will include disclosure of confidential data, infractions on free care entitlements, and damage to patient health due to provider negligence or error. Periodic patient surveys will help identify infringements of patients' rights and interests at the provider facility and individual provider levels.

- externally to the health sector, patients will have the right for out-of-court settlement with mediation by consumer protection agencies and through litigation in a court of law. Lawsuits will be seen as the extreme if not altogether unavoidable remedy to protect patients' interests in malpractice cases.

By 2015 the presented scheme of protection against illegal actions of health workers will be testing in local and regional pilots. It will be introduced (with the necessary modifications and revisions) step-by-step. By the end of the decade of the Strategy implementation, a regulatory base and enforcement practice will be established; legal experts trained in health litigation, provider compliance controls strengthened to ensure provider adherence to professional ethics and legal norms; a specialized consumer protection organization set up; mass media knowledge and skills developed, and public opinion mobilized.

Entitlements to free and subsidized health care: a serious barrier to equitable access is posed by patient charges at the point of service at levels that are unaffordable for the patient and his/her family and under the table payments requested by staff.

The government entitlements to free and subsidized (reduced) care will be strengthened in the following ways:

- Free services must be fully backed up with on-budget funding and adequate physical and human resources. Otherwise, free care becomes synonymous to low-quality care. It will impede rather than improve equitable access to health services. Instead of being a medium of social fairness, free services of low quality are bound to become the tool of socio-economic discrimination. Hence, the 'Basic Benefits Package' in health (BBP) will be shaped strictly within the budget funding envelope thus ensuring that quality free services are actually available for the eligible recipients.

- user fee levels must be reduced for low-income families to even out the financial burden across population income tiers. In the decade to come, the pro-poverty targeting of BBP will be improved under the health co-payment policy.

- consistent tracking of expenditures on health care and pharmaceuticals at patient and household levels.

- public entitlements to free care will put all citizens of Tajikistan on an equal footing in terms of access to health services that match the national health priorities. This Strategy reaffirms the right for free antenatal, childbirth, neonatal and children's care. The age-eligibility threshold for children's care will be progressively increased over the ten-year period. Starting in 2015, a once-in-three-years physical examination will be provided for the entire population free of charge.

- all of the above-presented efforts to strengthen the Basic Benefits Package will be predicated on cost-efficient and, therefore, rationally managed health care;

An important aspect of social and economic fairness is the issues of labor migration in Tajikistan. The health of labor migrants is discussed within the framework of cooperation with the EAEC and in the CIS Health Council. One of the positive aspects of this collaboration is the development of mutual mechanisms of recognizing labor migrants' medical certification by all countries who are members of this international grouping which improves the accessibility of workers to medical services.

In summary, this Strategy has presented a diverse program of innovative activities aimed at ensuring equitable access to health sector resources for all residents of Tajikistan.

In the next ten years, these variations will start leveling off across the patient population of Tajikistan, thanks to a stepped-up effort of health education, particularly, explaining to people the importance of seeking care in due time, rigorously complying with provider advice and prescriptions, and changing to healthier lifestyles. Nevertheless, the varied effectiveness of equally accessible care will persist. That is why the equity agenda will be limited to the objective of providing equitable access to health sector resources for the nation's entire population.

3. STRENGTHENING HEALTH SECTOR RESOURCES AND FINANCING

This chapter presents the resource-related priorities within the logical triad 'Results – Systems – Resources' that defines the basic structure of this Strategy. The resource component of the Strategy establishes a nexus between the volume of resources, on the one hand, and the quality, balanced allocation, and effective use of resources, on the other hand. In the next decade, Tajikistan will see increased levels, steadier supply, a structurally optimized allocation, and a better use of health sector resources. This applies to the personnel, logistical and financial support for treatment and prevention activities in Tajikistan.

§ 1. Development of Human Resources and Medical Science

It is generally agreed that prospects of health care system development and improving quality of medical, public health and pharmaceutical services considerably depends on proficiency and quality of training of medical and pharmaceutical workers as the main health care resource. The current situation in the health care sector implies implementation of deep reforms in the area of human resource management.

The aim of health workers policy is training and retraining of specialists with contemporary knowledge and skills in medical science and health care, who would be able to provide economical and clinical efficiency of high medical technology and new prevention techniques applied, diagnosis and treatment, achieving the optimum proportion of number of doctors and nursing staff, as well as eliminating imbalance in staffing at all health care system levels. Human resources management should be coordinated with educational policy in the continuing professional education system, as well as directed to promoting motivation of medical workers to raise professional skills. The main criteria of personnel policy, medical education, and incentive scheme for medical workers are quality of medical services rendered and patient satisfaction.

In recent years a number of legal documents, including "Concept of medical and pharmaceutical education reform in the Republic of Tajikistan" (endorsed by Government Resolution of RT #512 as of October 31, 2008), "Program of development of Tajik State medical University named after Abu-ali ibn Sino for 2006-2015" (enacted by Government Resolution of RT #446 as of October 3, 2006), "Program of medical workers training for 2010–2020" (endorsed by Government Resolution of RT #600 as of October 31, 2009), were approved in Tajikistan for the improvement of the health workforce.

The total number of doctors and paramedical workers in the country are 13,909 and 30,445 respectively. Availability of doctors per 10,000 population is 18.6 and for paramedical staff – 41.1. The corresponding figures in Central Asian countries on average are 28.2 and 75.5 respectively. These ratios of doctors and nurses are also lower when compared with indicators in the WHO European zone (33.9 and 72.7 respectively) and CIS (37.7 and 79.4).

The highest staffing level of doctors is seen in Dushanbe (67.2) and in Sugd Oblast (20.4), and the lowest one – in Khatlon Oblast (9.1 per 10,000 population) and in the Rayons of Republican Subordination (11.0).

One of the major problems affecting the decrease in the level of health care human resources is migration, which in turn is related to the low level of wages. Despite the lack of accurate data

on the percentage of human resources outflow, many medical workers especially young ones leave the country in search of higher wages. Many doctors and nurses leave the country for several months in a year to earn money for living and upon their return they either renew their work or leave the health care sector completely.

The most significant factor affecting the availability of medical human resources and its results is lack of funds, and in this case one of the solutions would be raising the salary. However merely increasing the salary and providing incentives for attracting and retaining staff in distant rayons would not be sufficient. Improving living conditions in rural area, adequate investments in human resources, as well as complying with the principles of efficient management will secure a more balanced distribution of human resources.

Thus, the issue of geographic imbalance of qualifications and employment is seen in the personnel planning and training system, as well as in the organizational misbalance (within one town or rayon) and lack of staff in medical facilities in other towns and rayons.

Training of medical and pharmaceutical personnel is carried out in 26 educational and scientific institutions. Analysis shows that the number of graduates and students enrolled in medical institutions from rayons with a low staffing level of doctors is lower compared to rayons with a higher level of staffing of doctors. This situation will be an obstacle for elimination of geographic misbalance of the staffing level of doctors in the future. Therefore the Government has made the decision to allocate proper benefits for graduates from these rayons. Training of specialists with higher medical and pharmaceutical education is conducted in Tajik State Medical University named after Abuali Ibni Sino, Tajik Institute of Post-Graduate training of medical workers (PGMI), and training of specialists with secondary medical and pharmaceutical education is carried out in 4 medical colleges and 10 medical training schools. TSMU enrolls 5,886 students and medical colleges and medical training schools - 18,514 students. There are about 852 graduates of TSMU, and 3,632 in medical colleges and medical training schools.

The number of annual graduate medical workers, given the health care sector reform and population growth, cannot meet the country demand and requires an increase of the annual enrollment into medical institutions.

The quality of training of medical workers should be improved with a view to implementation of the health care reform. TSMU is currently designing standards of higher medical education. Other factors directly affecting quality of training is the condition of educational institutions, availability of educational materials and level of knowledge of teaching staff.

According to the "Strategy of the Republic of Tajikistan in the area of science and technology for 2007–2015" the priority areas of health care research are as follows: infectious diseases, cardiovascular diseases, ontological diseases, digestive system diseases, mother and child health, endocrine diseases, eye disorders, sexually transmitted diseases, tuberculosis, HIV/AIDS, mental health and development of new pharmaceuticals.

There is a shortage of researchers in the following science areas: public health, cardiology, mental medicine, traumatology, narcology, nephrology, ophthalmology, transplantology and bioartificial organ, cardiovascular surgery, clinical laboratory diagnostics, medical-social expert examination and medical-social rehabilitation, pathologic anatomy, physiopathology, toxicology, forensic medicine, virology, and immunology. This lack requires promotion of cooperation with leading international scientific and educational institutions.

The State agency "Academy of Medical Sciences of Ministry of Health of the Republic of Tajikistan" was established to provide coordination of healthcare science and research institutions, introduction of state-of-the-art scientific achievements and new methods of diagnosis and treatment into medical practice. The Gastroenterology Institute of the Academy of Sciences of RT has been moved under the Ministry of Health of RT. At this stage most of the scientific institutions have no public accreditation that hinders higher quality training of scientific personnel.

This analysis of the status of healthcare human resources in the Republic of Tajikistan has identified a number of shortcomings in the area of planning, training and management of human resources, imbalance in the distribution of medical workers, lack of planning methods in accordance with demands, imperfect medical education system, low salary level and lack of motivation for improving quality of work, as well as incentive tools, low indicators of arrival of specialists to destinations, lack of well planned personnel lists considering institutional standards and actual workload, lack of management skills of health facilities' heads, and lack of data on scope of migration of medical workers for practice abroad.

The above-mentioned problems contribute to inefficient use of human resources and as a result affect the quality of medical care to the public. Based on the identified problems an integrated approach should be applied with regard to key aspects, including human resource planning, training and management. This approach will allow decrease and eventually eliminate the existing shortfalls; will provide an optimum balance of retaining the needed quantity and quality of health care personnel, and human resource development based on the demand of practical health care and the labor market condition.

Strengthening of healthcare human resources will be realized in the following directions: realignment of professional knowledge and skills of health care workers; optimization of human resource reallocation across the health care sector based on professional-qualification groups, level of care, types of health institutions and territory of the country; reinforcing financial and professional incentives; improving working conditions and strengthening support of the interests of healthcare workers; improving the quality of training of medical and pharmaceutical personnel and further medical science development.

Redirecting professional knowledge and skills of health care workers to new models of health care delivery: putting accent on strengthening of integrated therapeutic services, particularly further transition of PHC facilities to family medicine practice and gradual integration of vertical health care systems that will require cardinal changes in professional thinking, knowledge, and skills of medical workers. This will require the introduction of a single model of family medicine practice from pilot to national level

Structural optimization of healthcare human resource will be realized based on the following approaches and arrangements:

Filling family medicine vacancies in rural areas when economic incentives will substitute administrative measures and will be reinforced by other sources of social motivation. As women prefer to work close to their home and relatives, the success of family medicine practice will substantially depend on the compliance of geographic distribution of students of medical universities and colleges with the placement of the population of Tajikistan. To ensure such compliance, in the coming decade active enrollment of students from rural rayons, including remote ones, will greatly increase.

The professional-qualification framework will change in several directions. Advancing growth of PHC as a result of developing of family medicine practice will lead to redistribution of human resources into primary health care and firstly to rural homes and centers. The share of doctors of primary appointment will grow against the total number of medical personnel. The ratio of nurses and doctors will grow, not because of formal considerations (to approach "international standard"), but more based on the specific goal of improving quality of therapeutic treatment and labor productivity of medical workers in conditions of Tajikistan healthcare. If doctors are not sufficiently trained and work loaded, and the function of nurses is limited only to fulfilling the doctors' instructions, increasing the number of nurses to doctors would be meaningless; moreover, it may lead to a further decline of medical care quality. Advanced growth of nursing staff is justified in cases when functional duties and work load of doctors and nurses are clearly distinguished, where nurses are entrusted critical tasks substituting and complementing work of doctors. In the coming decade such conditions will arise in three directions of healthcare reform: within family

practice: considering staffing of rural health houses with nurse practitioners (in doctor's absence), ratio of doctors and nurses will be 2.5-2.8 to 1, that may exceed the current ratio of 2.5 to 1; within inpatient or institutional care nurses will have a more independent role in nursing and after-care of patients; in developing new social-medical services, particularly (nursing) care house for the aged; social-medical home nursing service for the handicapped and terminally ill patients. Incentives for raising labor productivity combined with operational-economic independence of medical and preventive treatment facilities will probably increase motivation of doctors to delegate part of their work load to nurses to raise efficiency and financial returns of their joint work.

The professional-qualification structure of healthcare professionals will become more diversified due to the increasing growth of number of doctors-dentists, nurse-technicians, engineers and engineers for operating medical equipment, as well as workers with nonmedical qualifications, primarily, specialists in the areas of systems analysis and planning, management, law, information technologies, socio-scientific and clinical studies, etc.

Reinforcing financial and professional incentives to improve labor intensity, providing quality medical care and respectful attitude towards patients

Strengthening financial incentives for good work of healthcare professionals will be realized in the following directions:

- the average salary in the health care sector will increase by 7.1 times in 2011-2020 (in terms of constant prices). Therefore, the salary of medical workers will reach the level considered fair on their behalf. This will significantly decrease staff turnover in the health care sector and primarily in the rural care network. Attractiveness of the healthcare sector will rise as a field of professional employment; along with increased competition and requirements for enrollment into educational institutions in regards to medical and other health care qualifications;

- the incentive remuneration function will get strengthened. Increasing the share of bonuses in its structure will make the income of practicing medical workers more dependent on their work efficiency and productivity;

- enhancing the role of nonfinancial factors of professional motivation: along with salary increases, healthcare professionals will increasingly experience nonfinancial "dividends" for their intense and successful work.

In the coming decade the following positive changes will take place in health care sector:

- labor safety requirements of medical workers will become an integral part of a new generation of standards of health care delivery. Compliance with these standards and enhanced monitoring of their realization will allow improved quality of working environment and decrease risks of occupational morbidity for healthcare professionals;

- position scale will become more multistage and will provide more frequent promotion of medical workers;

- providing computer technology and Internet connection tools for family medicine practice and other medical and preventive treatment facilities will considerably enhance access to information in professional activities of the health care sector and opportunities for continuous self-education.

- gradual transition of public medical and preventive treatment facilities to operational-economic independence within contractual relations with health authorities, as well as developing private therapeutic network will immeasurably expand the limits of professional and business initiatives – this is a significant motivational factor for the most competent and enterprising part of the health profession;

- integrated PHC model based on family medicine practice will lead to enhancement of the role of medical workers in local self-administration, and thus to strengthening their social authority. Political and civil weight of medical management will rise due to their leading role in interagency cooperation on issues of health promotion in Tajikistan;

- improving working conditions and enhancing support of interests of healthcare workers based on harmonization of state health policy and their professional and worldly motivation.

Effective use of more diversified, qualified, and motivated human resources will require modernization of personnel policy and methods of human resource management. The guarantee of continuous employment of graduates will be de-facto cancelled, firstly with introduced professional licensing; and secondly due to partial or complete release of the staff from the health facilities closed according to the structural optimization of the healthcare network.

After cancelling the guarantee of continuous employment, the Ministry of Health will study contemporary methods of human resource management in conditions of enhanced labor mobility. Specifically, continuous and universal enumeration of workers will be done based on personal and professional characteristics – in the public and the private sector; operational registration, liquidation of previous and establishing of new working places; stimulating professional-qualification and territorial mobility (support for acquiring new qualification and employment within or beyond the .

Forming a progressively thinking community of medical workers with an active civil position and advanced skills of professional and social leadership

The Ministry of Health has the task to draft a mid- and long-term forecast of supply and demand of human resources based on healthcare professions and qualifications, as well as training new workers and retraining of workers with experience in higher, specialized secondary and post-graduate education. Along with the introduction of new treatment models, particularly transition to integrated PHC based on family practice, functions of medical and nursing staff will be reviewed with a view to reflecting their increasingly diverse functions and more flexible organizational forms of using their labor. Many functions of human resource management will be realized by health authorities in cooperation with professional associations of doctors and nurses that will provide mutually agreed and acceptable approaches of dealing with surplus human resources in healthcare of the Republic of Tajikistan.

Improving quality of training of medical and pharmaceutical personnel will be a fundamental part of healthcare reform and will be achieved by the following:

- reform of secondary, higher, post-graduate and continuing medical education;

- improve state standards of medical and pharmaceutical education and develop new curriculum and programs according to the requirements of the World Union of Medical Education;

- improve the content of higher basic medical education in the Republic of Tajikistan providing training of general practitioners;

- improve post-graduate training through graduate education of doctors on basic and particular specialties;

- develop mechanisms of granting rights to graduates of medical and pharmaceutical educational institutions for individual professional activity including list of knowledge and skills on every qualification according to diploma and conformance with positions in healthcare facilities;

- improve competitiveness of graduates of medical educational institutions in the European and world labor markets;

- improve the process of employment after graduation by establishing a trilateral treaty between students, educational institution and future employer;

- establish educational-scientific-clinical bases combining educational institutions (medical university, colleges), core scientific-research institutes and clinical framework;

- optimization of legal and economic relations between scientific and educational health facilities and therapeutic institutions within a establishing single clinical base framework;

- establish electronic libraries and reference-information databases, introducing information technologies and quality management system into the educational process;

- develop a single criteria for forming professional associations based on medical qualifications (groups of specialties), developing mechanism for their participation in practice and certification of specialists;

- improve proficiency of healthcare workers based on further development of continuing medical education system for healthcare professionals including family medicine practice specialists;

- in line with a new public health model, it is necessary to introducing new professions to meet the needs of the population;

- train undergraduates in new and/or under resourced professional disciplines by developing educational programs;

- develop international cooperation in medical education area: the faculty\teachers and students exchange, international accreditation and recognition of diplomas.

Further development of medical science.

Further development of medical science with a view to improving quality of medical services envisages resolution of relevant healthcare challenges, introduction of new treatment methods and innovation of efficient technology:

- planning and conducting research in accordance with sectoral healthcare development programs and their priority directions;

- development of target scientific programs aimed at achieving specific results for state scientific order;

- development of incentive system, supporting development and introduction of innovation into healthcare;

- development and drafting plan for introducing results of scientific work into medical practice;

- concentration of funds and human resources for priority and innovation directions of medical science development;

- developing new quality and efficient drugs;

- forming a market of scientific medical services based on competition between scientific institutions of all forms of ownership;

- analysis and control of implementation of target and interagency scientific programs;

- training in critically insufficient scientific qualifications through training of specialists in leading foreign educational institutions;

- integration of medical science, education and clinical practice; scientific assessment and justification of economic and social efficiency of planned and realized measures in public health care.

§ 2. Improving the Supply of Pharmaceuticals and Pharmaceutical Activities

In recent years, after approving the Health Reform Concept and State Drug Policy in the Republic of Tajikistan, considerable work has been done to improve regulation of the pharmaceutical sector operation, quality of drugs and their affordability with a view of enhancing of controlling and licensing bodies, legal framework of pharmaceutical sector and rational use of drugs.

In 2008 the Law of the Republic of Tajikistan "On pharmaceuticals and pharmaceutical activity" was amended with a view to combat turnover of fake drugs. The Law prescribes measures of punishment for sale of fake drugs. Given the fact that according to regulations of the Law of Republic of Tajikistan "On narcotic drugs, psychotropic substances and precursors" sale of narcotic medications was a state monopoly, the Law was amended correspondingly that led to an increase of physical accessibility of the above mentioned medications.

Analysis of the dynamics in drug importation for the last 5 years shows that after cancelling VAT and custom duty on imported drugs, the volume of legally imported drugs increased 4 fold. This proves that the importation of contraband drugs is reduced as a result of legislation of the pharmaceutical market. During the last 5 years the number of registered drugs has increased 4.7 times. Despite positive shifts in the drugs registration process, the issue of unregistered medications availability on the local drug market remains significant.

During the last years, an improvement in the drug certification process has been observed. Certain measures have been undertaken for improving the certification system and strengthening the infrastructure of the Republican laboratory on drug quality control under the state Agency Supervision of Pharmaceutical Activity. The share of drugs not complying with state standards is decreasing every year. However, the situation needs some changes and it is vital to know how these

analyses are performed and what quality criteria are applied. The issue of drug certification (quality of pharmaceuticals) should be settled upon import and registration. Currently the infrastructure of the laboratory on drug quality control does not comply with up-to-date requirements of quality assurance and there are no laboratories for conducting modern immunobiological and radiologic research.

Analysis of prescription habits shows that overprescribing is widespread. This issue is most common among doctors working in urban centers rather than among doctors working in rural health facilities. Another problem regarding rational use of drugs is the lack of knowledge of doctors and pharmacists and a lack of sources of objective information on drugs.

In 2009, public expenses (per capita) on pharmaceuticals 1.83 times increased (US$ 0.53); however, the index still remains low in Tajikistan. Compared to Dushanbe, the cost of essential drugs in Sugd and Khatlon regions are higher by 15-18 and 20-25% respectively and in GBAO by 26-30%. To reduce prices and streamline the drug procurement process the Republican Center on Medicine and Medical-care Products Procurement was established under the Ministry of Health by Government Decree of RT № 516 as of December 30, 2005. At the moment branches of the Center operate in Sugd and Khatlon regions, and in GBAO.

Currently prices for drugs procured by the Republican Procurement Center are lower than those of wholesalers (by 20-25%) and retail drug-stores (35-50%). However, not all hospitals procure drugs from the Center because of the limited range of drugs available, as well as irrational procurement by the management of the medical facilities. A major task of the Republican Procurement Center is to assist medical institutions in purchasing generic and essential drugs. Analysis of the volume of generic and brand drugs procured in three major republican hospitals shows that from 2005 to 2008 the share of procured generic drugs grew by 16%. The share of procured essential drugs during the same period grew by 15%. It is very difficult to assess the percentage of proven quality procured drugs.

Improving commercial affordability of drugs requires additional measures and strengthening the work of the Republican Center on Drugs and Medical Commodities Procurement, and developing the domestic pharmaceutical industry with the support of the Government and partners.

According to MOH assessment, the pharmaceutical spending per patient is about 60% of the total cost of treatment. With the introduction of the BBP, the national Programs on fighting socially significant diseases (tuberculosis, HIV/AIDS, diabetes, coronary heart disease, malaria etc.), as well as the introduction of the Law "On medical insurance in the Republic of Tajikistan," it is vital to ensure proper procurement and rational use of quality, inexpensive essential drugs.

The accessibility of pharmaceuticals also depends on the availability of relevant numbers of pharmacies and their geographic location. At the moment in Tajikistan there are 1,328 pharmacies and 20% of them are located in rural areas, while on January 1, 2009, the percentage of the population living in urban areas was 26.3%, and in rural – 73.7%. Thus, the majority of pharmacies are located in urban centers and only a small percentage in rural area. This trend is connected with the unprofitability of rural drug-stores, the lack of policy supporting accessibility of drug-stores in rural and remote areas. A comparative analysis of physical accessibility and prices for drugs between urban and rural drug-stores in some rayons shows low physical accessibility and high prices in rural drug-stores. Another issue related to the development of rural drug-stores is the lack of pharmacists. It is very difficult to hire pharmacists to work in rural pharmacies and in future this will require developing some mechanism for supporting activities of rural drug-stores.

These existing problems related to quality assurance, rational use and drug accessibility require proper measures to ensure future development of the pharmaceutical sector in order to improve the quality of health care and services.

The following priorities are identified for improving the quality and decreasing the cost of medical services, through improving management of the pharmaceutical sector and providing

accessibility of inexpensive quality essential drugs by 2020: improving the drug quality assurance system; taking measures on rational use of drugs; and ensuring the availability of inexpensive drugs.

In order to achieve the goals and priorities set out, work should be carried out in the following directions:

Improving Drug Quality Assurance.

- raise efficiency of state control in the area of drug sales to decrease and prevent fake and unregistered drugs from entering the pharmaceutical market;
- review the existing drug registration system for greater transparency of the registration process and change the registration requirements. The registration system should encourage registration and re-registration of proven quality drugs for the essential drugs list;
- introduction of international standards (GLP, GCP, GMP) into domestic health care and pharmacy;
- improve physical infrastructure of Republican and Oblast Laboratories on Drugs and Medical Commodities Quality Control, State Agencies on Pharmaceutical Control, as well as establishing Immunobiological, toxicological and radiologic laboratories within these structures;
- organize training of specialists responsible for assuring quality of drugs according to international standards.

Taking measure on rational use of drugs

- eliminate overprescribing by doctors through educational training programs and introducing elements of rational use of drug into the curriculum of pre and post-graduate education, as well as improving the regulatory framework;
- review and introduce current clinical practice guidelines and essential drugs formulary;
- increase access to modern and accurate information on drugs;
- reestablish the dispensing of drugs on prescription and restore the role of hospital pharmacists as medical assistants in primary health care facilities;
- strengthen efficiency of control of drug advertising and take measures on regulation in the area of drug sales;
- conduct monitoring of the side effects of drugs and develop methods of information distribution on issues of safety and efficiency in drugs use;
- conduct research on use of drugs and regulation of pharmaceutical activity.

Assuring availability of inexpensive drugs:

- secure equal physical and economic access for the public to essential drugs;
- raise efficiency of public drug procurement through improving respective regulatory framework and take steps on decreasing the price of drugs;
- conduct monitoring and analysis of prices for pharmaceutical drug, decrease their prices and costs to the public for treatment;
- develop pricing mechanism promoting sale of quality and inexpensive drugs;
- prepare a list of drugs to introduce into the BBP and national programs for the most common diseases based on: analysis of clinical and cost efficiency; evidence-based medicine; and review of the existing practice of privileged dispensing of drugs;
- regulate promotion of drugs in the market by pharmaceutical companies;
- strengthen activity of Republican center for drug procurement and set proper procurement of quality generic and essential drugs at low prices from reliable suppliers;
- attract private pharmacies to resolve the issue of pharmaceuticals supply

§ 3. Modernization of Physical Assets

In the next ten years, the health care facility networks will be reconfigured both across levels and types of service based on the Health Sector Master Plan. The exterior and the interior of medical facilities will be upgraded to modern standards. Their access to utilities and modern medical technologies will significantly improve. All the respective changes will be planned and

implemented as part of a long-term structural optimization and investment program to be designed for the health sector of Tajikistan. The strategic elements of this program are laid out in this section:

Updating inventory of health services facilities: In 2010 under the World Bank funded project a survey was conducted in Tajikistan to elaborate a Master Plan for modernization of health assets\facilities. The resulting information will include the following: numbers, typology, and GPS coordinates of health care facilities; their capacity, staffing, floor space, access to utilities, supply of equipment, and care volumes and other data. The provider census data will inform structural optimization and investment solutions for the next decade.

Assessment of shortage of fixed assets: In 2012, the volume and structural parameters of the health care provider capacity will be compared with the parameters of capacity need by facility type and function. The following two questions will be answered: (i) Where and what health care facilities are missing? (ii) Where and what health care facilities do not meet local demand for services and why?

Assessment of excess provider capacity: Under-utilized provider facilities will be examined in more depth. If underutilization is caused by obvious excess of capacity, the recommendation will be to take respective facilities out of operation and close, write them off, or re-profile them. Indispensable provider facilities, underutilized as they may be, will be enrolled in a provider facility rehabilitation program and targeted with future capital investments.

Elaboration of the local, regional, and national lists of investment sites: Given that a common reason for low clinical volumes and inadequate quality of services lies in the weak supply of physical assets and technology to health care providers (particularly, lack and/or high wear and tear of fixed assets, i.e. buildings, structures and durable equipment), each district of Tajikistan will construct a list of investment titles for new construction and capital renovation projects in health care facilities. District lists will be collated by region and nationwide, and the resulting aggregate list will guide the health sector investment program over the next 10 years in line with the 2010 Master Plan recommendations. Investment project titles will be selected from this list for the rolling three-year investment management plans.

Design estimates by type of investment project: Master floor plans will be updated to reflect the changed functionality and care standards by provider facility type. Based on these solutions, standard investment projects will be designed and updated and their costs will be assessed for the new construction, capital renovation, retrofitting, and right-sizing of health care facilities. Project cost estimates will be geared to the domestic pricing of construction, installation, and repair works, as well as the prices of imported materials and equipment and internationally procured works and services, linked to technology imports.

Three-year and annual planning of investment activities: The health sector capital investment budget will be significantly increased and, importantly, will become steadier over time, thanks to investment planning by rolling three-year periods. The introduction of the three-year planning is important for a number of reasons: (a) The duration of an investment project usually exceeds one year. If sufficient funding is not set aside upfront, the amount of unfinished construction will grow. (b) Given a large backlog of investment demand in the health sector of Tajikistan, regions and rayons will avidly compete for investment resources from the central budget, particularly in the first few years. A three-year investment project list will be longer and more inclusive than a one-year list and, that way, more accommodating for the many contending applicants. (c) Given its large scale and high cost, the investment program in health will have to rely on support from the international development partners. Since many such partners would be more willing to invest through joint ventures with the Government of Tajikistan, a medium-term plan and funding will be welcome as a tool for all actors to minimize their investment risks in joint projects.

Investment budget planning: Three-year and annual investment budgets will be formed based on project costs and availability of funding. Local and regional budgets will serve as the primary source of investment funding for project sites on the district and regional investment title lists.

Local (regional) projects that match the national priorities of the structural optimization and investment policy will be subsidized from the central budget. Investment funds provided by the international development partners will be allocated in the priority order to the investment objects that also match the national priorities of structural and investment policy.

The inclusion of health services facilities on the investment title lists will be guided by the following considerations in line with the 2010 Master Plan:

- an investment project matches the structural priorities of the national health policy and advanced models of health care delivery: Other factors held constant, priority attention will be given to the new construction, capital renovation and retrofitting of rural primary health care facilities that will provide the physical asset base for family practice. An estimated nationwide demand for such facilities is 2.000. One-fourth of them are rehabilitated, the remaining ones will be built anew or undergo major capital renovation. Other structural optimization and investment priorities will include: (i) The modernization of district-level provider networks, including over 50 district health centers and 40 central district hospitals; (ii) Fixed investment to prepare closing and salvage or re-profile 'structurally-depressed' health care facilities. In the next decade, investment activities will emphasize the downsizing and re-profiling of the hospital network. The mostly unused rural line hospitals (SUBs) will be closed or renovated into health houses and centers. A transition to modern disease management strategies in such practice areas as TB, STI, drug-dependence, and psycho-behavioral disorders, will shift emphasis to outpatient care and social support. This, in turn, will reduce demand for inpatient services and, consequently, long-term hospital beds in 'dispensaries'. The latter will be closed or transformed into social-medical care facilities, such as nursing homes for the elderly and chronically ill.

- an investment project supports new standards of health care: In PHC, the standard floor plan, equipment list, and investment cost will be set out per rural health house and rural health center and differentiated by several family medicine practice modalities, outlined previously in this Strategy. Each standard PHC facility design will match the floor space, utility, and equipment requirements that, in turn, reflect the practice scope, disease management strategies, clinical protocols, enrollment, and catchment area size of a family health practice.

Only those PHC facilities will be included in the 10-years health sector investment program that meet concurrently the following conditions: firstly are provided with qualified medical staff; secondly are provided with recurrent financing; thirdly have an operations plan with carefully set parameters of service volumes and capacity utilization; as well as supply plans for pharmaceuticals, expendable materials, other health goods; works and services to maintain new facilities and equipment; and professional support in planning, analysis and information areas. Pre-investment feasibility studies will assess the probability of the future facility compliance with the above-listed conditions.

The outlined policies and procedures for fixed investment planning will be enhanced by the inclusion of the international development partner initiatives in the health sector investment program of Tajikistan. Joint efforts will especially be made on assessing the level of vulnerability of physical assets of the health sector to disasters.

Concurrently with the increased volume of investment activities, the issue of timely replacement of the worn-out and obsolete buildings, structures, and durable equipment will come to the fore. The introduction in 2012 of the depreciation of fixed assets as a financed cost will enable an important economic solution to this problem.

Starting in 2016, the Ministry of Health will establish a practice of feasibility studies of the privately-financed fixed investment projects: not just as a matter of compliance with the mandated process of investment authorization but also to identify projects for selective government guarantees on investors' private loans.

It is also suggested to introduce a mechanism of privatization of health care facilities that are inefficiently functioning; this would be carried out similar to the privatization of dental care facilities.

Along with the modernization of health care facilities, one prioritized direction will be step-by-step provision of up-to-date equipment, which would enable introduction of new diagnostic methods and high-technology treatment.

For the first phase it will be necessary to improve the technical base in the capital health care facilities (of republican and city level) as the most severe and difficult to diagnose cases are found there.

For the second phase it will be necessary to modernize the technical base in health care facilities on oblast level in order to provide the population access to computer (magnetic resonance) tomography, angiography; computerized ophthalmologic diagnosing, access to remote laboratory diagnosing and consulting systems (telemedicine) , systems for reanimation of newborns; lithotripsy; immune-typing of blood and other contemporary technologies.

For the third phase it will be necessary to provide the needed equipment for implementing clinical guidelines to the central rayon hospitals and the central city hospitals.

§ 4. Health Financing

The intent of health financing reform implemented to date has been to address two main problems:

- low state health budget and high population out-of-pocket payments which pose barriers to access to necessary health care services especially for the most vulnerable populations;

- outdated budget formation and resource allocation processes which limit risk-pooling to increase equity, hamper attaining efficiency increases by maintaining unaffordable infrastructure capacity, and do not promote shifting to more cost-effective primary health care.

A Health Financing Reform Inter-Ministerial Working Group was established in July 2003 to review policy options for health financing reforms, develop a legislative base for health financing reforms, and make recommendations for implementation. The Working Group developed a health financing strategy which outlined the main principles of financing reform for 2005 to 2015. Approved by the Government in May 2005, the Health Financing Strategy for 2005-2015 contains the following main objectives: gradually increase the government share of health care financing; pool budget funds for health care; establish the institutional structure for a single payer for health care; develop and implement new health provider payment systems; Increase the salaries of health care professionals; address the problem of informal payments in the health care system and introduce formal copayments for health services; improve the health care management system; develop private health service providers;

To implement the 2005-2015 strategy, the MOH created three sub-working groups:

- PHC per capita payment system;
- case-based hospital payment system; and,
- development and implementation of the program of state guarantees/basic benefit package;

In recent years, these groups have been active over the last few years and have succeeded in developing the regulatory base and starting implementation of a number of interventions.

The health reform process is led by the Ministry of Health (MOH). Development partners currently supporting it include the European Union, World Bank, USAID, Swiss Agency for Development and Cooperation, WHO, and the Aga Khan Foundation.

The health financing system is composed of 3 core functions: revenue collection, pooling of funds, purchasing of health services. These core functions are complemented by a policy on benefits and formal patients-copayments.

The present section of the National Health Strategy for 2010-2020 is consistent with and reinforces the vision of the Health Financing Strategy 2005-2015 and extends and enhances health financing reform in Tajikistan. It is moreover compatible with pre-existing commitments of the Government and MOH such as the 2008 Law on Mandatory Health Insurance.

The goal of the health financing reforms is development of a sustainable and integrated system of health financing based on increased health budget funding with equitable distribution of resources and health system efficiency increases enabling provision of universal coverage under the BBP, increased financial risk protection for the population especially vulnerable populations, improved access to health services, rational use of health sector resources, and incentives for improvement in quality of health services.

The main objectives of the strategy are to:

- Increase the share of public financing for the health sector;
- Provide the population with equal access to health services;
- Gradually equalize health financing across regions;
- Improve budget formation and health purchasing mechanisms including new output-based provider payment systems for the BBP;
- Increase the salaries of health care professionals and ensure financing for the availability of pharmaceuticals and medical material in public health facilities;
- Improve and increase transparency of BBP formal population copayments;
- Increase quality of health services, efficiency, and autonomy of health service providers;
- Clearly define and delineate functions, roles, and relationships of all health sector entities.

1) Revenue Collection Function: bringing increased resources for the healthcare system

In 1996, in Tajikistan real gross domestic product (GDP) was only 34 percent of the 1991 level. In 1998 GDP started to grow slowly, and since 2000 annual per capita GDP growth rates have been between 8 and 10 percent. Nevertheless, Tajikistan remains one of the poorest countries among the post-Soviet states, with a GDP of $518 per capita in 2007. This limits the capacity of the State to make a sufficient contribution to the costs associated with improving the healthcare system.

Over the last few years, the Government has increased general revenue funded health budget expenditures. In 2003, health budget expenditures were about $75 million or about $12 per capita. By 2007, total health expenditures were $245 million or about $34 per capita. From 2003 to 2007, health budget expenditures as a percentage of GDP increased from 1.3% to 1.9%. However, health budget expenditures as a percentage of GDP in the Republic of Tajikistan remain among the lowest in the world.

The share of the health budget in the consolidated (central + regional budget) is moreover relatively low as compared to other social spending (5.7% of consolidated budget in 2008).

As a result, government budget funding for health care makes up only 16% of total health sector expenditures. Donor financing contributes about 14% to total health sector funding. Households contribute 70% of total health sector funding. Although population copayments under the Basic Benefit Package have been formalized (see Basic Benefit Package Section), as public funding for health care is not sufficient private out-of-pocket payments increasingly fill the health financing gap. Many of the out-of-pocket payments are made informally to health care workers directly to receive services or inpatient drugs.

Introduction of a mandatory health insurance system, which has been explored by most countries of the Former Soviet Union, is a challenging policy option given the small size of the formal sector in Tajikistan. Nonetheless, a law on mandatory health insurance (MHI) was approved by the Government in 2008. The law stated MHI implementation would start January 2010, but due to the socio-economic situation as well as structural reasons the implementation is now put on hold until 2015. It is critical that MHI is implemented very slowly and carefully, aligned appropriately to the environment and consistent with general health financing reforms. MHI priority activities are included under each health financing function section.

The Republic of Tajikistan is implementing a Medium Term Expenditure Framework (MTEF) which has been piloted in the health sector since 2006. The MTEF is a key element of general public finance management reform as it supports improvements in fiscal discipline and sustainability, efficient resource allocation, operational efficiency, and transparency. Major achievements so far, include formulation of the budget program structure of the Republican budget, drafting of program-associated performance indicators as well as substantial improvements in the overall budgeting process starting from the Government to the line ministry level. A key objective of the MTEF reform will be to change the budget planning from the old post-soviet system based on inputs and incremental budgeting to budget planning based on efficiency and performance. The MTEF should positively impact the health sector by improving estimation, formation, predictability, and management of the health budget; and contribute to linking the health sector strategy and health priorities to the health budget and funds flow.

Priority Activities:

- gradually increase the health budget as measured by health budget expenditures as a percentage of total government expenditures. Establish concrete plans with predetermined numbers. Increases in health budget expenditures will be a condition or indicator for development partner investment in the health sector strategy;
- perform analyses of the National Health Accounts (NHA), on the basis of the work initiated in 2009 and 2010 between the MoH (Department of the economy and health budget planning and HAPU), the MoF and the State Statistical Agency to show sources and uses of health sector funds and other operations research or special studies to inform policy decisions;
- strengthen MTEF as a tool for health budget planning;
- monitor budget execution to help ensure predictable and consistent funds flow to health service providers;
- analyze potential resource collection scenarios as part of the establishment of the MHI scheme;
- develop a regulatory framework for private financing through voluntary health insurance (VHI), in preparation of development of VHI, granted that private health expenditures will remain a major source of funding for the healthcare system in the next ten years;
- determine roles and relationships of health sector stakeholders to improve forecasting, collection, and execution of health sector budget from various funding sources.
- grounded in overall progress in the implementation of the Strategy, transform modalities of DPs' assistance to the health care sector, toward a SWAp in Tajikistan. From the current mostly project-based approach, donors support may progressively move toward a mix of parallel project-based and budget-support earmarked to health, with disbursements made based on results achieved.

2) Pooling of Funds Function: improving pooling of resources

Pooling of funds is the level of health budget consolidation (republican, oblast, city, or rayon). It is critical to access, equity, and financial risk protection as it allows equal and fair distribution of health funds to the entire population. Pooling of funds is also a pre-condition for the health purchasing function including implementation of new output-based provider payment systems to enable health system restructuring and efficiency increases as well as population choice and at least limited provider competition.

Significant differences in health financing currently exist in Tajikistan both within oblasts (between rayons) and between oblasts. For example, in 2009 the rayon health budget per capita in Khatlon Oblast rayons varies from 12 to 51 somoni per capita. In addition, health financing and service delivery is very fragmented as separate health systems are funded and operated at republican, oblast, city and rayon levels. These duplicating and overlapping geographic health systems substantially contribute to the excess capacity and low efficiency which heightens the impact on the health budget.

The Republic of Tajikistan Health Finance Strategy for 2005-2015 includes pooling or consolidating health budget funds at least at the oblast level. The National Health Strategy maintains this basic objective in the pooling of funds function.

Over the last five years, how to pool funds at least at the oblast level has been the subject of extensive policy dialogue. However, limited progress has been made and the health budget is not pooled or consolidated at the oblast level. The PHC per capita payment system is currently being implemented with rayon level pooling of funds. Rayon level pooling of funds has been a practical and successful first implementation step for PHC. However, as implementation progresses the large differences in health budget funding across rayons is emerging as a major obstacle. A mechanism for oblast level pooling or at least geographic equalization across rayons is required to enable further expansion of the PHC per capita payment system. While pooling of funds at the rayon level with some mechanism to equalize health budget funding across rayons is a viable option for PHC, oblast level pooling of funds is an essential precondition for implementing changes in the hospital sector.

During the Health Strategy development process, Working Group dialogue resulted in the specification of a technical option for pooling funds or consolidating the health budget at the oblast level. This option is summarized as follows:

- the decentralized revenue (budget) structure in Tajikistan is based on national, oblast, and rayon levels and change to the Tajik current law is needed;

- the Oblast Finance Department (OFD) is responsible for forming and controlling the budget within the entire oblast (across all rayons). The establishment of budget control figures at the oblast level can be used to calculate unified provider payment rates across rayons. Unified provider payment rates are in effect virtual pooling of health budget funds and can be determined and managed by the OHD as health service purchaser;

- national level subventions can be used at the oblast level. Based on approved per capita financing norms, use these funds in oblast rayons.

Over time, increasing the share of state health budget funding and pooling health budget funds at the oblast level will increase equity and financial risk protection for the entire population. However, given that 70% of health funding currently comes from population out-of-pocket payments, there is a long way to go before reasonable financial risk protection for the population is obtained. In the short-term, formalized community financing or community level pooling could contribute to increased financial risk protection especially if done within the framework of the BBP. Introducing community financing outside the BBP framework increases the risk that more vulnerable communities will not benefit from health financing reform over time leaving them always more vulnerable. Community financing contributing to reducing individual financial risk for BBP formal co-payments or other paid services could reduce individual risk in the short-term but also enable the community to benefit from improvements in health financing in the long-term as the health budget increases and population copayments decrease.

The current Strategy is consistent with the dynamic introduced in the Health Financing Strategy for 2005-2015 and Mandatory Health Insurance Law, as they envision a single-payer system in Tajikistan.

Including program budgeting in implementation of the MTEF will enable linking health sector policies, plans, and programs, including the Health Strategy, to budget formation and resource allocation. According to 2010 Budget Instructions the line ministries will also have to define key outputs for their budget programs.

Priority Activities:

- Pooling of funds or health budget consolidation at the oblast level;
- Improve budget formation including introduction of program budgeting for health;
- Conduct operations research on such topics as monitoring equalization of geographic resource equalization;

- Explore potential for introducing community financing within the broader health financing reform and BBP framework;
- Analyze scenarios for the development of MHI scheme based on this oblast level funds pooling;
- If oblast level pooling is implemented together with national level subventions but it does not result in equalizing health budget funding (as defined by payment formulas) for the entire population, national level pooling would be considered.

3) Health purchasing function: establishing a single purchaser at oblast level

The health purchaser administers the pool of funds (consolidated health budget) and implements health purchasing mechanisms. The Health Financing Strategy 2005-2015 states that the health purchaser would be the Oblast Health Department (OHD) Economic and Financial Relations Department (DEFR) or OHD Finance Department. The Health Strategy also contains this critical assumption or health policy decision.

In the past five years health purchasing mechanisms including new output-based provider payment systems and BBP introduction have progressed on a pilot level in selected rayons. However, they have been developed and implemented through a patchwork of Tajikistan institutions without fully defined roles, and with extensive donor/project support. This progress is not sustainable without the establishment of a new institution or designation of an entity within an existing institution with a mandate to be the health purchaser and required health/finance information systems and human resources capacity.

In a way compatible with future MHI development, the single health purchaser at oblast level will pool public funds from different sources and contract with accredited public and private service providers.

Over the last year, the MOH has led dialogue on the establishment of new Rayon Health Departments/Sectors (RHDs). The role of the RHD is to supervise the quality and provision of care. RHD is not a fund-holder and will not have a pooling or purchasing function. Throughout the dialogue the MoH and development partners have come to a consensus that the established RHDs won't perform these functions not to increase the budget administrative lines or reduce disbursements for direct costs associated with patient treatment and health program implemenmtion

Priority Activities:

- Establish a health service purchaser in the OHD Finance and Economic Forecast Department;
- Develop and implement plans to build general systems and human resources capacity in the OHD Finance and Economic Forecast Department;
- Develop mechanisms and capacity in the OHD Finance and Economic Planning Department for specific functions of health service purchaser including budget formation, calculation of unified provider payment system rates, processing and approving provider reports. It is expected that health budget funds flow would remain within the Treasury System but the OHD Finance and Economic Planning Department as health purchaser must have a substantial role in financing and administering health programs to ensure matching of health priorities and health financing;
- Define and develop roles and relationships between all health financing stakeholders including MOH, MOF, Local Administrations, OHD, OFD, RHD, Treasury System, and health providers

4) Health Purchasing Function: improving resources allocation

In addition to the low level of funding, the nature of health budgeting and resource allocation adds obstacles to improving equity, access, efficiency, and quality in the health sector. As substantial increases in state funds for health care are not expected in the short-term in Tajikistan, reforms in budget formation and resource allocation offer the most viable option for improving the performance

of the health system. In essence, it is critical to maximize and extend the impact of the limited health budget.

The allocation of resources to health care providers in Tajikistan generally follows the traditional chapter (line-item) budgeting process, allocating health funds across facilities by infrastructure or input measures such as the number of beds or size of the staff, rather than the population covered or services provided. The budgets must be strictly used by line item. Reallocation across line items requires permission, which can be a lengthy process for a small reassignment of funds across line items. Protected line items such as salaries and utilities cannot be changed. In summary, there is no or limited incentives for health facilities to improve internal resource allocation.

The objective of health purchasing improvement implemented to date is moving from normative-based budget formation to output-based provider payment systems including PHC per capita and case-based hospital payment systems to improve equity and efficiency in the health system.

Especially, these purchasing mechanisms will create financial incentives for restructuring, rationalization and efficiency increases in the network of health facilities (hence reinforcing the dynamic created by the forthcoming Restructuring Master Plan), and enable increases in workforce pay in line with the Human Resource sub-strategy and overall wage reforms in the economy.

PHC Per Capita Payment System Implementation:

Since 2005, implementation of a PHC per capita payment system has been piloted and rolled-out in Tajikistan. Phase I of the PHC per capita payment system includes only variable costs and has been implemented through the following steps:

- Initial pilot in Dangara and Varzob rayons;
- In 2007, improvements in the PHC per capita payment system codified in a joint MOF and MOH decree and expanded to 15 rayons;
- In 2008 the PHC per capita payment system expanded to 15 rayons included pooling of funds at the rayon level, at least 40% of rayon health budget allocated to PHC, creation of PHC Network Manager position, a separate budget of expenditure (budget plan) for PHC, and per capita payment system design for variable costs including three parameters: the health budget of the rayon, the size of the population of the rayon, and an age/sex adjustment;
- In 2009, a joint MOH and MOF regulation on per capita financing separated PHC accounting, human resources management, and capital assets;
- In 2009, the new PHC per capita payment system was expanded to all 44 rayons in Khatlon and Sugd oblasts, three RRS rayons, and one GBAO rayon with implementation beginning April 1, 2009;
- In the future, PHC per capita payment will be defined on an oblast level by the OHD. The capitation payment will be allocated from the OHD to contracted PHC service providers and calculated based on the number of individuals enrolled with the PHC provider;
- The MoH plans to roll out the per-capita scheme piloted to the entire country starting in the second half of 2010. Additionally, one pilot rayon will apply the capitation mechanism to all its expenses;
- Implementation of case-based hospital payment system;
- The pooling of funds at the oblast level and existence of the institute of health care service purchaser are pre-conditions to proceeding with implementation of a case-based hospital payment system.

Other Health Services and Functions.

Health purchasing reform to date has been confined to individual health services especially PHC and hospital services. Health purchasing improvements have not yet been initiated for other health services or functions including public health, vertical infectious disease control systems, medical education, and capital investment.

When MHI is implemented in Tajikistan, all sources of funding should have unified pooling and purchasing arrangements to ensure one BBP for all citizens of Tajikistan and health financing reforms which support continuous increases in both equity and efficiency. .

Priority Activities:

- Continuous strategy development and monitoring to ensure provider payment systems and other health purchasing mechanisms match BBP structure and entitlements;
- Complete national roll-out of PHC per capita payment system (variable costs);
- Design, pilot and roll-out PHC per capita payment system (all costs including salaries), continuous refinement of system;
- Link new financial incentives with continuous improvement in PHC structure, human resources planning and management, scope of services and continuum of care, service delivery, and integration of vertical systems into PHC;
- Introduce, expand, and continuously refine a case-based hospital payment system;
- Identify and resolve budget formation or funds flow issues hampering output-based provider payment system implementation;
- Introduce, expand, and continuously refine new payment systems for other individual health services including emergency and outpatient specialty care;
- Develop mechanisms to pay for health promotion activities and ensure that provider payment systems contain incentives for health promotion;
- Develop mechanisms to pay for high-cost tertiary services;
- Improve pharmaceutical drug procurement and financing systems including for outpatient drugs;
- Pilot, evaluate, and expand pay-for-performance adjustments in the provider payment systems;
- Develop regulatory framework to contract with private service providers.

Public Health, Infectious Diseases, and Other Health Services and Functions:

- Introduce, expand, and continuously refine new payment systems for vertical systems including TB and HIV. These new payment systems should contain financial incentives for further integration of vertical systems with the general health system;
- Introduce, expand, and continuously refine new payment systems for public health services including SES and medical education;
- Improve mechanisms for capital investment and capital asset maintenance.

Cross-Cutting or Supporting Activities:

- Improve health information systems using new provider payment systems;
- Link provider payment systems to quality assurance mechanisms.

Health Policy Analysis Unit will conduct research or special studies on topics such as impact of selected provider payment systems on system performance.

5) Health Purchasing Function, a prerequisite: Provider Autonomy and Enhanced Health Management Capacity

In order for the health purchasing function to achieve the desired objectives and new output-based provider payment systems to be effective, it is necessary to increase management capacity and the autonomy of health care providers to respond to new incentives in the system. For example, the case-based hospital payment system is intended to give the hospital manager more autonomy to restructure the hospital and manage his entire budget including combining health budget and formal copayment revenue for all cases to create a complete hospital budget. In particular, providers should be granted autonomy to reallocate their budgets across line items to improve internal efficiency and meet service delivery priorities.

Activities implemented to date by the MOH and development partners have focused on business plans for PHC facilities in concert with the new PHC per capita payment system and limited health management training.

Priority Activities:

- Develop and implement a legal and policy framework to increase health service provider autonomy;
- Develop and implement a legal and policy framework for private sector development and regulation;
- Support expansion of business plan development for health service providers;
- Support financial and information system improvements;
- Continuously improve health management through training, capacity building, and provider level health system management improvements;
- Establish a Master's in Health Management program;
- Coordinate and harmonize health financing reform and public finance management including continuous improvement in Treasury System operations;
- Improve health purchaser and health provider accounting and financial management systems and reporting, fiduciary capacity building, internal and external audit, internal controls, etc.

6) Patients' Entitlements: Improvements to the Basic Benefits Package

The health financing through revenue collection, pooling of funds, and health purchasing are the policy levers or tools that the Government and MOH of Tajikistan can use to ensure the population's entitlement to health services in the BBP. However, full realization of the BBP also requires clear and realistic BBP specification including formal population copayments.

The 2003 constitutional referendum modified the constitutional provision for free health care services (Article 38) allowing public health facilities to provide paid services to the population. Since then the health reform process in Tajikistan has taken important steps toward aligning commitments for free health care with available resources and formalizing previously informal population out-of-pocket payments.

Since 2004, the MOH has developed and refined the BBP. The structure has been consistent and contains seven categories defining types of health services in the BBP: emergency and ambulance care, PHC, outpatient specialty care, outpatient drugs, inpatient or hospital care, dental care, and sanitary and hygiene services. The BBP defines the health care services guaranteed to be provided for free and identifies a set of additional services that are paid either partially or fully by the patient. The guaranteed package includes basic PHC services, with most preventive services provided to the entire population free of charge. Currently, the BBP is implemented in eight pilot rayons.

In December 2008, the Government of Tajikistan approved Decree #600 on introducing paid services based on price lists. An intensive review of Decree #600 by MoH and development partners resulted in agreement that the price lists will be aggregated into 12 copayment categories and would be merged into the BBP. Formal population copayment categories will be prospective rather than retrospective with a small number of simple, clear and transparent copayment categories. The general strategy for formal copayments is step-by-step aggregation of all population fees into a small set of formal copayments that group or bundle services and are prospective so the population knows in advance what they need to pay, to whom and for what.

A sliding-scale formal copayment rate is applied to hospital services. The 2009 BBP included ten formal copayment categories. Exempt populations are also entitled to a limited subsidy on a set of prescription drugs. The BBP includes mechanisms to promote efficiency in resource allocation, such as mandatory referral from a primary care physician to obtain services for free or with a copayment from specialists or hospitals

In 2011, the MoH plans to roll-out the BBP scheme to all cities and rayons of Sugd Oblast in addition to pilots in other rayons.

Finally, if MHI is implemented in Tajikistan, the initial objective will be reducing population formal copayments under the BBP.

Priority Activities:

- Specify and approve the BBP on an annual basis to ensure that primary preventive medical services are incorporated and encouraged;
- Continue to refine the BBP and close the gap between the state health budget and BBP commitments;
- Expand the BBP nationwide and link directly with output-based provider payment systems to match BBP commitments with provider payment;
- Continue to improve formal copayment structure and determination of copayment level including bundling the entire price list into formal copayments;
- Assess and improve the BBP exemption structure;
- Conduct research or special studies on BBP, funding gap, and population out-of-pocket payments.

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4. MONITORING AND EVALUATION

The system of monitoring and evaluation of the National Health Strategy of the Republic of Tajikistan for 2010-2020 will allow an objective assessment of the achievements of the health system, the way of gradual changes in the health sector and population health, and the improvements needed to ensure for further development of the population's health.

Monitoring and evaluation will be conducted regularly to ensure effective implementation and successful performance of the tasks and activities. Within the Ministry of Health an inter-sectoral steering committee will be established to ensure the above-mentioned activities. The steering committee will include representatives of key ministries and agencies, NGOs, professional associations and Development Partners. MOH will have a lead role in this committee.

Monitoring and Evaluation principles – to provide independent evaluation, transparency, process and result based orientation by involving independent experts, based on effective reports and conducted surveys. Monitoring and evaluation will be carried out on the basis of approved indicators.

Monitoring and Evaluation process - monitoring and evaluation of the Strategy will be carried out continuously, and the main tools will be the annual reports. Evaluation will be conducted once in five years, interim will be in 2015 and the final in 2020.

Report on monitoring with evaluation of activity progress and proposals for improving the process is currently under discussion of MoH and DPs.

Reports will be available for all stakeholders and the public.

CONCLUDING PROVISIONS:

1) This Strategy serves as the guide for a program-based planning of the health sector of Tajikistan in the next 10 years. In 2010, approximately 5-7 programs will be developed in compliance with the Strategy's guidelines with the overarching purpose to modernize health sector systems and strengthen health sector resources. .

2) Health sector programs will be developed under the aegis of the Ministry of Health of RT. Program activities will be matched to the designated agencies (central and regional ministries, agencies, and other organizations) in charge of program implementation, as well as to resources and funding sources, implementation timeline, and benchmark indicators. To avoid duplication, activities and funding will be coordinated across programs. The pre-programming stage will produce an Activity Plan to Implement the National Health Strategy of the Republic of Tajikistan.

3) Health sector programs will be designed for 10 years (2011-20). Program activities, budgets, and benchmarks will be subject to correction based on mid-term evaluation at the end of 2015, after the program implementation in 2011-2015. .

4) In most if not all programs, the need for international technical assistance and financial support from international development partners will be identified. The international development agenda to address this need will be established under sectoral coordination of international cooperation in the health sector in Tajikistan.

5) The forthcoming 10-year programs will absorb the ideas and guidelines of the previously adopted health sector 'sub-strategies' for development of individual areas of prevention and treatment work, health systems and resources, so long as the latter are aligned with this National Health Strategy of the Republic of Tajikistan

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Implementation mechanism to the National health Strategy of the Republic of Tajikistan for the period of 2010-2020 years

Implementation mechanism to the National health Strategy of the Republic of Tajikistan for the period of 2010-2020 years

Goals: **1. Health promotion and improved living conditions;**
2. Systemic transformation and modernization of health care;
3. Health care resource and finance development.

Priority directions	Objectives	Indicators and timing/expected results
1	2	3
1. Strengthening of mother, newborn, child and adolescent health	1) Strengthening of reproductive perinatal health for healthy childhood	Increase coverage of pregnant women with adequate prenatal care (2009 - 35 %; 2015 - 50%; 2020 – 75%)
		Reduce the number of children born with low birth weight (lower than 2.500 g) (2009- 6.4 %; 2015 - 6% and in 2020 - 5% of the total number of newborns).
		Increased number of children under the age of 6 months exclusively breastfed (2009– 61,0 %; 2015– 70 % ; 2020– 85 %)
		Reduce neonatal mortality by 50% (2009- 10,2; 2015 – 35; 2020 - 26 cases per 1,000 live births)
		Reducing infant mortality (2007– 46,0; 2015 – 25,0; 2020 – 20,0 per 1,000 live births)
		Reduced mortality of under-five children (2007 – 53; 2015 – 38,0; 2020 – 25,0 per 1,000 live births)
	2) Ensuring safe maternity	Reducing the number of abortions (per 1,000 women of reproductive age (2009 – 9,8 ; 2015 – 7,0; 2020 – 5,0)
		Contraception prevalence rate in reproductive age women (2009- 17.6 %; 2015 – 25 %; 2020 - 30 %)
		Reduce maternal mortality (2009 - 46,5; 2015 – 30,0; 2020 – 25,0 per 100 000 population)

1	2	3
2. Prevention and control of infectious diseases	1) Prevention and decrease the incidence of viral hepatitis and water-borne diseases	Reduced incidence rate of viral hepatitis type B (2009 – 3.7 ; 2015 .– 1.5 ; 2020 – 1.5 per 100,000 population)
		Reduction of incidence rate of viral hepatitis type A (2009 - 141,6; 2015- 100,0; 2020- 70 per 100, 000 population)
		Increased proportion of people having access to safe drinking water (2009 – 58.1 %; 2015 - 80 %; 2020 - 90 %)
	2) Counteract HIV / AIDS epidemic	Stabilization of the spread of HIV / AIDS (2009 - 1853; 2015 - less than 1% of the total population on the country; 2020- lower than 1% of total population of the country)
	3) Strengthening of tuberculosis service	Reduced tuberculosis incidence (2009.- 78,7; 2015 – up to 60 cases and 2020 - to 40 cases per 100,000 population)
		Increased the proportion of cured among newly detected TB cases with Smear (2009 – 90.0%; 2015 – 85,0%; 2020 – 87.0 %)
		Reduction of tuberculosis mortality (2009 – 5.2 ; 2015 – 4.0 ; 2020 – 3.0 per 100 000 of population)
	4) Prevention and reduced malaria incidence	By 2015, the RT will become a malaria-free country
	5) Prevention and reduction of incidence of particularly dangerous infections and other infectious diseases	Retention of hemorrhagic fever incidence rate(2009- 0.07 ; 2015- 0,06 ; 2020 - about 0,05 per 100 000 population)
		Stabilization of salmonellosis incidence rate (2009- 0.1 ; 2015- 0,08; 2020 – about 0,06 per 100 000 population)
	6) Prevention of vaccine-manageable infections	Hold the measles morbidity rate (2009- 0.00 ; 2015- 0,01 ; 2020- 0,01 per 100 000 population)
3. Reducing the burden of non-communicable and chronic diseases	1) Ensuring access to health care and medication for the cardiovascular diseases	Reduce mortality from coronary heart disease (2009 - 23,1; 2015 – 22,5 ; 2020 – 20,5 per 100 000 population)
	2) Early detection and timely treatment of oncological diseases	Increase the proportion of patients with newly detected cancer pathology at early stages of malignant process (2009–64,2 %; 2015– 70%; 2020 – 80 %)

1	2	3
4. Health determinants and healthy lifestyle	1) Provision of timely medical care in case of injuries	Reducing mortality of injuries (2009 - 20.4 ; 2015 – 19.8 ; 2020 – 19.3 per 100 000 population)
		Reduction of disability resulted from injuries (2009-40 %; 2015–35 % ; 2020 –30%)
	2) Monitoring of drinking water safety	Increased proportion of population having access to safe drinking water (2009 - 58,1 %; 2015 – 80 %; 2020г. - 90 %)
	3) Reducing the prevalence of behavioral risk factors	Reduced prevalence of behavioral risk factors: - smoking (2009 – 40.2%; 2015 – 80 %; 2020 – 90 %) - alcohol abuse (2009 – 18.4 %; 2015 – 15%; 2020 – 10 %) - overweight (2009 – 118.4 per 100.000 population; reduce by 10% in 2015; 2020 – y 15%)
		Increased birth life expectancy (2009 - 71.2 years; 2015 – 73 years; 2020 – 75 years)
	4) Increasing public awareness	Ratio of population having the necessary knowledge and practice behaviors reducing the risks of HIV infection, STDs and other infections (2009-3,2%; 2015 - 10,0% ; 2020 – 15,0%)
		Ratio of families, having knowledge and skills to differentiate the symptoms of respiratory diseases and organize home care for a sick child (2009- 47.2%; 2015 - 70% ; 2020- 85%)
		Ratio of families with under-five children, trained to home-based treatment of diarrheal diseases (2009-42.1%; 2015- 75%; 2020 - 90%)
5. Strengthening of public leadership for health protection	1) Governance system improving	Establishing city/district health units/sectors within 2012
		Improving the vertical system of public health management (2010-2012)
		Improving public monitoring services in medical, pharmaceutical and sanitary-epidemiological activities, as well as internal audit services in the structure of health care by 2012
		Increasing the number of trained professionals in the field of health care management (2009 – 13 persons; 2015 – not less than 50 people; 2020 – not less than 100 people)
	2) Creation of a unified information health system	The introduction and improvement of the DHIS2 system (2015 -pilot segment; 2020 - all regions)
		The introduction and improvement of information hospital care system (using the registration form 066\u) (2015- pilot segment; 2020- all regions)
		Creating of a compatible national consultative diagnostic telemedicine system (2015- pilot segment; 2020- specialized city, region and national centers)

1	2	3
	3) Modernization of legislation and regulatory acts	Adoption of new and revision of existing laws on protecting the environment, sanitary well-being, infectious disease prevention, industrial safety, provision safety of food and medicine, protection of health rights and responsibilities of health workers and patients
		Adoption of new or revision of current government regulations on health, finance, staff training and education, licensing, rights and responsibilities of health workers, ensuring quality and safe medicines, immunobiological preparations, medical supplies, introducing a package of Basic Benefits Package (BBP), enhancing state sanitary-epidemiological surveillance
6. Improving the quality and accessibility of medioprophilactic care	1) Strengthening the PHC role. The introduction of family medicine practice	Increasing the proportion of family practice doctors against the total number of PHC physicians (2009 – 15,8 %; 2015 – 50%; 2020 – 80%)
		Reducing the number of ambulance calls in the working hours of PHC facilities (2009 – 30 %; 2015 – 20.0% ; 2020 - 40 %)
		Reduced hospitalization rate of patients with chronic extensive diseases (asthma, diabetes, hypertension, congestive heart failure, etc.) (2009 – 64.0 %; 2015 – 50%; 2020 – 40%)
		Reduced demand in inpatient care (number of bed-days per 1,000 population, 2009 –1142.6; 2015 – 15% ; 2020 – by 30%)
	2) Licensing and certification of medical workers	Increased number of licensed and certified health workers (2009 – 33 %; 2015 – up to 10%; 2020 – up to 30 %)
	3) Accreditation of health facilities	Increasing the number of accredited health facilities (2009 – 0 %; 2015 – up to 10 %; 2020 – up to 30 %)
	4) System of treatment and preventive care standards	Expansion of the practical application of clinical guidelines and diagnostics and treatment protocols, (2009 – 20% ;2015 – 50%; 2020 – 80%)
	5) Increasing availability of health services	The increase in the number of visits per inhabitant per year (2009 – 4.2; 2015 – 6.0 ; 2020 – 8.0)
		Reduced proportion of those who got sick but didn't seek medical care (2009 – 40 %; 2015 – 30.0 %; 2020 – 20.0 %)

1	2	3
7. Development of Human Resources	1) Adequate supply of qualified personnel, meeting the societal needs	Reducing the deficit in physicians: total / rural areas (2009 - 9601/9170; 2015 - 8640 / 8253; 2020 - 8161/7795 persons)
		Increased availability of doctors / middle medical staff per 10 000 population (2009 – 19,2/43,3; 2015 – 20,0/45,0; 2020 – by 22/50)
	2) Creating of an effective training system	Creation of TGMU clinic by 2012
		Increasing the share of physicians / middle level health care professionals having qualified categories (2009 – 51,9/29,8 %; 2015 –65,0/35 %; 2020 – 70,0/45 %)
		Revision of curriculum of the TGMU medical faculty by 2012
8. The development of medical science and innovation	1) Planning and conducting research in accordance with industry development programs and health care priorities	Increasing research priority areas respectively, and industry programs (2009 - 0%, 2015-25%, 2020-50%)
	2) Support the development and implementation of scientific achievements and innovations in health care.	Increased funding for research papers and innovative technologies (2009 - 1.7 mln. somoni); 2015-30.0%; 2020-50.%)
	3) Development and implementation of new methods and technologies for prevention, diagnosis and treatment of socially significant diseases	Increasing the number of developed and implemented new methods and technologies for prevention, diagnosis and treatment of socially significant diseases (2009-0%; 2015-10%; 2020-25%)
9. Improving the drug supply and pharmaceutical activity	1) Improved model of drug supply	Increased number of pharmacies in rural areas (2009 -20 %; 2015 – 25 %; 2020 - 30 %)
		Increasing the number of registered essential drugs (2009- 35 %; 2015 – 55 % ; 2020- 65 %)
		The share of the cost of pharmaceutical drugs, controlled through the distribution system (by 2015 - 50 %; 2020 - 65%)
		Increasing the number of registered drug under the INN (generic) (2009- 40 %; 2015 – 50 % ; 2020- 60 %)

1	2	3
	2) Improving the quality of medicines	Increased proportion of medicines produced under the standard GLP, GCP, GMP the of registered ones (2009- 15 %; 2015 – 25 %; 2020- 40 %)
	3) Develop and introduce new pharmaceutical drugs	The number of developed and introduced pharmaceutical drugs ((2009 - 2; 2015 – 20; 2020-25)
10. Modernization of production and technological base	1) Improving standards of health care facility network and introduction of new approaches to their planning and design	Construction, repair and reconstruction of investment health facilities in accordance with the Health Facility Rationalization Master Plan (2010)
	2) Restructuring of the hospital sector putting priority on multifield hospitals	Mono profile hospitals, restructured into multifield hospitals (2009 - 2; 2015 – 5; 2020 - 10)
	3) Rationalization of the public health network with a priority on PHC development C	The number of underutilized hospitals transformed into PHC facilities (2009 - 8 ; 2015 – 15 ; 2020 - 20)
11. The development of the financial base of health care	1) AIncreased funding for health	The growth of health expenditure as of percent of GDP 2009- 1,9 %; 2015- 3,4 %; 2020- 4,4%)
		Increased health expenditure against all public expenditure (2009 – 6,4 %; 2015- 10,0 %; 2020- 15,0 %)
	2) Accumulation of funds	The number of regions whose resources are accumulated at the regional level (2009 - 0; 2015- 30 ; 2020 - all regions)
	3) Introduction of a single payer system at the regional level	Creating of Obligatory Health Insurance Fund (OHIF) by 2015.
	4) Resource allocation improvement	The number of regions which introduced a per capita funding model, including all budget lines (2009 - 0; 2015- 30 ; 2020- all regions)
		The number of regions with introduced hospital case-based pay system (2009 - 8; 2015- 50; 2020- all regions)
		The share of public expenditure through the MTEF (2009 - 10 %; 2015- 80 %; 2020.- 100 %)
	5) Improved procurement system	The share of public procurement through authorized purchase bodies (2009 -70%; 2015- 85%; 2020-100%)
		Number of persons specifically trained in procurement of goods, works and services (2009 - 4; 2015-150; 2020- 300)
	6) Improved and scaled up implementation of Basic Benefits Package (BBP)	The number of regions with implemented BBP (2009 - 8; 2015- 50; 2020- all regions)

Annex 1
Approved by order
of the Ministry of Health
of the Republic of Tajikistan
dated 21.08.2010 № 494

Action Plan to Implement the National Health Strategy of the Republic of Tajikistan (NHS of RT), 2010-2020

Implementation Phase I: 2010 – 2013

Action Plan
to Implement the National Health Strategy of the Republic of Tajikistan (NHS of RT), 2010-2020

Implementation Phase I: 2010 – 2013

Code Number	Activities	Strategy Ref No	Implementation Period	Participating agencies	Participating Development Partners	Results
1	2	3	4	5	6	7
1. PUBLIC GOVERNANCE IN HEALTH						
1.1 NATIONAL HEALTH POLICY		120-166				National Health Policy developed. It is aligned with, and elaborates the NHS policy guidelines. Policy package includes policy statement document, implementation assessment framework, and mechanism for policy update through evidence-based research and stakeholder policy dialogue..
1.1.1	Organize under MoH a working coordination group consisting of MoH department heads led by Minister, coordinate activity on NHS implementation.			MZ-1		The effective internal coordination between MOH departments has been instituted by conducting regular meetings (once a month). Meeting minutes are available for all interested parties.
1.1.2	Review of international sources to specify the range of issues to be reflected in the National Health Policy (NHP) agenda of Tajikistan	135	2011 (1)	MZ-2, MP-1,,	MP-1, MP-6	Analytical briefs. Health policy agenda defined.
1.1.3	Summative review of documented experience of the pilot-projects, health professionals, patients and households surveys, and other statistical studies conducted in / on the health sector of Tajikistan.		2011 (2)	MZ-2, PE-1-4,MZ-5	MP-1, MP-5,MP-6, MP-7, MP-9	Analytical report 'Review of empirical Evidence for future Health Policy Design in the Republic of Tajikistan'

1	2	3	4	5	6	7
1.1.4	Raise the awareness of national and health sector leadership, health care providers and general public on health policy issues and periodically test this level of awareness.		2011 (3)	MZ-1, MZ-2,GU-1, GU-2, GU-3, GU-6	MP-1, MP-6	A policy meeting at the MOH. A series of publications on key health policy issues in the popular and professional press, including 'The Health Care Sector of Tajikistan' journal. A health policy web page on the health.tj websites. A media kit. A workshop for journalists. Interviews, news, and analytical reporting in the media.
1.1.5	Prepare and conduct the National Health Summit. .		2011 (4)	MZ-1, MZ-2,MZ-5	MP-1, MP5, MP-6	Summarize first year of Strategy implementation with DPs and make recommendations for future progress.
1.1.6	Develop organizational and technical capacity standards for health policy management and implementation assessment, particularly, skills mix, staffing schedule, job descriptions of health policy professionals; role of MOH, academia, advocacy groups, teams of domestic and international experts		2011 (2)	MZ-2, MZ-4;MZ-5,	MP-1, MP-5, MP-6; MP-9	Report 'Organizational and Technical Capacity Requirements for Health Policy Design, Implementation, and Assessment'
1.1.7	Design health policy training curricula for: (a) schools of medicine; (b) continuing education of health policy leaders and other health professionals		2012	MZ-2, MZ-4, PK-1, PK-2, PK-4,	MP-1, МП-6, MP-9	Training materials and resource requirements are developed for each of the four program categories including instructional objectives, courses, course syllabi, reading materials and other information sources; physical facilities; and practice base requirements. Health policy training programs are implemented at the Tajik Medical University, and Institute for Postgraduate Medical Training.
1.1.8	Conduct regular training on health policy		2011 (32012	MZ-2,	MP-1, MP-6	A 1-2-week workshop program, including a compilation of case studies in health policy.
1.1.9	Implement at country level accelerated seminars on health policy for senior-level executives		2012	MZ-2,MZ-20,	MP-1, MP-5, MP-6	Quarterly health policy seminars conducted in Dushanbe.
1.1.10	Annual conduction of «Flagship course» on health policy at national and regional levels		2011- 2013	MZ-2	MP-1, MP-5, MP-6	Annual workshop for a multi-stakeholder audience with inputs from the leading international experts, including health policy managers from peer countries.

1	2	3	4	5	6	7
1.1.11	Develop information resources in health policy areas: setting up a paper and electronic repository of documents and publications searchable through an annotated catalogue. Set up on-line catalogue of web-accessible sources.		2012 (1)	MZ-2, MZ-5; MZ-20, PK-1, PK-3	MP-1, MP-6, MP-9	Health Policy documentation repository at the MoH, also in charge of dissemination at regional and local levels. Electronic library on the MOH web site. Feasibility study of a MoH server with registered user access.
1.1.12	Publications on health policy topics in on-line and conventional journals – national, regional and international ones.		2011 (3)	MZ-1, MZ-2, MZ-20	MP-1, MP-6	Publications in national level social sciences journals and at least one publication over the first two years on NHS implementation in an international peer-reviewed journal.
1.1.13	Participation in regional and international study tours, other exchange programs, international conferences and other initiatives in health policy areas.		2010 - 2013	MZ-1, MZ-2, MZ-5	MP-1, MP-5, MP-6	Programs and announcements of study tours and international events are tracked. Study tours participants will include health administrators, technical experts, faculty, and post-graduate students.
	1.2 HEALTH SECTOR LAWS AND REGULATIONS	3.1.3 154-162				Laws, regulatory acts, and compliance controls are aligned with NHP and effectively support its implementation.
1.2.1	Legal and regulatory review to identify changes to be made in the current body of laws and regulations to ensure their compliance with the NHS		2011 (1-2)	MZ-5, MZ-11 and other MOH departments; GU-5	MP-7, MP-9	Executive brief "On the Priority Measures to Align the RT Laws and Regulations with the NHS.
1.2.2	In-depth review of laws and regulations for compliance with the NHP and NHS.		2012 (4)	MZ-2, MZ-5, MZ-11	MP-1, MP-6, MP-9	Analytical brief describing Laws and Regulations to be developed, amended or cancelled in order to Align Specific Laws and Regulations with The NHP and NHS.
1.2.3	Draft the Law of the Republic of Tajikistan "On Public Health Protection", new version		2011 (3)	MZ-13, MZ-11, GU-5; other RT agencies	MP1, MP-9	MOH and all stakeholders agree, and government approves the draft of "The Law on Health Protection.
1.2.4	Draft and pass the Law of the Republic of Tajikistan "About Sanitary and Epidemiological Safety of the Population", (new version)		2011 (3-4)	MZ-9, MZ-18, MZ-11, GU-5	MP1, MP-9	MOH and all stakeholders agree and government approves the draft of the Law "About Sanitary and Epidemiological Safety of the Population.

1	2	3	4	MZ-9, MZ-18, MZ-11, GU-5	6	7
1.2.5	Draft the "Law on Patient Rights."		2012 (1-2)	MZ-5, MZ-11, GU-5, PO-5, PO-11, PO-14	MP1, MP-9	All MOH and stakeholders agree and government approves the draft "Law on Patient Rights".
1.2.6	Draft Government Decree "On the Bodies, Participants and Procedures of Inter-sectoral Collaboration on the National Health Agenda of Tajikistan."		2011 (3)	MZ-1, MZ-2, MZ-5, MZ-11, GU-5	MP-1, MP-6, MP-9	Approve draft Government Decree "On the Vehicles, Participants and Procedures of Inter-sectoral Collaboration on the National Health Agenda of Tajikistan" prepared
1.2.7	Expert support of the draft Government Decree "On the Responsibility of Budget Administration Agencies for the Accelerated Growth of Health Expenditure and Effective Control over the Use of Budgetary Funds in the Health Sector of RT".		2011 (2-3)	GU-2, GU-3, GU-5, MZ-2, MZ-7, MP-9	MP-1, MP-6, MP-9	The RT Government Decree On the Responsibility of Budget Administration Agencies for the Accelerated Growth of Health Expenditure and Effective Control over the Use of Budgetary Funds in the Health Sector of the RT" reviewed, debated, revised as needed, and adopted.
1.2.8	Draft Government Decree "On Training, Professional Licensing, Certification, Rights, and Responsibilities of Health Care Providers."		2012 (4)	MZ-5, MZ-11, PO-1-3, PK-1-2, PK-4	MP-9	The RT Government Decree "On the Training, Professional Licensing, Certification, Rights, and Responsibilities of Health Care Providers in the RT" reviewed, debated, revised, and adopted.
1.2.9	Analytical review of regional regulatory frameworks for compliance with the NHS		2011 (1-2)	MZ-11, MZ-2, MZ-5, RE-1-4, MP-9	MP-1, MP-6, MP-9	Regulatory brief "Issues of Regional Regulatory Base to Advance NHS in regions of the RT".
1.2.10	Review priority MOF orders to improve regulatory support of the NHP and strategy.		2011 (3-4)	GU-3, MZ-7, MZ-2	MP-1, MP-6, MP-9	Regulatory brief to the Minister of Finance "A Priority List of the MOF Orders and Guidelines to Be Voided, Amended and Adopted to Strengthen Regulatory Support of the NHP and Strategy" – prepared, reviewed, revised

1	2	3	4	5	6	7
1.2.11	Draft and provide expert support for MOF Order that will mandate changes in health sector budget planning and control over the use of funds, particularly, to ensure steady growth of health financing and more effective use of funds to support health care activities in Tajikistan. More specifically, the MOF will mandate a steady growth of allocations to health. Federal subsidies to the regions will be established; and new provider reimbursement systems and payment transaction centers will be set up in the health sector of Tajikistan.		2012 (1-3)	MZ-7, MZ-2, GU-3	MP-1, MP-6, MP-9	Draft MOF Order "On the Implementation of The RT Government Decree "On the Responsibility of Budget Administration Agencies for the Accelerated Growth of Health Expenditures and Effective Control over the Use of Budgetary Funds in the Health Sector of the RT" completed, reviewed, debated, revised, and adopted
1.2.12	Review regional laws about oblast and district-level health budget planning, particularly, to establish a regulatory approach to provider public contracting and reimbursement		2012 (1-3)	RE-1-4, MZ-11, MZ-2, MZ-5, GU-3	MP-1, MP-6, MP-9	Draft regional laws"On the Oblast- and District-level Health Budget Planning" completed, reviewed, debated, revised, and adopted.
1.2.13	Develop a priority list of MOH orders to improve regulatory support of the NHS of RT.		1011 (1-2)	MZ-2, MZ-5, MZ-11, M1 and most other MOH departments,	MP-1, MP-6, MP-9	A regulatory brief by the MOH Legal Department to the Minister of Health "A Priority List of MOH Orders and Guidelines to Be Voided, Amended, and Adopted to Strengthen Regulatory Support of the NHP and Strategy" – prepared, reviewed, revised, and adopted.
1.2.14	Draft and provide expert support for MOH Order that will establish the roles of the health administrative entities in the health sector budget planning, mechanisms of health sectoral grants to the regions, provider public contracting and reimbursement, and incentives for care quality and volumes.		2011 (3-4)	MZ-7, MZ-11, GU-3, MZ-2, MZ-5	MP-1, MP-6, MP-9	Draft MOH Order "On the Implementation of The RT Government Decree "On the Responsibility of Budget Administration Agencies for the Accelerated Growth of Health Expenditures and Effective Control over the Use of Budgetary Funds in the Health Sector of the RT" completed, reviewed, debated, revised, and adopted.
1.2.15	Draft and provide expert support for an MOH Order regulating terms and conditions of health care provider licensing and certification.		2012 (2)	MZ-15,, MZ-5, PO-1-3, PK-1-2, PK-4	MP-9	Draft MOH Order "On the Training, Professional Licensing, Certification, Rights, and Responsibilities of Health Care Providers in the RT" completed, reviewed, debated, revised, and adopted.

1	2	3	4	5	6	7
1.2.16	Draft and provide expert support for MOH Order establishing terms and conditions of accrediting health care provider facilities – public and private.		2012 (3)	MZ-3, MZ-5	MP-9	Draft MOH Order "On the Terms and Conditions of Accrediting Health Care Provider Facilities" completed, reviewed, revised, and adopted.
1.2.17	Draft and adopt an MOH Order mandating design, implementation, and use of practice guidelines (clinical protocols), epidemic risk/ disease management guidelines.		2011 (1-2)	MZ-3, PO-2, PO-3, MP-9	MP-9	Draft MOH Order "On the Design, Implementation, and Use of Practice Guidelines in the Health Sector of Tajikistan" completed, revised, and adopted.
1.2.18	Draft and provide expert support for MOH Order that regulates health workforce training standards and accreditation of basic and postgraduate training institutions and programs		2013 (3-4)	MZ-15, PK-1-2, PK-4, GU-7	MP-9	Draft MOH Order "On Health Workforce Training Standards" completed, revised, and adopted.
1.2.19	Draft and provide expert support for MOH Order that will set out statistical reporting, data management, and operational and strategic research requirements, as well as the architecture and resources of the HIS		2012 (1-2)	MZ-2, MZ-5, MZ-7, MZ-20 and most other MOH departments, GU-14, GU-13, MP-9		Draft MOH Order "On the Integrated Health Information System" completed, reviewed, revised, and adopted.
	1.3.INTER-INSTITUTIONAL AND INTER-AGENCY COLLABORATION AGENDA IN THE HEALTH CARE SECTOR	3.2.5 148-167				The mechanism of Inter-institutional and inter-agency collaboration in health has been designed and implemented. Collaborative process established. Five inter-sectoral health agendas have been managed in 2011-13.
1.3.1	Prepare and conduct inter-agency meeting to develop a shared approach to multi-sectoral collaboration in health. Establish a "farm-to-fork" food safety control system that ensures a holistic approach to food safety and intersectoral and interdisciplinary collaboration. Design a standard set of measures to prepare all agencies for intersectoral collaboration on health protection issues. Prepare coordination meeting to determine participants and vehicles of multi-institutional and multi-sectoral activities in promotion of population's health.		2011 (1)	MZ-1, MZ-5, GU-1 and most other go's agencies	MP-1	Inter-agency memorandum of intent "On the Joint Measures to Implement the RT Government Decree "On the Vehicles, Participants, and Procedures of Inter-sectoral Collaboration in Health" adopted. Ministry-specific orders "On the Measures to Integrate the Ministry (Agency) into the Inter-sectoral Collaboration in Health". The agencies, representing 8 categories of NHS implementers (see The List at the end of the Action Plan), selected their delegates. The meeting agenda has been approved by all the stakeholders. Draft resolutions and other meeting documents have been prepared..

1	2	3	4	5	6	7
1.3.2	Strengthen the work of the Tajikistan Codex Contact Point and the Codex Alimentarius Intersectoral Working Group in order to harmonize food safety requirements necessary for fulfilling requirements of the World Trade Organization (WTO) Agreement of the Application of Sanitary and Phytosanitary Measures		2011 (1)	MZ-1, MZ-5, GU-1 With other governemnt bodies involvement	MP-1	"Tajikistan Codex Strengthened
1.3.3	Amend the Statutes of the National Health Council (NHC);		2011 (2)	MZ-5, GU-3-23, RE-1-4, PK-1-17, MK-1-8, LU-1-100, PO-1-17	MP-1-13	The NHC start-up documents prepared, submitted for stakeholder consideration, approved and presented to the NHC inaugural session.
1.3.4	Conduct the NHC inaugural session. Election of the NHC Board and Chairperson.		2011 (3)	MZ-5, MZ-1, GU-3-28	MP-1-13	NHC inaugural session concluded. A stakeholder consultation process adopted to work on multi-sectoral health topics.
1.3.5	Organize and conduct multi-agency and multi-organizational activities on the first health topic: "Issues with Water Quality as the Main Public Health Risk in the Republic of Tajikistan."		2011 (4) - 2012 (2)	MZ-9, MZ-18, LU-34, GU-6, GU-10, GU-11, GU-12, GU-14	MP-1	For each health topic selected for NHC hearings, the following standard set of multi-agency and multi-organizational activities has been conducted: (1) Situation analysis and problem definition; (2) Sending inquiries to stakeholder agencies and receiving their response; (3) Presenting the problem for NHC hearings; 4) Hearings and party deliberations at an NHC session or several sessions; (5) Summary report with targeted directives and recommendations; (6) Action plan, including implementation timeline and progress monitoring tools; (7) NHC press-release and press-conference; (8) Progress monitoring and evaluation; (9) Progress briefing; (10) Concluding assessment report.

1	2	3	4	5	6	7
1.3.6	Organize and conduct multi-agency and multi-organizational activities on the second health topic, tentatively: "Nutrition Dietary Patterns, and Food Safety in Tajikistan." Especially on legislative reform and institutional capacity building, mapping the current laboratories practices and elaboration of recommendations for the concept and strategy of optimization the food control, strengthening laboratory capacities for the application of risk analysis framework, training of food processors on good practices developing effective inspection system, food safety curriculum modernization in educational establishments.		2012 (1-2)	MZ-9, MZ-18, LU-41, LU-38, GU-6, GU-10, GU-12, GU-20, GU-23,	MP-1	
1.3.7	Interaction on the third health topic, tentatively: "Quality of Roads and Vehicles, and Traffic Safety."	153,154	2012 (2-4)	MZ-12, LU-25, GU-4, GU-13, GU-22,	MP-1	
1.3.8	Interaction on the fourth health topic, tentatively: "Physical Health and Psychological Welfare Risks in Home, School, and Workplace Environments."		2013 (1-3)	MZ-6, LU-04, LU-07, LU-13-16, GU-4, GU-7-9, GU-16-18	МП-1	
1.3.9	Interaction on the fifth health topic, tentatively: "The Roles of Families, Communities, and Local Authorities in Supporting Chronically Ill, the Elderly, and the Disabled"		2013 (2-4)	MZ-3, RE-1-4, LU-38, LU-33, GU-8, GU_9, GU-17	МП-1	
	1.4 FUNCTIONAL MANAGEMENT OF HEALTH CARE SYSTEM		2010-2012			Institutional structure, roles, and relationships issues such as MOH structure, MOH capacity building, role of NGO, role of Rayon Health Departments and etc..
1.4.1 1.4.2	Modernization of vertical health management system Modernization of oversight agencies in medical, pharmaceutical and sanitary-epidemiological activities, as well as the agencies for internal audit of health care structure		2012			

1	2	3	4	5	6	7
1.4.3	Functional review of management at MOH, including job descriptions, roles and responsibilities		2011	MZ-1	MP-5	Functional review completed.
1.4.4	Functional review of Republican Institutions.		2011	MZ-1	MP-9	Functional review completed.
1.4.5	Functional review of Oblast health Department including description of roles and responsibilities		2011	MZ oblast and rayon Health offices	MP-9	Functional review completed
1.4.6	Define role and responsibility of Rayon Health Department, including: Financial functions, Human resource and assets management, Hospital Quality Control, PHC Quality Control, Public Health/SES, and HMIS		2011	MZ oblast and rayon Health offices	MP-9	Functional review completed.
1.4.7	Capacity Building for Rayon Health Department by all individual functionsa		2011-2012	MZ	MP-5	Training on capacity building completed. Functions reinforced
	1.5 COORDINATION OF INTERNATIONAL AID AND TECHNICAL COOPERATION					Mechanisms to coordinate international resources are implemented. International health budget supplementation effectively contributes to implementation of the NH strategy. Ten percent of international funding earmarked for technical cooperation has been allocated to the projects, successfully managed by the MOH in 2015.
1.5.1	Create Coordination Council for international cooperation (CCIC) with participation from MOH, MOF and international development partners.		2010 (4)	MZ-5, MZ-1	MP-1-13	A mechanism for coordination of the international aid and technical cooperation has been designed, discussed with international development partners, revised, and adopted by an RT Government decree. A multilateral memorandum has been signed on the terms and conditions of coordinating international aid and cooperation in the health sector of Tajikistan.

1	2	3	4	5	6	7
1.5.2	Review this Action Plan from the standpoint of future need for international financial and technical support. Align Strategy implementation activities by three factors of need: (1) Shortage of domestic funding; 2) Insufficient technical experience; (3) Lack of necessary commodities and services.		2010 (4) и ҳар 6 мох.	MZ-5 , MZ2	MP-1-13	Analytical report "Assessment of Need for International Support with Implementing the NHP and Strategy," detailing factors of need, as well as subject areas and specific activities that critically depend on international aid.
1.5.3	Project physical volume and monetary value of external support for the first three years of Strategy implementation. – This would be part of assessing the overall resource and funding requirements for the NHS.		2010 (3-4)	MZ-5	MP-1-13	A three-year allocation plan has been designed for external support funds, detailing externally funded health expenditures by section and major activity of this Action Plan.
1.5.4	Design (or update) mechanisms to include international funding in the three-year and annual budget planning cycles.		2011 (1-2)	GU-3	MP-6, MP-5, MP-1-131	A Memorandum of Understanding between the RT Government and international development partners "On the Terms and Conditions of the Planning, Allocation, and Use of Donor Funds Provided for Direct Financial Support of the Health Sector of the Republic of Tajikistan". A Government Directive to ensure MOU implementation. An MOF Order to enforce the Government Directive.
1.5.5	Design standard operating procedures to manage technical cooperation, particularly, to enable competitive bidding to procure professional consulting services; project management guidelines, as well as M&E frameworks.		2011 (1-2)	MZ-5, MZ-1	MP-6	Guidelines for the procurement of professional consulting services to support NHS implementation. An accompanying set of standard operating procedures and other bylaws. An MOH Order that adopts the Guidelines and the accompanying documentation package.
1.5.6	Strengthen professional knowledge and skills of government officials in charge of the technical cooperation, particularly in such areas as developing Scope of Work statements, managing competitive bidding, managing and evaluating projects, and coordinating activities with international donors.		2011 (3) – 2012 (2)	MZ-5	MP-1-13	Training program designed, training materials developed, program participants identified, faculty recruited, workshops conducted, acquired knowledge and competencies tested.

1	2	3	4	5	6	7
1.5.7	Prepare international fund allocation plans as part of the MTEF planning by three-year rolling periods.		2010 (4) – 2011 (1)	MZ-7, RE1- 4, GU-3	MP 6	Three-year fund allocation plans developed, discussed with international development partners, coordinated with the MOF, revised as needed, and adopted by the MOH and MOF.
1.5.8	Prepare annual fund allocation plans involving international financing.		2011 (1), 2012 (1), 2013 (1)	MZ-7, PE1- 4, GU-3		Annual fund allocation plans developed, discussed with international development partners, coordinated with the MOF, revised as needed, and adopted by the MOH and MOF.
1.5.9	Design, coordinate, and implement technical cooperation projects.		2011 (2)	MZ-5, MZ-1	MP-1-13	In 2012-13, the MOH will manage one technical cooperation project a year. Project implementation period will not exceed one year; approximate budget will be limited to Euro 150,000.
	1.6 INFORMATION AND ANALYTICAL SUPPORT OF THE HEALTH CARE SECTOR	3.2.3 120-141				Integrated Health Information System (HIS) strengthened to produce relevant and timely data and quality information, to enable the Tajik authorities to follow up the objectives, outputs and outcomes as defined in the Health Strategy
	HIS status and planning					
1.6.1.	Develop an HIS strategy road map including an HMIS strategy 2011-2015		2011	MZ-20;MZ-1; MZ-18, GU-14	MP 6	Priority HIS strategy supporting the monitoring and evaluation of the Health Strategy
1.6.2	Strengthen coordination mechanisms among different agencies for an effective HIS		2011-2013	MZ-20;MZ-1; MZ-18, GU-14	MP 6	Working group established
1.6.3	Review and finalize the current list of health indicators		2011-2013	MZ-20; MZ-1	MP-6	Capacities strengthened in order to effectively implement HMIS activities
1.6.4	Establish metadata dictionary of indicators based on the template used in WHO World Health Statistics Indicator Compendium, and translate it in Russian and Tajik		2011-2013	MZ-20; MZ-1	MP-6	

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1.6.5	Review all the primary and secondary forms according to the revised indicators, translate into Russian and Tajik and distribute		2011-2013	MZ-20;MZ-1	MP-6	Equipment distributed
1.6.7	Computerize the primary and secondary forms using DHIS adapted to the revised forms		2011-2013	MZ-20;MZ-1	MP-6	Training completed
1.6.8	Roll out the adapted DHIS2 system, including purchasing and installation of necessary equipment in 10 rayons		2011-2013	MZ-20;MZ-1	MP-6	Presentation and dissemination of medical statistical data improved
1.6.9	Capacity building in data collection and analysis at republican, oblast, rayon and facility level and in HIS software application use		2011-2013	MZ-20;MZ-1	MP-6	Procedures established
1.6.10	Improve presentation and dissemination of medical statistical data		2011-2013	MZ-20;MZ-1	MP-6	Training and awareness measures completed
1.6.11	Establish procedures to monitor and control the quality of data		2011-2013	MZ-20;MZ-1	MP-6	Mechanisms established. Improved decision making
1.6.12	Rise awareness about the need to disseminate and effectively use health related information		2011-2013	BT-20, BT-1	МП-6	Training and awareness measures completed
1.6.13	Support to development of incentives schemes for evidence based decision making in health		2011-2013	BT-20, BT-1	МП-6	Mechanisms established. Improved decision making
1.6.14	Conduct Strategic research in areas of: comprehensive burden of diseases analysis, National Health accounts, health policy research		2011-2013	MZ-2, MZ-5	MP-1, MP-6	Strategic research conducted and used in formulating /adjusting health polices
	1.7 MONITORING AND EVALUATION AND HEALTH POLICY ANALYSIS					Provide evidence-based analysis to inform health-policy decisions.
1.7.1	TDesign framework and program to monitor and evaluate health policy implementation		2012 (4)	MZ-2, MZ-20	MP-1, MP-6	"Methodological Guidelines for the National Health Policy Implementation Assessment".

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	Conduct research and produce special data on Health System reforms.	491	2011-2013	MZ-2	MP-1; MP-6;	Process established for the determination of the HPAU annual work plan in a participatory manner with MoH Department and in line with the NHS. Planned studies accomplished
1.7.2	Assess health policy implementation. Recommendations for improvements in problem areas.		2013 (3) --	MZ-2, MZ-5, MZ-20	MP-1, MP-6	Annual progress report 'Health Policy Implementation in the Health Sector of Tajikistan'.
	2. INCREASING THE QUALITY OF HEALTH CARE					
	2.1 STRENGTHENING FAMILY MEDICINE AS A BASIS FOR INTEGRATED PHC					Pace and success of transition to Family Medicine practice will be determined by the achievement of NHS objectives in most of the Strategy's and Action Plan's sections. This section of the Action Plan guides to the iimplementation of Family medicine as a basis for integrated PHC.
2.1.1	Strengthen role and functions of Family Medicine Association to enable it to function in Primary Health Care reform in Tajikistan	2011		ПО-18	МП-7 МП-9	Charters revised, regular meetings taking place and discussion of progress is held regularly
2.1.2	Design and approve the Law on Family Medicine and the Program on Family Medicine Development for the period of 2010-15	2011		ВТ-1	МП-9	The Law "On Family Medicine) adopted, the Program on on Family Mediocre Development formulated
2.1.3	Ensure step-by-step investment in the family medicine infrastructure and basic equipment, including the procurement of consumables and spare-parts.	2011-2013		MZ-19	MP 5, MP-7, MP-9	Rehabilitated FM infrastructure. Budget allocated for the procurement of consumables and spare parts for basic equipment.
2.1.4	Developed Plan for Integration of vertical programs. Integrate the vertical program centers into PHC (family medicine). Gradually integrating preventive and curative functions of the vertical centers into family medicine	2011		MZ-3, MZ-5	MP-7 MP 9	"Program of PHC integration of vertical program centres into PHC designed. This will be a crosscutting program that will include activities from all NHS-derived programs. Its purpose is to facilitate requisite multi-area management of PHC reforms and Family Medicine practice support.

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2.1.5	Develop and implement adequate motivation mechanisms (including financial incentives) for FM specialists for attracting and retaining in PHC	2011		MZ-3, MZ-5, MZ-7	MP-5, MP 6, MP9	New salary and incentive system has developed for FM specialists
2.1.6	Raise the status and public perception of Family Medicine by population and other medical specialists.	2011-2013		MZ – 1;PO-18	MP-7, MP-9	Enhanced reputation of FM as a profession.
	2.2. QUALITY ASSURANCE	220-228				
2.2.1	**LICENSING OF HEALTH CARE PROFESSIONALS**					Organizational and technical tools for professional licensing have been developed;
2.2.1.1	Develop conceptual and methodological design of professional licensure and certification of health care professional for Tajikistan, based on NHS requirements and international best practice.		2011 (4) – 2013 (1)	MZ-3, MZ-17, PK-1, PK-2, PK-4,	MP-9	Analytical report "Conceptual and Technical Primer for Professional Licensure and Certification of Health Care Providers in Tajikistan" which will detail organizational and technical tools of professional licensing have been developed
	2.2.2 ACCREDITATION OF HEALTH CARE AND MEDICAL EDUCATIONAL FACILITIES	(229-256)				Organizational and technical foundations of the accreditation of health care and medical educational facilities are developed; a 'mock' accreditation of health care providers is prepared and scheduled for 2010-13
2.2.2.1	Review and background analysis of the health care legal framework for accreditation in the RT	230	2010	MZ-3, MZ-17, MZ-1, RE-1-4, LU-1, LU-30, PO-2-3,	MP-1, MP-9, MP-10	Analytical review of the legal framework from the perspective of establishing a system of health facilities accreditation and developing accreditation standards; Technical Report "Conceptual and Technical Design of Provider Facility Accreditation for the Health Sector of Tajikistan".
2.2.2.2	Create the Republican Center for accreditation of health care organizations (RCAHO)	231	2010	MZ-3, MZ-17, MZ-1, RE-1-4, LU-1, LU-30, PO-2-3, MZ-23	MP-1, MP-9, MP-10,	The Republican Center for Accreditation of Health Care organizations has been created with bylaws, personnel arrangement and activity plan for the initial three years.

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2.2.2.3	Design a Regulation on accreditation in health care in RT	232	2010	MZ-23	MP-10	Regulation on accreditation in health care in RT has been developed and approved
2.2.2.4	Creation of the Supervisory Board on accreditation		2010	MZ-23	MP-10	Regulation "On the Supervisory Board on accreditation " has been developed and approved
2.2.2.5	Create the Committee on quality and safety of health facilities.		2010	MZ-23	MP-10	Regulation " On the Committee on quality and safety of health facilities" has been developed and approved
2.2.2.6	Develop a Regulation on clinical audit		2010	MZ-23	MP-10	Regulation on clinical audit has been developed and approved
2.2.2.7	Develop accreditation standards for obstetrics facilities, the system of their ranking and scoring. Developing guidelines for experts and users of the standards		2010-2011	MZ-23	MP-10	Working group has been set up; Accreditation standards for obstetrics facilities, the system of ranking and scoring have been developed and approved; Guidelines for experts and users have been developed and approved
2.2.2.8	Technical assistance of foreign consultants		2010-2011		MP-9	List of foreign consultants defined and approved
2.2.2.9	Training of experts and standards users		2011	MP-9	MP-1-13	Training packages have been developed and approved; necessary training materials and visual aids provided; trainings conducted, order of monitoring established.
2.2.2.10	Testing standards in pilot facilities		2011	MZ-23	MP-9, MP-10	Testing has been conducted; results analyzed, standards have been improved and submitted for approval
2.2.2.11	Conduct the first formal accreditation procedures of obstetrics facilities		2011-2012	MZ-23	MP-10	Accreditation conducted; facilities accredited
2.2.2.12	Improve the current accreditation procedure of medical education institutions in RT.		2013 (2)	MZ -5, PK-1-2, PK-4, GU-7	MP-10	Technical report "Conceptual and Technical Design of the accreditation of medical and nursing education programs and institutions".
	2.3 PRACTICE GUIDELINES AND EVIDENCE BASED MEDICINE	250-256				

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2.3.1	Continue developing and introduction clinical protocols for prevention, diagnostic and treatment of diseases and syndromes, based on the principals of evidence-based medicine.				MP-9	Clinical protocols for all priority diseases are developed, adopted and these guidelines are followed by medical personal
2.3.2	Develop conceptual, methodological and organizational basics of health care management. Explicate the three-tier approach to designing quality-of-care standards by developing clinical protocols and guidelines and risk/disease management strategies, and defining practice scope of health care facilities.		2011 (1-2)	MZ-3, MZ-1	MP-9	Programmatic document "Conceptual, Methodological, and Organizational Approach to Health Care Management in Tajikistan" designed, debated, revised as needed, and adopted by an MOH order.
2.3.3	Strengthen and enhance the role of the TSMU Evidence Based Medicine Centre as an entity that will guide the design and implementation of new practice guidelines.	239-241	2011 (4)	MZ-3, MZ-6, LU-1-3, LU-30, PK-1-2, PK-4, PO-2, PO-3	MP-9	The role of TSMU EBM Centre enhanced.
2.3.4	Develop a process to design, implement and monitor clinical protocols, including selection and customization of prototypes; revision and expansion of the current list of covered diseases and integration of new clinical protocols in health workforce education programs and health care practice.		2011 (3)	MZ-3, MZ-6, LU-1-3, LU-30, PK-1-2, PK-4, PO-2, PO-3	MP-7, MP-9	An organizational and procedural approach to clinical protocols and guidelines design and implementation has been discussed with all the stakeholders, agreed upon, and adopted by an MOH order.
2.3.5	Engage clinical societies and other professional organizations in practice guidelines design	238	2011 (4)	MZ-3, MZ-6, LU-1-3, LU-5, LU-5-8, LU-18, LU-25, LU-30, LU-40, PK-1-2, PK-4, PO-2, PO-3	MP-9	For each disease management guideline, international best-practice prototypes are selected and adapted for the resource and organizational constraints of the health sector of Tajikistan; the resulting draft guidelines are discussed by clinical expert panels. Expert discussions emphasize the link between clinical protocols, referral guidelines, and integration of health care resources at the provider, household, and community levels.
	2.4. ACCESS TO HEALTH CARE	3.3.6 252-275				Variance in access to health care resources is declining between urban and rural populations, and across income groups

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2.4.1	Review of public access to health care and respect of the patients' rights		2012 (1-2)	MZ-5, MZ-11, GU-5, GU-8, PO-4, PO-12, PO-14, PO-15	MP-9	Requisite clauses are included in the Basic Law on Health Protection.
2.4.2	Optimize the location of Family Medicine practice using 2010 Population Census data. An objective of this exercise is to ensure more equitable geographic access to integrated primary care.	263	2011-2012	MZ-20, GU-14	MP-9	"An updated scheme (map) of Family Medicine practice locations". Starting in 2013, "The Updated Map" will guide the planning of fixed investments, human resources, supplies and financing of the primary health care in Tajikistan.
2.4.3	Develop a master-plan of structural optimization of health care provider networks with the emphasis on improved access to services in remote areas.	262	2013	MZ-2; MZ-19	MP-1, MP-6	Technical reports on the optimization of provider network. "
2.4.4	Develop mechanisms to involve patients, families and communities into healthy life style and health promotion.	264	2011 (1-4)	MZ-3, MZ-6, RE-1-4, LU-03, LU-05, LU-07, LU30, LU-38 PO-3-17	MP-7, MP-9	"Guidelines for Engaging Patients, Families, and Communities into Preventive, Curative, and Rehabilitative Health Care" are developed.
2.4.5	Design policies and procedures to manage patient complaints at the provider and health administration levels. Develop mechanisms to ensure patient rights protection through litigation and out of court settlement.	268-271	2011	MZ-5, MZ-3, PO-4-17,	MP-9	"Policies and Procedures to Protect Patient Rights in the Health Sector of Tajikistan" – designed, debated, revised as needed, and adopted by an MOH order or an RT Cabinet of Ministers decree.
2.4.6	Conduct pilots to establish practices in the areas of patient advocacy and rights protection.	268-271	2012	MZ-2, PE-1;PO-4-17,	MP-9,	Pilots established with patient advocacy, patient rights protection, and provider ethics control.
2.4.7	Estimate relationship between eligibility for free (or subsidized) care and patients' status under BBP	271	2011 (2-4)	MZ-5, MZ-3, MZ-7, GU-14,	MP-1, MP-6, MP-9	Report "Review of Current and Proposed Alternative Eligibility Criteria for Free (Subsidized) Health Care in Tajikistan".
	2.5 PRIORITY PROGRAMS					
2.5 1	**Reproductive Health, Safe Maternity and New Born and Adolescent Health**	2.2 32-57				Maternal and neonatal mortality are declining at rates consistent with NHS target indicators set out for 2020.
2.5.1.1	Establish a Mother and Child Health Technical Coordination Group (MCH TCG)		2010		MP-1, MP-10, MP-2, MP-5, MP-3, MP-9, MP-8, MP-7	Regulation on Mother and Child Health Technical Coordination Group has been developed and approved

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2.5.1.2	Develop a conceptual and definitional framework for reproductive and perinatal health care.		2011 (2)	MZ-3, MZ-6, LU-3, LU-4, LU-5, LU-30	MP-1, MP-9	A section on reproductive and perinatal health for the "Handbook of Health Care Administrator": the material written, published, circulated to users, and posted on the MOH website.
2.5.1.3	Review and assessment of target population groups by regions and districts.		2012 (1)	МЗ-20, ГУ-14	MP-9	Statistical abstract from the 2010 Population Census and Analytical Report; specified list of target groups; developed sampling plan and data grouping; statistical abstract received and circulated
2.5.1.4	Collection and analysis of key reproductive and perinatal health indicators.		2012 (1)	MZ -1, MZ-20, GU-4, GU-14,	MP-9	Statistical compendium based on the 2010 population census, department\agency and analytical reporting.
2.5.1.5	Expert review and revision of medical and nursing education curricula and courses in the areas of reproductive and perinatal health in the framework of training and skill upgrading of general practitioners and nurses.		2012 (2) – 2013 (2)	PK-1-2, PK-4, MZ-6, LU-3, LU-05, LU-30, LU-36, LU-38, PO-2	MP-9	The structure and content of education curricula and courses are updated; provided with modern teaching materials, and integrated into the medical and nursing education programs. Rules are established for their further periodic update.
2.5.1.6	Update content, tools and materials for health education of youth on the issues of reproductive health, family planning, prevention of HIV/AIDS and other STDs.	23	2011 (2) -- 2013 (2)	LU-18, LU-36, LU-38,	MZ-6, MP-9 MP-13	Revised and expanded sets of materials for social marketing and population health education, including a course on reproductive health for schools, technical colleges and university-level education programs.
2.5.1.7	Improve practical guidelines to prevent mother-to-child transmission of HIV/AIDS.	34	2012 (1-4)	MZ-3, LU-36, PO-3	MP-1, MP-2 MP-9, MP-13, MP-10,	During the first three years of NHS implementation, a post-birth dose and a 6-month regimen of ARV therapy have been administered to all infants born from infected HIV mothers.
2.5.1.8	Develop, print and disseminate information-education materials and managing a large-scale public awareness campaign, centered on the reproductive and perinatal health agenda.		2011 (2) --	MZ-6, LU-38, GU-18, PO-7, PO-8, PO-9, PO-14, PO-17,	MP-1, MP-9, MP-10, MP-13	Information education materials brochures, posters. TV programs) developed; Air time for social marketing has been increased; educational courses have been implemented; Family Medicine practices are supplied with information and education materials, and contraceptives; practitioners are trained to communicate with patients and families.

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2.5.1.9	Design a one-time (cash/food) handout for women who signed up for antenatal care in the first 12 weeks of pregnancy.	25	2013 (2)	PE-1-4, MZ-6	MP-2(?)	A standard value of handout determined; the content of the package has been customized to match local preferences; local funding is provided; implementation is on track.
2.5.1.10	Develop practice guidelines for home-based deliveries.	31	2012 (1-4)	MZ-3, MZ-6, LU-5, PE-1-4; PO-3	MP – 1 MII-1	Clinical protocols "Safe Childbirth at Home" and "Post-partum Monitoring and Care" have been designed and estimated for resources and costs. Additional provider training and improved equipment/supplies for family medicine practice recommended.
2.5.1.11	Developing practice guidelines for newborns care.	32	2010- 2011	MZ-6, LU-5, LU-6, PO-2,	MP-9, MP-10, MP-2	
2.5.1.12	Develop and improve standard regulations in obstetrics and perinatology		2010-2012	MZ -1	MP-9, MP-10	Standard regulations in obstetrics and perinatology have been developed and approved
2.5.1.13	Develop a system of regionalization, organization and improvement of perinatal care		2011-2012	MZ -1 PK-1-2	MP-9, MP-10	System of regionalization, organization and improvement of perinatal care has been developed and approved
2.5.1.14	Develop and improve educational programs, standards, and guidelines on improvement of the quality of care in obstetrics and perinatology and their implementation in pre/post diploma medical curriculums		2011-2012	MZ -1 PK-1-2	MP-1, MP-2, MP-8, MP-9, MP-10	Educational programs, standards, and guidelines have been developed, approved and implemented; necessary educational materials and visual aids are provided; developed documents implemented in academic curriculums; the order of their revision is established
2.5.1.15	Organization and provision of seminars for health providers providing reproductive and perinatal health services on use of the safe motherhood standards		2011-2012	MZ -1 PK-1-2	MP-1, MP-2, MP-3, MP-8, MP-9, MP-10,	Training packages have been developed, necessary materials and visual aids provided, trainings conducted; order of monitoring established
2.5.1.16	Develop list of essential drugs and equipment to ensure safe motherhood and prevention of HIV/ AIDS prevention and transmission at all levels of obstetric service. Provision of obstetrics and reproductive health facilities with essential drugs and equipment		2010-2011	MZ -1 PK-1-2	MP-1, MP-2, MP-3, MP-9, MP-10, MP-13	list of essential drugs and equipment has been developed; obstetrics and reproductive health facilities provided with essential drugs and equipment

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2.5..1.17	Development of integrated tool for monitoring and evaluation of obstetrics and reproductive health facilities		2011	MZ -1	MP-9, MP-10	An integrated tool for monitoring and evaluation of the quality of service provision in obstetrics and reproductive health facilities has been developed and approved
2.5..1.18	Organization and provision of monitoring and evaluation of the quality of medical services on safe motherhood		2011-2012	MZ -1	MP-9, MP-10	Monitoring and evaluation of the quality of medical services on safe motherhood arranged and provided in an established order
2.5.1.19	Develop and implement mechanism of referral mother and infants to next level of medical care provision		2011-2012	MZ -1	MP-9, MP-10	Mechanism for referral of mother and infants to next level of medical care provision developed and implemented
2.5.1.20	Upgrade infrastructure and improve equipment supply of maternal hospitals and obstetric units in Khatlon region		2010-2013	MZ -1	MP-11	Obstetric and neonatal care of the hospitals of Khatlon region will be rehabilitated and equipped and the staff will be trained.
2.5.1.21	Implementation of clinical standards (clinical practise guidelines) in the practice of obstetric facilities in Khtalon region		2010-2013	MZ -1	MP-10, MP-11	The staff of obstetric and neonatal care oft he hospitals of Khatlon region work using clinical practise guidlines.
2.5.1.22	Developing and improving model regulations in obstetrics and perinatology		2010-2012	MZ -1	MP-10,	Regulations in obstetrics and perinatology have been developed and approved
2.5.1.23	Implementation of the standard regulations in obstetrics and perinatology in maternal hospitals of Khatlon region.		2010-2013	MZ -1	MP-11	The number of hospitals using regulations in obstetric and perinatology of Khatlon region is increased
2.5.1.24	The development of the standard list of equipment for obstetric and neonatal care hospitals and emergency care.		2010-2013	MZ -1	MP-11	The standard list of equipment for obstetric and neonatal care of the hospitals of Khatlon region is made and approved. The hospitals are equipped with the same equipment.
	HEALTHY CHILDHOOD	2.3 38-63				Infant and under-5 children's mortality are declining at rates that keep improvements on track with the NHS target indicators for 2020.

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2.5.1.25	Scaling up parent/family education to teach adults and children about food safety how to identify the most common diseases of early childhood and remedy them with prompt and effective action, particularly, in preventing diarrhea and ARIs	43	2011 (3)	MZ-6, LU-06, LU-7, LU-30, LU-33, LU-38, LU-40, PO-7, PO-9, PO-13, PO-14	MP-2, MP-9	Public health guidelines "Parent/Family Education to Identify, Control and Treat Common Children's Diseases", and "Empowering the Family and Community to Improve Household Hygiene" have been designed. The derived activity program has been estimated for, and provided with resources (e.g., IEC materials and requisite health supplies). New public health guidelines have been integrated into medical education, and implemented in Family Medicine practice, and especially introducing of safe and appropriate complementary feeding on time, breastfeeding practices and child growth monitoring.
2.5.1.26	Design and implement a public health guideline "Developing Family and Community Skills in Improving and Sustaining Hygiene in Households", particularly, to maintain clean air and safe drinking water; ensure prompt waste removal, and educate children on the importance of being clean and neat.	45	2012 (3)	MZ-6, LU-14, LU-7, LU-30, LU-40, GU-7, GU-8, GU-9, GU-16, PO-9, PO-12, PO-14, MP-2	MP-2, MP-7, MP-9	
2.5.1.27	Implement priority measures to improve the nutritional status of breastfeeding mothers and infants, as well as under-five children, who are anemic, stunted, and severely or chronically malnourished.	51	2011 (1)	MZ-6, LU-41,LU-07, LU-30, LU-40,	MP-2, MP-7, MP-9	Promotion of exclusive breastfeeding is conducted in all public health education formats; breastfeeding is the focus of antenatal post-partum care. Micronutrient supplements to prevent and treat anemia are in adequate supply and actively used by Family Medicine practice.
2.5.1.28	Improving supply of children's vaccines of good quality. This includes: priority effort to restore missing/failing components of cold chain as part of health sector investment program; (re) assessment, if required, of annual demand for vaccines with appropriate adjustment in the vaccine procurement plans.	52, 53, 54	2011 (1)	MZ-6, MZ-18, LU-35, MK-2,	MP-2	Number of vaccine stock-out days has declined to a 'background noise' level, heralding the achievement of a sustainable supply of children's vaccines, mandated under the National Immunization Schedule.
2.5.1.29	Develop and implement a modified approach to children's immunizations managed by Family Medicine practice.	55	2012 (3)	MZ-6, LU-6, LU-40; LU-30, LU-33,LU-38, PO-2; PO-3; MPA-1	MP-1, MP-2 MP-9	Practice guideline "Children's Immunization Services under an On-going Immunization Campaign Approach" has been designed, estimated for resources and costs, included in the medical and nursing education programs, and implemented in Family Medicine practice.
2.5.1.30	Update the existing IMCI guidelines and incorporate them into daily PHC practice	58	2013 (1)		MP-2, MP-9	PHC workers using updated IMCI guidelines in daily practice.

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2.5.2.	**Prevention and Control of High-impact Infections**					Prevention, diagnostics, and treatment of HIV/AIDS, other STDs, and tuberculosis are steadily moved to modern health care management standards, including IEC, express-testing, and effective medications
2.5.2.1	Strengthen surveillance systems to monitor outbreaks of infectious diseases and increase early warning and response capacity in line with international standards.			MZ – 1	MP-15	Improved surveillance capacity
2.5.2.2	Design and staged implementation of policies and guidelines on nosocomial infection control		2013	MZ – 1	MP-13, MP-9	National nosocomial infection control guideline and strategy updated and inn line with international nosocomial infection control standards.
2.5.2.3	Reinforce the implementation blood safety regulations and procedures		2013	MZ – 1	MP-13, MP-9 MP-15	donation and transfusion of Blood and blood products are free of charge
2.5.2.4	Design and staged implementation of policies and guidelines towards universal access of HIV/AIDS prevention, treatment, care and support interventions.	61-66	2012 (1) --	MZ-3, LU-36, PO-2, PO-6, PO-15, PO-7, PO-8	MP-13, MP-9, MP-14	National strategic plan, HIV/AIDS legislation, and by-laws are updated and consistent with international and national standards.
2.5.2.5	Measure a coverage of HIV/AIDS prevention interventions of high-risk groups (IDUs, sex SWs, MSM,) as well as other vulnerable groups (youth, migrants, women, prisoners and street children)		2012	MZ-3, LU-36, PO-2, PO-6, PO-15, PO-7, PO-8	MP-13, MP-9	1. Comprehensive harm reduction package is offered to at least 35 % of the estimated number of IDUs 2. HIV/AIDS prevention package (IEC, condoms and STI treatment) offered to vulnerable groups and general population at all levels
2.5.2.6	Provide a comprehensive package of HIV treatment, care and support to people living with HIV/AIDS		2013	MZ-3, LU-36, PO-2, PO-6, PO-15, PO-7, PO-8	MP-13, MP-9	At least 90% of the eligible PLWHA are offered ARV therapy and opportunistic diseases treatment including Tuberculosis
2.5.2.7	Design and staged implementation of disease management guidelines for STIs, emphasizing confidential treatment of patient information; screening of syphilis, chlamydia and other infections; on-the-spot microbial treatment of STDs (Syndrome STIs management)	68-69	2012 (1)	MZ-3, LU-18, LU-30, PO-2, PO-7, PO-12	MP-9	Clinical protocol "Diagnostic and Treatment of STIs in Family Medicine Practice" has been developed, assessed for resources and costs, and integrated into Family Medicine practitioners' training. Outpatient management of STIs is shifting toward Family Medicine practice.
2.5.2.8	Тақвияти корҳо бо аҳолӣ оид ба профилактикаи СТАҶИ, бо истифодаи стратегия ва усулҳои нав, аз ҷумла дар асоси тафриқабандии нисбатан дақиқи гурӯҳҳои таҳти хатар	69	2012 (1)	MZ-3, LU-18, LU-30, PO-2, PO-7, PO-12, GU-18	MP-13, MP-9	Public health guideline "Prevention of STDs through Targeted Risk Management" has been designed and implemented with better targeting of STD prevention and care to labor migrants and adolescents, and by involving men in supporting the norms of safe sex and prudent behavior.

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2.5.2.9	Reinforce implementation of TB control Program based on Stop TB strategy (enhance quality of DOTs, expand MDR-TB treatment, improved TB/ HIV collaboration, PAL, PPM implementation, political commitment, TB program in Prison)		2012 (1)	MZ-3, LU-31, PO-2	MP-1, MP-9	Disease management guideline "Management of Tuberculosis, Based on DOTs in Family Medicine Practice" has been designed, assessed for resources and costs. Implementation is underway.
2.5.2.10	Improve TB case detection and cure rate of the new SS+ TB cases		2013	MZ – 1, LU-31, PO-2.	MP-1, MP-9	At least 70% of the New SS+ TB patients are detected and 85% successfully treated among new SS+
2.5.2.11	Scaling up of access to diagnostics and treatment of resistant TB patients		2012-2013	MZ-3	MP-1, MP-13, MP-9,	1. National guidelines on resistant TB management is developed and implemented. 2. 60% of the estimated resistant TB cases are confirmed by laboratory and offered treatment. 2011
2.5.2.12	The development and implementation of the Rationalization plan of the National TB service/ hospital network in the Republic of Tajikistan		2010-2012	MZ – 3; LU-31; PO-2	MP -11	Plan of rationalization of TB hospital network of the RT approved and implemented in the framework of national TB program for 2010-2015
2.5.2.13	The organization of appropriate hospital conditions for TB treatment including MDR on a national level (rehabilitation and equipment supply) under DOTs plus strategy		2010-2012	MZ – 3; LU-31; PO-2	MP-11, MP-13	Republican TB clinical hospital „Shifo" is rehabilitated and equipped by modern medical and non-medical equipment, MDR Dpt. Was organized and functioning.
2.5.2.14	The development and implementation of the conception of TB laboratory network in Tajikistan		2010-2012	MZ–1	MP-1, MP-11, MP-13	The conception of TB laboratory network of Tajikistan is approved and inplemented
2.5.2.15	Organization of the National TB reference laboratory, staff training, external and internal quality control		2010-2012	MZ–1	MP-11	National TB refernce laboratory is organized and functioning in accordance with international standards.
2.5.2.16	The development and implementation of regionalization and rationalization plan of Regional TB Hospital Service in Sughd region		2010-2013	MZ–1	MP-11	Plan of regionalization and rationalization of the regional TB hospital network approved and implemented.
2.5.2.17	Organization of appropriate conditions for hospital treatment of TB patients under DOTs strategy in the Regional TB hospital of Sughd region „Digmoi" (rehabilitation, equipment, training of staff)		2010-2013	MZ–1	MP-11	Regional TB hospital of Sughd region „Digmoi" is rehabilitated, equipped and the staff trained

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2.5.2.18	Reinforce implementation of malaria elimination strategy at all levels through multi-sectoral approach mechanisms and interventions.		2013	MZ-3	MP-1, MP-13	Malaria prevalence is contained to less than 0.01/1000 population
2.5.2.19	Taking measures on reducing cases of dumping sewage, polluted and dirty water into rivers and reservoirs.		2011-2013	MZ-1;MZ-18	MP-1,	Measures are taken on reducing cases of dumping sewage, polluted and dirty water into rivers and reservoirs, due to technical reconstruction of infrastructure.
2.5.2.20	Construction of highly effective and modern facilities for sewage treatment, paying special attention to biological purification.		2012-2013	MZ-1 ;MZ-18	MP-1	Highly effective and modern buildings on purification of sewage, paying special attention to biological sewage purification are constructed.
2.5.2.21	Prohibit dumping unpurified sewage into riverside used for recreation and etc.		2010-2013	MZ-1 ; MZ-18	MP-1	Dumping unpurified sewage into riverside used for recreation and etc is prohibited.
2.5.2.22	Develop an efficient and cost effective mechanism encouraging employers to provide safe and healthy workplaces, including favorable taxation for businesses with non accidental operation, carrying out automation and modernization of the production and technology processes.		2010-2013	MZ-1 ;MZ-18	MP-1	Efficient and cost effective mechanism aiming at employers on providing safe and healthy workplaces, including favorable taxation terms for those employers who provide non accidental exploitation of modern technologies, is developed and in place.
2.5.2.23	Develop the unified system (methodology) for organizing and conducting state sanitary – epidemiological surveillance of transportation means (vehicles).		2010-2013	MZ-1 and local state agencies	MP-1	A unified system (methodology) for organizing and conducting state sanitary – epidemiological surveillance over transportation means (vechicles) is developed.
2.5. 2.24	Creating conditions for replacing outdated technology at industrial and agricultural entities; planning and implementing measures on protection of population from excessive impact of traffic noise (vehicle and aviation).		2010-2013	MZ-1 , MZ-18,	MP-1	Favorable conditions for replacing outdated technology at industrial and agricultural entities, planning and conducting measures on protection of population from excessive influence of traffic noise (vehicle and aviation) is developed.
2.5.2.25	Continue issuance of passports to those organizations and administrative units dealing with radiation control over the external surrounding environment..		2010-2013	MZ-1, MZ=18		Issuance of passports to those organizations and administrative units dealing with radiation control over the external surrounding environment is ongoing
2.5.2.26	Strengthen and implement epidemiological surveillance over non infectious diseases, in order to determine casual fact-finding spreading of chronic and non-communicable diseases, including occupational diseases.		2010-2013	MZ-1;	MP-1, MP-1-15	An epidemiological surveillance over non infectious diseases, determining casual fact-finding spreading of chronic and non infectious diseases, including professional illnesses is improved and in place.

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2.5.3	**Non-Infectious And Chronic Diseases**	2.5 76-83				Common non-infectious and chronic diseases are controlled with active contribution from the patients. Quality of life of the chronically ill and the elderly has increased thanks to a more effective disease management and social-medical rehabilitation.
2.5.3.1	Design and implement a disease management guideline for diabetes, including monitoring by a qualified health care provider, medication support, and training patients in managing their condition.	79	2012 (1-4)	MZ-3, PO-2, LU-32	MP-1, MP-9	Disease management guideline "Diabetes Management as a Joint Effort of Qualified Health Care Providers, Patients and Their Families" has been designed, integrated into provider education, and matched to procurement plans for insulin and other health supplies for home-based use. Implementation is managed by Family Practice at a realistic pace.
2.5.3.2	Design and implement a disease management guideline for chronic non specific lung diseases including monitoring by a qualified health care provider, training patients in managing their condition, and educate families and community members on care and support of individual children and relatives.	79	2012 (1-4)	MZ-3, LU-6, LU-33, LU-40, PO-2	MP-1, MP-9	Disease management guideline "Managing Asthma in Children and Adults as a Joint Effort of Qualified Health Care Providers, Patients, Their Families, and Communities" has been designed, integrated into provider education, and pharmaceutical procurement plans. Staged implementation is managed by Family Medicine practice.
2.5.3.3	Implementation of the tasks outlined by National Programs to prevent traumatism, cardio vascular and oncology disease and diabetes.		2010-2013	MZ-1	MP-1-15	Tasks foreseen at National Programs are implemented.
2.5.3.4	Continuous improvement of emergency aid and ambulance care in line with development of catastrophe medicine.		2010-2011	MZ-1	MP-1, МП-1	Strengthening of Emergency Services
2.5.3.5	Improving Laboratory Services.		2012	MZ-1	MP-1, MP-11, MP-9	External quality assessment system established. Reference laboratory setup.
	2.6 PUBLIC HEALTH					
2.6.1	Develop the Integrated Action and Monitoring Plan on population's awareness about healthy lifestyle.		2011	MZ-1, MO,	MP-1	Integrated Action Plan developed
	2.7 COMMUNITY AWARENESS AND PARTICIPATION IN HEALTH PROMOTION		2011			

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2.7.1	Scaling up information and education campaigns to curb unhealthy behaviors, particularly, intensifying social marketing against alcohol, drug addiction and smoking, through targeting youths and parents as role models for children.	82	2011 (3) --	MZ-9, LU-38, GU-16, GU-17, GU-18, PO-6, PO-9, PO-13	MP-1, MP-7, MP-9	Social marketing content has been designed and is broadcast in prime time and most popular media; increasingly integrated into pop culture. School-based awareness campaigns are based on interactive methods, e.g., experience sharing and learning through group activities.
2.7.2	Encouraging mutual support by individuals with shared health and age problems and related social experience.		2011 (1) --	LU-28, PO-11, PO-15	MP-1, MP-7, MP-9	Clubs by shared interest have emerged under the community and health center auspices, including retiree clubs, associations of alcoholics, drug-dependants, etc.
	3. STRENGTHENING HEALTH SECTOR RESOURCES					
	3.1 HUMAN RESOURCE					
3.1.1	Workforce Planning					
3.1.1.1	Review a list of professions and occupations in the health sector of RT and its periodic updating procedure.	303, 332	2011 (1-2)	MZ-4, MZ-15, GU-8, GU-7, GU-14, PO-1, PO-3,	MP-9	"Classification List of Health Care Professions and Occupations" has been reviewed and accepted for professional discussion and official adoption.
3.1.1.2	Update / revision of job descriptions and professional requirements for Family Medicine practitioners.	318	2011 (2-4)	MZ-3, MZ-6, LU-30, PO-1, PO-3	MP-7, MP-9	A human resource planning brief has been prepared, discussed, reworked as needed, and adopted by a Minister's of Health executive order.
3.1.1.3	Refine yearly demand assessment for physicians and nurses, including Family Medicine practitioners.	318	2012 (1-2)	MZ-15, GU-8, GU-14, PO-1, PO-3	MP-9	Assessed demand for Family Medicine practice staff, including: family doctors, PHC "specialists" and nurses
3.1.1.4	Determine functions, job descriptions and professional skills requirements for health sector workers in non-medical occupations.	311	2011 (2-4)	MZ-3, MZ-15, GU-8, GU-7, GU-14, PO-1	MP-9	A human resource planning brief has been designed, discussed and adopted by a Minister's of Health executive order.
3.1.1.5	Project demand for health sector workers of key non-medical occupations.	318	2011 (4) – 2012 (1)	MZ-15, GU-8, GU-14, PO-1	MP-9	Projection conducted.
3.1.1.6	Revise new salary schedule for health sector workers and the procedure of ensuring annual higher levels of labor remuneration/compensation in the health sector.	305-308	2012 (3-4)	GU-3, GU-8,	MP-9	MOF order or the RT Government decree "Salary Schedule of Health Sector Workers and the Terms and Conditions of Its Annual Revision per NHS Salary Growth Targets".

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3.1.1.7	Implementation of the basic principles of the hospital management in the rehabilitated and equipped hospitals of Khatlon region and the Republican TB hospital "Shifo"		2011-2014	MZ -1	MP-11	Hospital management is implemented and is functioning in the rehabilitated and equipped hospitals of Khatlon Region and Republican TB Clinical Hospital „Shifo" .
	3.1.2 HEALTH WORK FORCE DEVELOPMENT	282-346				Health Sector professionals are adequately trained and suitably remunerated. Professional and occupational mix of health workforce is on a path to diversification.
3.1.2.1	Develop education curricula for Tajik health sector managers, systems analysts, andplanners	319-346	2012 (1-4)	MZ-3, MZ-4, GU-7, PK-1-2, PK-1	MP-9	Training programs for these non-medical occupations have been designed, approved, and implemented in at least one general education institution (university level).
	3.2.1.CREATION OF AN EFFICIENT SYSTEM OF MEDICAL EDUCATION					
3.2.1.1.	Revise State standard for higher professional medical education in TSMU		2011	MZ -1; PK-1	MP-7,	New State Standard developed
3.2.2	Increase the number and strengthen Clinical training bases of TSMU, PGMI, medical colleges and school to ensure medical students have sufficient and appropriate supervised medical exposure. Strengthen the teaching capabilities and clinical training bases		2011-2013	MZ -3;MZ-4, GU-7; PK-1-2, PK-1	MP-7, MP-9	Clinical training bases are identified and contracted by educational institutions and MoH, and their teaching capacities are strengthened. Increased number of clinical hours for students
3.2.3.	Development of continuing medical education for health professionals (after piloting with Family Doctors) based on modern international standards		2011	MZ -1; PK-2	PK-1; MP-7, MP-9	System of CME piloted and introduced.
	3.3. DEVELOPMENT OF MEDICAL SCIENCE		2011			
3.3.1	Development Plan					
3.3.1.1	Introducing a modern innovative medical technology in health care practice.					
3.3.1.2	Planning of priority directions in the development of medical science.		2013			

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	3.4.IMPROVING SUPPLY OF PHARMACEUTICALS	299-317				Supply of pharmaceuticals has improved both in quality and price. Work has started to ensure more safe and effective use of medications in the health sector of Tajikistan.
3.4.1	Refine the List of Essential Drugs	299, 310	2011 (1-3)	MZ-8, MZ-3, MZ-6, LU-30, MZ-1	MP-9	The List of Essential Drugs has been updated.
3.4.2	Review and make recommendations to improve the current system of drug procurement for the health sector.	301	2011 (4) – 2012 (1)	MZ-8, MZ-16, MZ-1, MZ-2	MP-9	Recommendations implemented .
3.4.3	Review of the current practice of registration and certification of pharmaceuticals in the market of Tajikistan.	302	2012 (2)	MZ-16, MZ-1, MZ-2, GU-20, GU-23	MP-9	New or revised bylaws adopted for the National Research Center for Pharmacology and the National Center for Procurement of Pharmaceuticals and Other Health Commodities.
3.4.4	Refine the national list of free pharmaceuticals for privileged groups of the population.		2013 (2)	MZ-8, MZ-16, M MZ-1, MZ-2	MP-7,MP-9,	A list of free medications for the use in provider facilities and dispensation in pharmacies is available in each provider facility and pharmacy, and can be accessed by patients.
3.4.5	Analyze labeling and user instructions content, and preparing recommendations for improvement	313	2012 (3)	MZ-16, GU-23, MK-1, MK-2	MP-9	Analytical brief "Analysis and Recommendations to Improve the Quality of Labeling and User Instructions for Medications"
	3.5. MODERNIZATION OF PHYSICAL ASSETS	318-334				Five-year investment program has been adopted to support Family Medicine practice and facilitate structural rationalization of health care provider networks. The program is backed up with technical documentation, funding, and is on track to successful implementation.
3.5.1	Prepare health care provider census in Tajikistan, including census program, questionnaires, and field activity planning.		20110 - 2011	MZ-20, MZ-10, GU-14	MP-5, МП-5	The health care provider census program and tools have been designed.
3.5.2	Design and programme a database for health care provider census data entry and management.		2011 (1)	MZ-20, M-3	MP-9	Database has been programmed and tested; provided with documentation.

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3.5.3	Analyze provider census data on a data subset relating to PHC facilities. Identifying the gap between the actual PHC provider networks and optimal solutions and standards in terms of location, workforce, physical plant, and technology available to facilities that have and are expected to accommodate the Family Medicine practice in RT		2011 (4)	MZ-3,	MP-5, MP-6	Technical report "Assessment of Need for Additional Facilities and Resources to Facilitate Transition to Family Medicine: Evidence from the National Health Care Provider Census of 2011".
3.5.4	Feasibility study of underutilized health service provider capacity and recommendations for improvement.		2011 (4)	MZ-3, RE-1-4	MP-5	Technical brief "Recommendations for Closing and Rehabilitating Health Care Provider Facilities in Tajikistan" is prepared for the first 20 districts of RT and contains facility-specific rationalization plans for preferred scenarios, e.g. closure, modernization with or without re-profiling, etc.
3.5.5	Provide standard architectural design for seven modalities of rural health houses as the host facilities for Family Medicine practice.		2011 (2-4)	MZ-19, MZ-8, GU-22	MP-5, MP11	Architectural design and blueprint documentation for each modality developed, checked for compliance with construction rules and safety standards, and adopted for next five years.
3.5.6	Form construction / investment title (site) lists at the district, regional and national levels, primarily to prioritize the development of Family Medicine practice in strict compliance with new standards of care.		2011-13	MZ-7, MZ-19, GU-3	MP-5	Construction / Investment titles have been listed for 2011-15 and grouped by type of investment activity: new construction, remodeling, and retrofitting. Priority is given to rural health houses and centers, and to district-level facilities, expected to provide critical support to Family Medicine practice.
3.5.7	Develop a five-year investment program and a three-year investment plan with the emphasis on new construction, remodeling, and retrofitting of rural PHC networks.		2012 (2-3)	MZ-7, MZ-19, GU-3, RE-1-4	MP-5	A five-year investment program (2011-15) and a three-year investment plan (2011-13) have been designed by matching investment sites (item 3.3.8) to standard architectural designs (item 3.3.7) and NHS target spending on health sector investments.
3.5.8	Management and oversight of construction and renovation projects across all the approved investment sites: competitive selection of contractors, quality and timeliness control, walk-through and acceptance.		2011 -	MZ-19	MP-5, MP-11	Semi-annual progress reports on the implementation of annual investment plans in the health sector of Tajikistan
3.5.9	Start-up management -- putting new, renovated and retrofitted facilities in operation: timely initiation of operating financing, recruitment of additional staff, etc.		2011 -	MZ-7, MZ-15	MP-5, MP-11, МП-5, МП-11	

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3.5.10	Development of the design of rehabilitation and the standard list of equipment, procurement, implementation, commissioning and hand over of district and regional hospitals of Khatlon region		2010-2014	MZ-1	MP-11	Critically important subunits and departments (admission rooms, operational theaters, ICU and reanimation, obstetric & gynecologic dpt. and neonatal care) of the central district and regional hospitals will be modernized.
	4. HEALTH CARE FINANCING	403-513				On-budget health financing is growing at a steady pace. Share of public health expenditure is increasing as percent of total budget outlays. Financial pressure on households from paying for health services is declining, particularly, on low-income households. Provider reimbursement methods incentivize productive performance and quality of care
	4.1 REVENUE COLLECTION FUNCTION					
4.1.1	Prepare concrete plans with predetermined numbers to gradually increase the health budget as measured by health budget expenditures as a percent of total government expenditures.	427	2011	MZ-7;	MP-6; MP-7; MP-9;	Plans developed and approved. Indicator on level of budget monitored.
4.1.2	Perform National Health Accounts (NHA) to show sources and uses of health sector funds to inform policy decisions.	428	2011, 2013	MZ-7, MZ-2, GU-3, GU-14	MP-1, MP-5, MP-6;	NHA reports.
4.1.3	Strengthen Midterm Expenditure Framework as a tool for health budget planning.	429	2010-13	MZ-7	MP-6;	MTEF functioning as tool for health budget planning.
4.1.4	Monitor budget execution to help ensure predicable and consistent funds flow to health providers.	430	2011-2015		MP-6;	Indicator on budget execution monitored.
4.1.5	Perform analysis of the advantages and disadvantages of MHI including forecasting or modeling of various scenarios for sources of funds and determining how to incorporate them into a comprehensive framework for overall health revenue planning.	431	2013	MZ-2; MZ-5; MZ-7	MP-1; MP-6;	Analysis produced and inserted into policy dialogue process.
4.1.6	Determine roles and relationships of health sector stakeholders to improve forecasting, collection, and execution of health sector budget from different funding sources.	433	2011	MZ-2; MZ-5;MP-9;	MP-1; MP-6; MP-9	Roles and relationships established including SWAp without or without budget support.
	4.2 POOLING OF FUNDS FUNCTION					

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4.2.1.	Feasibility assessment and plan for pooling of funds or health budget consolidation at the oblast level.	446	2011	MZ-2; MZ-7	MP-1; MP-6; MP-7; MP-9;	Detailed plan for pooling of funds developed.
4.2.2	Implement plan to pool funds.	446	2012	MZ-52; MZ-25; MZ-7	MP-1; MP-6; MP-7; MP-9;	Pooling of funds accomplished.
4.2.3	Improve budgeting including introduction of program budgeting for health.	447	2011-2012	MZ-5; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Program budgeting introduced. Health budget formation consistent with new output-based provider payment systems.
4.2.4	Conduct operations research or special studies on such topics as monitoring equalization of geographic resource equalization.	448	2012-2013	MZ-2;	МП-1; МП-6; МП-7; МП-9	Plan for policy analysis and operations research studies developed and implemented. Specific study performed to determine whether oblast pooling is sufficient or national pooling is required to equalize per capita funding.
4.2.5	Explore potential for introducing community financing within the broader health financing reform and BBP framework.	449	2012	M3-7	MP-1; MP-6; MP-7; MP-9;	Feasibility study.
4.2.6	If oblast level pooling is implemented together with national level subventions but it does not result in equalizing health budget funding (as defined by payment formulas) for the entire population, national level pooling would be considered.	451	2013-2013	MZ-5; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Based on special study and monitoring of oblast pooling, determine whether national pooling or geographic equalization is required.
	4.3 **HEALTH SERVICE PURCHASER**					
4.3.1	**Institutional Capacity**					
4.3.1.1	Establish a health purchaser in the OHD Finance Department.	456	2012	MZ-5; MZ-2; MZ-7; RE-1-4	MP-1; MP-6; MP-7; MP-9;	Health purchaser established. Infrastructure including computer system provided.
4.3.1.2	Develop and implement plans to build general systems and human resources capacity in the OHD Finance Department.	457`	2012-2014	MZ-5; MZ-2; RE-1-4	MP-1; MP-6; MP-7; MP-9;	Operating systems and processes established. Human resources capacity developed.
4.3.1.3	Develop mechanisms and capacity in the OHD Finance Department for specific health purchaser functions including budgeting, calculation of unified provider payment system rates, processing and approving provider reports.	458	2012-2014	MZ-5; MZ-2; RE-1-4	MP-1; MP-6; MP-7; MP-9;	Specific health financing training and capacity building accomplished.

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4.3.1.4	Define and develop roles and relationships between all health financing stakeholders including MOH, MOF, Local Administrations, OHD, OFD, RFD, Treasury System, and health service providers.	459	2011	MZ-5; MZ-2; MZ-3; MZ-7	MP-1; MP-6; MP-7; MP-9;	Roles and relationships established in legal and regulatory framework and implemented.
4.3.2	**HEALTH SERVICE PURCHASING FUNCTION**					
	Individual Health Services					
4.3.2.1	Continuous strategy development and monitoring to ensure provider payment systems and other health purchasing mechanisms match BBP structure and entitlements.	475	2012-20 13	MZ-5; MZ-2; MZ-3; MZ-7	MP-1; MP-6; MP-7; MP-9;	Monitoring determines provider payment matches BBP.
4.3.2.2	Complete national roll-out of PHC per capita payment system (variable costs).	476	2011	MZ-5; MZ-7;	MP-6; MP-7; MP-9;	Roll-out completed.
4.3.2.3	Design, pilot and roll-out PHC per capita payment system (all costs including salaries), continuous refinement of system.	476	2012-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	System designed. System piloted. System rolled-out.
4.3.2.4	Link new financial incentives with continuous improvement in PHC structure, human resources planning and management, scope of services and continuum of care, service delivery, and integration of vertical systems into PHC.	477	2011-2013	MZ-5; MZ-3; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Plans developed to link health financing reform and service delivery improvement.
4.3.2.5	Introduce, expand, and continuously refine a case-based hospital payment system.	478	2011-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-9;MP-11	Case-based hospital payment system introduced.
4.3.2.6	Identify and resolve budget formation or funds flow issues hampering output-based provider payment system implementation.	479	2011-2012	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Health funds flow consistent with output-based provider payment systems.
4.3.2.7	Introduce, expand, and continuously refine new payment systems for other individual health services including emergency and outpatient specialty care.	480	2012-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Provider payment systems designed, developed, and implemented.
4.3.2.8	Develop mechanisms to pay for health promotion activities and ensure that provider payment systems contain incentives for health service promotion.	481	2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	Health promotion activities funded and incentives to increase health promotion in place.

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4.3.2.9	Develop mechanisms to pay for high-cost tertiary services.	482	2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	Механизмҳо ва системаҳо таҳия ва ҷорӣ карда шуданд
4.3.2.10	Improve drug procurement and financing systems including for outpatient drugs.	483	2011-2013	MZ-5; MZ-7; MZ-8; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Нақшаи муфассал ва фарогири хариди воситаҳои доруворӣ таҳия ва татбиқ гардид
4.3.2.11	Pilot, evaluate, and expand pay-for-performance adjustments in the provider payment systems.	484	2012-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-5; MP-6; MP-7; MP-9;	Нақшаи пардохт барои ҳар як ҳолати муолиҷа ё ФОР омӯхта ва таҳия карда шуд. Ҷорӣ намудани нақшаи мазкур
4.3.2.12	Provide expertise and develop regulatory framework to contract private providers.	485	2013	MZ-5; MZ-7; MZ-2;	MZ-2; MP-6; MP-7; MP-9;	Заминаи қонунгузорӣ таҳия гардид
	4.3.4 **PUBLIC HEALTH, INFECTIOUS DISEASES, AND OTHER HEALTH SERVICES AND FUNCTIONS.**					
4.3.4.1	Introduce, expand, and continuously refine new payment systems for vertical systems including TB and HIV.	486	2012-2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-9	MP-1; MP-6; MP-7; MP-9;MP-13	Payment systems designed and developed. Payment systems implemented.
4.3.4.2	Provide financial incentives for further integration of vertical programs with the general health system.	486	2012-2013	MZ-5; MZ-7; MZ-2; MZ-3; MZ-6;MZ-9	MP-1; MP-6; MP-7; MP-9;MP-13	Detailed plan developed for integration of vertical programs with the general health system.
4.3.4.3	Introduce, expand, and continuously refine new payment systems for public health services including SES and medical education.	487	2012-2013	MZ-5; MZ-7; MZ-2; MZ-9	MP-1; MP-6; MP-7; MP-9;	Payment systems designed and developed. Payment systems implemented.
4.3.4.4	Improve mechanisms for capital investment and capital asset maintenance.	488	2012-2013	MZ-5; MZ-7; MZ-19; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Detailed plan developed for capital investment including whether payment included in provider payment systems or separate, whether Certificate of Need (CON) required, who/how purchase, how include capital maintenance.
	4.3.5 **FIDUCIARY RISK AND FINANCIAL MANAGEMENT**					
4.3.5.1	Improve health information systems and new provider payment system (PPS).	489	2011-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-9;	Detailed HIS and PPS plan developed. HIS and PPS plan implemented.
4.3.5.2.	Link provider payment systems to quality assurance mechanisms.	490	2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Detailed plan developed.

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	4.4 **HEALTH PROVIDER AUTONOMY AND HEALTH MANAGEMENT**					
4.4.1	Develop and implement a legal and policy framework to increase health provider autonomy.	494	2011-2012	MZ-5; MZ-2;	MP-1; MP-6; MP-9;	Legal and regulatory framework developed and approved. Framework implemented.
4.4.2	Develop and implement a legal and policy framework for private sector development and regulation.	495	2012	MZ-5; MZ-2;	MP-1; MP-6; MP-9;	Legal and regulatory framework developed and approved
4.4.3	Support expansion of business plan development for health providers.	496	2011-2013	MZ-5; MZ-2; MZ-3; MZ-7	МП-1; МП-6; МП-7; МП-9;	Business plans developed.
4.4.4	Support health provider financial and information system improvements.	497	2011-2013	MZ-5; MZ-7; MZ-2;	MP-1; MP-6; MP-7; MP-9;	Financial and information systems improved.
4.4.5	Continuously improve health management through training, capacity building, and provider level health system improvements.	498	2011-2013	MZ-5; MZ-3, MZ-2; MZ-4;MZ-6;	MP-1; MP-6; MP-7; MP-9;	Detailed plan for health management training and education developed and implemented.
4.4.6	Coordinate and harmonize health financing reform and public finance management including continuous improvement in Treasury System operations.	500	2011-2012	MZ-5; MZ-3, MZ-2; MZ-4;MZ-6	MP-1; MP-6; MP-7; MP-9;	Conducted assessment of harmonization requirements for health financing and public finance management.
4.4.7	Improve health purchaser and health provider accounting and financial management systems and reporting, fiduciary capacity building, internal and external audit, internal control..	501	2011-2013	ВТ-5; ВТ-7; ВТ-2;	МП-1; МП-6; МП-7; МП-9;	Нақшаи дақиқ таҳия гардид. Нақша бояд амалӣ карда шавад
4.5	**BASIC BENEFIT PACKAGE (BBP))**					
4.5.1	Refine and scale-up the BBP on an annual basis.	508	2011-2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	BBP improved and expended .
4.5.2	Close the gap between the state health budget and BBP commitments.	509	2011-2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	Study determines gap. Gap closes.
4.5.3	Expand the BBP nationwide and link directly with output-based provider payment systems to match BBP commitments with provider payment.	510	2011-2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	BBP expanded nationwide step-by-step.

1	2	3	4	5	6	7
4.5.4	Continue to improve formal copayment structure and determination of copayment level including bundling the entire price list into formal copayments	511	2011-2013	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	Formal co-payment list refined periodically.
4.5.5	Assess and improve the BBP exemption structure.	512	2011-2012	MZ-5; MZ-7; MZ-2; MZ-3;MZ-6	MP-1; MP-6; MP-7; MP-9;	BBP exemption structure improved.
4.5.6	Conduct research or special studies on BBP, funding gap, and population out-of-pocket payments.	513	2011-2013	MZ-2; MZ-5	MP-1; MP-6; MP-7;	Studies conducted.

Annex 2
Approved by order
of the Ministry of Health
Republic of Tajikistan
dated 21.08.2010 № 494

Monitoring and Evaluation Matrix of the National Health Strategy of the Republic of Tajikistan 2010-2020

MONITORING AND EVALUATION MATRIX OF THE NATIONAL HEALTH STRATEGY OF THE REPUBLIC OF TAJIKISTAN 2010-2020

Health System Pillars/ Programs		Health impact indicators			Final policy outcome indicators			Intermediate policy outcome indicators			Milestones	
		Indicator	Source	Targets	Indicator	Source	Targets	Indicator	Source	Targets		Year
1	2	3	4	5	6	7	8	9	10	11	12	13
1. PUBLIC GOVERNANCE IN HEALTH												
1.1	National Health Policy							Review of international Health Policy experiences and frequency of conducted tests (every year)	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					Results of Health Policy comprehension tests among MoH staff.	MoH (Know-ledge test)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Review of National experiences conducted and refreshed periodically (every year)	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					% population aware of main health policy initiatives	MoH/ Opinion Polls/ Surveys	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Number of students enrolled in Health policy curricula	PGMI / Med. Univ.	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Health Policy Training Activities developed and approved	2011
								Number of Health Policy decision makers retrained familiarized in Health policy.	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Press kit and content of seminar for the press developed and revised following the launch of major health policies.	2012
								Number of press kits distributed and participants of the press attending seminars.	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		2011
								Number of Health Policy reference books and articles available to MoH staff.	MoH9	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		2011
								Number of MoH Internal Coordination Meetings held		Baseline: : 2013: 20 2017: 20 2020: 20	Health Policy repository scope and functions developed and approved	
1.2	Health Sector Laws and Regulations				% legal package implemented	MoH/MoF/ MoJ/ MoET	Baseline: 50% 2013: 70% 2017: 80% 2020: 90%	% of the package developed and approved.	MoH/ MoF/MoJ	Baseline: 50% 2013: 70% 2017: 80% 2020: 90%	Assessment of Health Sector Laws and Regulations низомно-маҳои бахши тандурустӣ	2011
					Health Policy Index (from 0 to 10)	MoH/MoF/ MoJ/MoET	Baseline: 5 2013: 7 2017: 8 2020: 9				Package of additions and amendments to be made in line with the NHS, developed and approved.	2012
1.3	Inter-institutional/ agency/sectoral collaboration				Number of laws produced based on or taking into account NHC recommendations	MoH/MoF/ MoJ/ NHC	Заминавӣ: 2013: ↗ 2017: ↗ 2020: ↗	Number of recommenda-tions and directives, per year.	NHC (national health council))	Baseline: : 2013: ↗ 2017: ↗ 2020: ↗	NHC approved	2012

1	2	3	4	5	6	7	8	9	10	11	12	13
1.4	Functional Management of the Health System				% of budget funds which reach district-level facilities	MoH/MoF (PETS+ surveys)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% completion of functional reform of the MoH.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Vertical functional review of the MoH released, weakness identified	2010
							Baseline: 2013 2017 2020	% facilities yearly audited internally	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Action plan for MoH functional reform adopted	2012
							Baseline: 2013 2017 2020	% facilities yearly audited externally or jointly with development partners	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Audit scope and rules developed and approved. RaiZdrav introduced	2012 2012
1.5	Coordination of International Aid and Technical Co-operation				% of DPs assis-tance as part of all sources	MoH (NHA)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% of Donors financial support pooled	MoH / DPs	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Funding gap for the implemen-tation of consecutive Action Plans assessed.	2011
								Proportion of Donors that pool funds in health	MoH / DPs	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	MoU and Roadmap on SWAP signed between the MoH and DPs on SWAp	
								Number of coordination events per year.	MoH / DPs	Baseline: 12 2013: ↗ 2017: ↗ 2020: ↗	Institutional framework for SWAp designed and approved.	2011

1	2	3	4	5	6	7	8	9	10	11	12	13
1.6	Information and Analytical Support of the Health Care Sector				% of health fa-cilities that submit timely, complete, accurate data to the national level	MoH (official re-porting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Number of health facilities using effectively new software	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	HIS strategy roadmap for 2011-2015 developed	2011
								Number of health workers trained	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	List of indicators finalized	
								Official annual health statistics report published yearly	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Forms revised and computerized	2010
1.7	Monitoring and Evaluation and Policy Analysis				Yearly number of decisions adjust-ing policy based on M&E informa-tion and evidence-based analysis.	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% MoH departments and subordinated centers applying the M&E framework	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	M&E framework approved	2010
								% end of year effective completion of the M&E Matrix	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	HPAU strengthened	
								Number of health policy briefs and reports produced by the MoH and disseminated.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
2. DELIVERING QUALITY HEALTH SERVICES												
2.1	Strengthening Family Medicine Practice				Number of FM doctors per 10000 inhabitant	MoH (official re-porting	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% students en-rolled in FM initial training as part of total stu-dents	MoH (official reporting)	Baseline 2013: ↗ 2017: ↗ 2020: ↗		
					Number of FM nurses per 10000 Inhabitant	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% of inpatient/ outpatient prac-titioners enrolled in FM retraining as part total re-trained.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		

1	2	3	4	5	6	7	8	9	10	11	12	13
					% FM doctors as part of total PHC doctors	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Annual rate of increase of FM practitioners' wage.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					% FM nurses as part of total PHC doctors	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗					
					Rate of utilization of the health services at PHC level	MoH (Surveys)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗					
					Level of satisfaction of the population by the health services provided at PHC level (by the FM specialists)	MoH (Surveys)	Baseline:: 2013: ↗ 2017: ↗ 2020: ↗					
					% reduction of hospital admissions for chronic conditions (asthma. Diabetes, hypertension etc…	MoH (Surveys)	Baseline:: 2013: ↗ 2017: ↗ 2020: ↗					
2.2	Quality Assurance: • Certification of Health Care Professionals • Accreditation Provider Facilities and Education Programs				Share of workforce certified according to new norms (Medium term goal: provision of medical services is only provided by Licensed practitioners)	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Yearly number of certified doctors	MoH (official reporting)	Baseline: 2013 2017 2020	Republican Center for Accreditation of Health Care organizations created	2011

1	2	3	4	5	6	7	8	9	10	11	12	13
								Yearly number of practitioners certified and re-certified	MoH (official reporting)	Baseline 2013: ↗ 2017: ↗ 2020: ↗	Regulation on accreditation in health care and health education facilities in RT has been developed and approved	2011
					Share of facilities accredited.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Yearly number of facilities accredited	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
2.3	Practice Guidelines and Evidence Based Medicine							Number of Clinical Protocols systematically reviewed for updating	MoH	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Clinical protocols for all priority diseases are developed, adopted.	2011
2.4	Improving Access to Health Care				PHC visits per year per inhabitant	MoH (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: 5	% facilities incorporated to the GIS system.	MoH (official reporting)	Зами-навй: 2013: ↗ 2017: ↗ 2020: ↗	Chapters on improving access in rationalization plans and HR plans.	2010
					% sick people not seeking care for geographical/social reason	MoH (Survey)	Baseline: 2013:↘ 2017: ↘ 2020: ↘	% population covered by the BBP	MoH (official reporting)	Baseline; 2013: ↗ 2017: ↗ 2020: ↗		
					% sick people not seeking care for financial reason	MoH (Survey)	3Baseline: 2013:↘ 2017: ↘ 2020: ↘	Nationwide % of identified BBP vulnerable groups covered by BBP.	MoH (official reporting)	Baseline; 2013: ↗ 2017: ↗ 2020: ↗		

1	2	3	4	5	6	7	8	9	10	11	12	13
					Share of individual OoP in total health expenditure	MoH/GKS (NHA)	Baseline: 72% 2013: 2017: 2020:50%		MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					Health expenditure as share of total household expenditures for the poorest quintile.	MoH/ MedStat (Surveys)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Number of telemedicine units procured and operating.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Telemedicine system designed and approved	2012
					Number of patients served by telemedicine per year	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Average yearly mileage of mobile telemedicine units.	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
2.5 Priority programs												
	a) Mother and child health (MCH)	Neonatal mortality rate	Medstat	Baseline: 2013:↘ 2017: ↘ 2020: 26	% fully immunized children			Timely initiation of breastfeeding	MoH (Survey)	Baseline: 61%[1] 2013: 2017: 2020:		
		Infant mortality rate	Medstat	Baseline: 46 2013:↘ 2017: ↘ 2020: 20	% low birth weight infants	MoH (official reporting)	Baseline:: 77.3% 2013: ↗ 2017: ↗ 2020: ↗	Exclusive breastfeeding rate 0-6 months	MoH (Survey)	Baseline: 61% 2013: 2017: 2020: 85%		
		Under-5 mortality rate	Medstat	Заминавӣ: 9.8 2013:↘ 2017: ↘ 2020: 5.0	Underweight prevalence (moderate and severe)	MoH (official reporting)	Baseline: 9.7% 2013:↘ 2017: ↘ 2020: 5%	Use of Oral Rehydration Theraphy (ORT)	MoH (official reporting)	Baseline: 49 % 2013: 2017: 2020: 75%		
					Stunting prevalence (moderate and severe)	MoH (official reporting)	Baseline:: 15% 2013: 2017: 2020:	Care seeking for suspected pneumonia)	MoH (official reporting)	Baseline: 58% 2013: 2017: 2020:		

1	2	3	4	5	6	7	8	9	10	11	12	13
					Wasting prevalence (moderate and severe)	MoH (official reporting)	Baseline:: 39,2% 2013: 2017: 2020:	Antibiotic treatment of suspected pneumonia	MoH (Survey)	Baseline: 64% 2013: 2017: 2020:		
						MoH (official reporting)	Baseline:: 6.7% 2013: 2017: 2020:	Vitamin A Supplementation (children under 5)	MoH (Survey)	Baseline: 41% 2013: 2017: 2020: 30.0%		
		Maternal mortality rate	Medstat	Заминавӣ: 47.2; 2013:↘ 2017: ↘ 2020: 25.0	% coverage of antenatal care	MoH /MedStat	Baseline:: 2013: 2017: 2020:	% pregnancy receiving proper number of ante natal checks.	MoH (official reporting)	Baseline: 64,8% 2013: 2017: 2020:		
						MoH /MedStat	Baseline:: 77.3% 2013 2017 2020	Number of reproductive health standards and guidelines adopted and available in facilities.	MoH (official reporting)	Baseline 2013: ↗ 2017: ↗ 2020: ↗		
								% of PHC facilities providing at least 4 types of contraceptives	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					Contraception prevalence rate (%)	MoH /MedStat	Baseline:: 2013: ↗ 2017: ↗ 2020: ↗	% women of reproductive age using modern contraceptive means	MoH (official reporting + survey)	Baseline 2013: ↗ 2017: ↗ 2020: ↗		
					% mothers birth spacing of at least 3 years	MoH /MedStat	Baseline:: 18% 2013: 2017: 2020: 30%	% women of reproductive age using modern contraceptive means	MoH (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		

1	2	3	4	5	6	7	8	9	10	11	12	13
					% deliveries in medical facilities	MoH /MedStat	Baseline:: 2013: ↗ 2017: ↗ 2020: ↗	% of personnel trained on efficient perinatal care, standards and protocols	MoH (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
								% facilities ready to render Emergency Obstetric Care services	MoH (official reporting)	Baseline: 35% 2013: 2017: 2020:75%		
					Iron deficiency rate among pregnant women	MoH /MedStat	Baseline:: 2013:↘ 2017: ↘ 2020: ↘	% pregnant women offered iron tablets	MoH (official reporting + survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
					% home deliveries assisted by medical personnel trained in midwifery.	MoH (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% proximity health personnel trained in midwifery.	MoH (Survey) MoH (Survey)			
	b) Infectious diseases	Case Detection Rate among New Smear positive TB patients	Medstat	Baseline: 32% 2013: 40% 2015: 50% 2017 2020: 70%	At least 70% of the new smear positive TB cases are detected	MoH (official reporting	Baseline:: 2013: 40% 2015:50% 2017 2020: 70%	Number and % of new smear positive cases confirmed by microscopy as per DOT strategy	MoH (official reporting	Baseline: 32% 2013: 40% 2015:50% 2017 2020: 70%		
		Treatment Success Rate among new smear positive TB patients	Medstat	Baseline: 2013: 2015: 2017 2020: 90%	At least 90% of the new smear positive TB cases are successfully treated	MoH (official reporting	Baseline: 2013: 85% 2015: 88% 2017 2020: >90%	Number and % of the new smear positive TB cases successfully completed treatment	MoH (official reporting	Baseline: 82.4% 2013: 85% 2015: 88% 2017 2020: 90%		
		Case detection and treatment coverage for MDR-TB	Medstat	Baseline: 2013: 2015: 2017 2020: 80%	At least 80% of the confirmed resistant TB cases detected and provided quality drug resistant TB treatment	MoH (official reporting	Baseline: 2013: 85% 2015: 88% 2017 2020: >90%	Number and % of MDR-TB cases confirmed by bacteriology laboratory and provided TB resistant treatment	MoH (official reporting	Baseline: 2009: 50/2500 2% 2013: 1200/2500 48% 2015: 80% 2017 2020: 80%		

1	2	3	4	5	6	7	8	9	10	11	12	13
		HIV/AIDS prevelance rate among general population.	Medstat	Baseline: - 2013:<1% 2015:<1% 2017: 2020:<1%	% of most at risk population groups who are HIV infected	MoH (official reporting	Baseline 2013: 48% 2015:80% 2017: 2020: 80%	Number and % of estimate high risk groups (IDUs, SWs and MSM)population covered with HIV/AIDS prevention Interventions	MoH (official reporting	Baseline 2013: 12000/ 25000 (48%) 2015: 60% 2017: 2020: 80%		
					% of adult and children with HIV/AIDS known to be on treatment 12 months after initiation of antiretroviral therapy	MoH (official reporting		Number and % of adult and children with HIV/AIDS treated with antiretroviral therapy	MoH (official reporting)	Baseline: 424/920 2013: 850/920 2015: 80% 2017 2020: 90%		
					% of infant born to HIV-infected mothers who are infected	MoH (official reporting	Baseline: 2009:17% 2013:<25% 2015:25% 2017: 2020:25%	Number and % of HIV-positive women who received antiretroviral to reduce the risk of mother to child transmission	MoH (official reporting	Baseline: 2013: 2015: 2017 2020:		

1	2	3	4	5	6	7	8	9	10	11	12	13
					% of donated blood units screened for HIV in a quality-assured manner	MoH (official reporting	Baseline: 2013 :65% 2015: 75% 2017: 2020: 80%	Number and % of voluntary (non-enumerated blood donors)	MoH (official reporting	Baseline: 40% 2013: 60% 2015: 80% 2017: 2020: 100%		
					%of households with at least one insecticide treated net and/or sprayed by indoor residual spraying in the last 12 months	MoH (official reporting	Baseline: 100% 2013: 100% 2015: 100% 2017: 2020: 100%					
					OPV-3 immunization coverage rate	MoH (official reporting	Baseline: 50,3% 2013: 2017: 2020:					
		Blood safety and universal precautions	Med-stat	Baseline: 2013: 2017: 2020:								
		Malaria prevalence rate	Med-stat	Baseline; 2.3/100,000 2013:<1 /100,000 2015: <1/100,000 2020: <1/100,000	Measles immunization coverage rate	MoH (official reporting	Baseline: : 2013: 2015 2017: 2020:	Number and percentage of malaria foci by village, district and region	MoH (official reporting	Baseline: 306 2013:< 200 2015: <100 2017: 2020: < 50		

1	2	3	4	5	6	7	8	9	10	11	12	13
		Acute polio incidence rate	Med-stat	Baseline: 100% 2013:100% 2015: 100% 2017: 100% 2020: 100%	Number of hemo-transmission infections	MoH/Blood Center		Results of blood analysis	MoH/ Blood Center	Baseline: 100% 2013: 100% 2015: 100% 2017: 2020: 100%		
		Provision of safe blood	Med-stat	Baseline: 2013: 2017: 2020:							Implementation of National Program	2011 - 2015
	c) Non-Infectious and Chronic Diseases	Mortality indicator from cancer	Med-stat	Baseline: 2013: 2017: 2020:	Indicator of life-expectancy of patients with cancer	MoH	Baseline: 2013: 2017: 2020:	Indicator of early detection of cancer	MoH	Baseline: 2013: 2017: 2020:	Implementation of National Program	2011-2015
		Morality indicator from cardiovascular diseases	Med-stat	Baseline: 2013: 2017: 2020:	Indicator of life-expectancy of patients with cardiovascular diseases	MoH	Baseline: 2013: 2017: 2020:	Indocator of early detection of cardiovascular diseases	MoH	Baseline: 2013: 2017: 2020:	Implementation of National Program	2011-2015
		Indicator of diabetes morbidity	Med-stat	Baseline: 2013: 2017: 2020:	Indicator of disability from diabetes	MoH	Baseline: 2013: 2017: 2020:	Indicator of diabetes complications	MoH	Baseline: 2013: 2017: 2020:	Implementation of National Program	2011-2015
		Indicator of morbidity from the pulmonary chronically diseases	Med-stat	Baseline: 2013: 2017: 2020:	Indicator of disability from chronically pulmonary diseases	MoH	Baseline: 2013: 2017: 2020:	Indicator of complications of chronically pulmonary diseases	MoH	Baseline: 2013: 2017: 2020:	Sector Program developed and approved	2011-2020
		Indicator of illicit drug addicted people	Med-stat	Baseline: 2013: 2017: 2020:	Indicator of illicit drug addicted	MoH	Baseline: 2013: 2017: 2020:	Indicator of using of illicit drugs	MoH	Baseline: 2013: 2017: 2020:	Implementation of National Program	2011-2015

1	2	3	4	5	6	7	8	9	10	11	12	13
		Mortality and long-term disability resulted by road and occupational injures	Med-stat	Baseline: 2013: 2017: 2020:	Indicator mortality and disability resulted by road and occupational injuries	MoH	Baseline: 2013: 2017: 2020:	Number of road and occupational injuries	MoH	Baseline: 2013: 2017: 2020:	Implementation of National Program	2011-2015
2.6	Public health and healthy life style	Life expectancy	Med-stat	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% household with access to safe water	MoW	Baseline: 58,5% 2013: ↗ 2017: ↗ 2020: ↗	Number yearly of graduates in public health	Med. Univ. PGMI /	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Reformed public Health Law Developed and approved.	2011
			Med-stat		Use of improved sanitation facilities	MoH (Survey)	Baseline: 99.4% 2013: 2017: 2020:					
					% prevalence rate of excessive alcohol consumption	MoH (Survey)	Baseline: : 2013: ↘ 2017: ↘ 2020: ↘					
					% prevalence of illicit drugs consumption	MoH (Survey)	Baseline: : 2013: ↘ 2017: ↘ 2020: ↘					
					% prevalence rate of smoking among general population	MoH (Survey)	Baseline: : 2013: ↘ 2017: ↘ 2020: ↘					
					% prevalence rate of overweight among general population		Baseline: : 2013: ↘ 2017: ↘ 2020: ↘					

1	2	3	4	5	6	7	8	9	10	11	12	13
2.7	Community Awareness and Participation				% contacts with advocacy groups leading to a positive outcome	MoH/DPs (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Number of contacts with patient's rights advocate	MoH/DPs	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Charter of Patient's Rights designed and approved.	
					% of population aware of BBP entitlements and other patients rights	MoH (Survey)	Baseline: : 2013: ↗ 2017: ↗ 2020: ↗	% of rayons regularly implementing community awareness and participation activities	MoH	Baseline: 99.4% 2013: ↗ 2017: ↗ 2020: ↗	MoH/DPs guidelines on community mobilization designed and approved.	
					% of population having received information on HIV and other STDs prevention.	MoH (Survey)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗					
					% families able to self diagnose respiratory diseases and to organize home care	MoH (Survey)	Baseline: : 2013: ↗ 2017: ↗ 2020: ↗					
					% families with children under 5 able to present, self diagnose diarrhea and seek timely treatment	MoH (Survey)	Baseline: : 2013: ↗ 2017: ↗ 2020: ↗					
3. RESOURCE												
3.1	Human Resources: • Workforce Planning •Workforce Development				% completion of projected needs for: PHC doctors	MoH (official reporting)	Baseline: 2013 :↗ 2017: ↗ 2020: 100%	Percentage of the graduates of med. uni. and medical colleges sent to work in PHC.		Baseline: 2013:↗ 2017: ↗ 2020: ↗	Projected needs determined for: PHC doctors PHC nurses and feldshers Hopsital Doctors Hospital Nurses	

1	2	3	4	5	6	7	8	9	10	11	12	13
					PHC nurses and feldshers		Baseline: 2013 :↗ 2017: ↗ 2020: 100%	Number of health specialists admit-ted to work in PHC facilities.		Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Training and retraining needs for above mentioned categories determined.	
					Hospital doctors		Baseline: 2013 :↗ 2017: ↗ 2020: 100%					
					Hospital nurses		Baseline: 2013 :↗ 2017: ↗ 2020: 100%					
					PHC / Hospital doctors ratio.		Baseline: : 2013 :↗ 2017: ↗ 2020: 100%					
					PHC/Hospital nurses ratio.		Baseline: : 2013 :↗ 2017: ↗ 2020: 100%					
3.2	Medical Education				% of the medical workforce still requiring retraining In PHC In Hospitals	MoH/PGMI	Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013 :↗ 2017: ↗ 2020: Baseline: 2013: ↘ 2017: ↘ 2020: ↘	Yearly number of medical students enrolled Yearly number of newly graduated: PHC doctors	Med. Uni./ med college and medi-cal training facilities Med. Uni/ PGMI	Baseline: 2013 :↗ 2017: ↗ 2020: Baseline: 2013 :↗ 2017: ↗ 2020: ↗ Baseline: 2013 :↗ 2017: ↗ 2020: ↗	- New Standard developed and implemented - Increased student clinical exposure - CME imple-mented	

1	2	3	4	5	6	7	8	9	10	11	12	13
					Number of Clini-cal Training Bases	MoH		PHC nurses and feldshers		Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
								Hospital doctors		Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
								Hospital nurses	PGMI			
								Yearly number of retrained: PHC doctors		Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
								PHC nurses and feldshers		Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
								Hospital doctors		Baseline:: 2013 :↗ 2017: ↗ 2020: ↗		
					Number of Medi-cal Staff using ac-quired knowledge from CME in eve-ryday practice	MoH (Survey)	2013 :↗ 2017: ↗ 2020: ↗ 2013: 2017: 2020:	Hospital nurses Number of Clini-cal bases	MoH	Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
								Number of Medical Staff attested and certificated using CME	MoH	Baseline: 2013 :↗ 2017: ↗ 2020: ↗		
3.3	Medical Science											
					Number of results effectively used in medical practice	MoH/ Medi-cal Sciences Academy	Baseline: 2013 :↗ 2017: ↗ 2020: ↗	Number of sci-entific work con-ducted on health priorities.	MoH/ Medical Academy	Baseline: 2013 :↗ 2017: ↗ 2020: ↗		

1	2	3	4	5	6	7	8	9	10	11	12	13
3.4	Pharmaceuticals				Share of out of standard and counterfeit drugs as part of total available in pharmacies. % of prescriptions of essential and generic medicines in total prescriptions. % prescriptions of antibiotics as share of total prescription % prescription of injection drugs as share of total prescription % essential and generic medicines in drugs procured by health facilities. % pharmaceutical expenses as part of total private OoP	MoH (Survey/ inspections) MoH (Survey) MoH (Survey) MoH (Survey and NHA) MoH (Survey MoH (Survey	Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: 2017: 2020: Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline:: 2013 :↗ 2017: ↗ 2020: ↗	Микдори ҳарсолаи тафтишҳо (инспексияҳо) барои ошкор намудани доруҳои контрафактӣ Рӯйхати семоҳаи воситаҳои асосии доруворидастрас дар фурӯши чакана Тағйир додани нархи миёнаи чаканаи воситаҳои асосии доруворӣ	МоН МоН (Survey) МоН (Survey)	Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020:	МоН position on elimination of counterfeit drugs reaf-firmed. Guidelines on rational drug use designed and approved.	

1	2	3	4	5	6	7	8	9	10	11	12	13
					% patients not buying prescription drugs due to unavailability % patients not buying prescrip-tion drugs due to financial reasons.	MoH (Survey) MoH (Survey	Baseline:: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: ↘ 2017: ↘ 2020: ↘					
3.5	Physical Assets				Number of hospitals per 10000 Number of PHC per 100000 Number of Phar-macies per 100000 in cities.	MoH/ Medstat (official reporting MoH/ Medstat (official reporting MoH/Med-stat (official re-porting	Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020:	Number of PHC created. % PHC reno-vated. % of Hospitals rationalized.	MoH/ (official reporting) MoH/ (official reporting) MoH/ (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline:: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline:: 2013: ↗ 2017: ↗ 2020: ↗	Infrastruc-ture Rationa-lization Plans developed, approved and implemented.	

1	2	3	4	5	6	7	8	9	10	11	12	13
					Number of Pharmacies per 100000 in rural areas. Number of Hospital beds per 100000 hab. Number of operational emergency vehicles per 100000 Average hospital occupancy rate. Investment in PHC infrastructures as share of total investment Percent PHC meeting international physical quality standards. Percent Hospitals meeting interna-tional physical quality standards.	MoH/ Medstat (official reporting MoH/ Medstat (official reporting MoH/ Medstat (official reporting MoH/ (official reporting) MoH/ (official reporting) MoH/ (official reporting) MoH/ (official reporting)	Baseline: 2013: 2017: 2020: Baseline: 91,0 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020:	% of Hospitals renovated.	MoH/ (official reporting)			

1	2	3	4	5	6	7	8	9	10	11	12	13
					% hospitals having a Hospitals Safety Index superior to 0.66 (satisfactory)	MoH/ (official reporting)	Baseline: 2013: 2017: 2020:	Average Hospital safety index	MoH/ (official reporting)	Baseline:: 2013: 2017: 2020:		
4. HEALTH CARE FINANCING												
4.1	*Revenue collection*				% consolidated State budget dedi-cated to the health sector Annual increase of the share of consolidated State budget dedicated to the health sector. Ratio of executed/ planned resources for health, in Consolidated budget	MoH/MoF MoH/MoF MoH/MoF	Baseline: 6% 2013: 2017: 2020: 10% Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020:	Consecutive Health Sector ac-tion plan costed.	MoH (official reporting)	Baseline: 1: 2013:1 2017:1 2020:1	MTEF developed in line with the budget process and reflecting agreed sector priorities in line with the NHS	2010
4.2	Function of pool-ing of funds				% of consolidated budget pooled at oblast level Per-capita budget allocated to oblast pool per oblast.	MoH/MoF MoH/MoF	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Number of OHD applying new pooling statute	MoH (official reporting)	Baseline: 2013: 2017: 2020:	Statute of OHD as pool of funds de-veloped and approved.	2012

1	2	3	4	5	6	7	8	9	10	11	12	13
4.3	*Health service purchasing :* *• Heath service purchase function,* *• Individual health services purchasing,* *• Public health and other Purchasing,* *• Fiduciary risk and financial management*				*Resources allocation indicators* *% of public health care resources channeled through purchaser/provider contracts.* Per-capita public resources contracted per oblast.	MoH (official reporting) MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 40% 2013: ↗ 2017: ↗ 2020: 60%	Number of OHD applying new single purchaser statute % PHC working under per-capita contract with a single oblast purchaser.		Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: 20% 2017: ↗ 2020: ↗	Statute of OHD as single Purchaser developed and approved. Autonomous statute of Health Facilities developed and approved.	2011
					% of public budget for health allocated to PHC *Utilization indicators* *Number of PHC visits per year per inhabitant.* Hospitalization rate	MoH (official reporting) MoH/ Medstat (official reporting) MoH/Medstat (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: ↘ 2017: ↘ 2020: ↘	% Hospitals working under per-case contract with a single oblast purchaser.		Baseline: 2013: ↗ 2017: ↗ 2020: ↗		
4.4	*Health Provider Autonomy and Health Management*				% of PHC under retrained managerial staff	MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Yearly number of retrained managers		Baseline: 2013: ↗ 2017: ↗ 2020: ↗	Training and re-training framework for Healthcare managers designed.	

1	2	3	4	5	6	7	8	9	10	11	12	13
4.5	*Basic Benefit Package*				% of population covered by the BBP Nationwide % of total population meeting BBP vulnerable groups' criteria covered by BBP.	MoH/SSC (official reporting) MoH/SSC (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: ↗ 2017: ↗ 2020: ↗	% facilities operating under BBP scheme. Average % of BBP resources going to salaries	MoH (official reporting) MoH (official reporting)	Baseline: 2013: ↗ 2017: ↗ 2020: ↗ Baseline: 2013: 2017: 2020:	Ҳар сол тағдиди назар ва тасдиқи қоидахои БКД	Ҳар сол
					Share (%) direct referral to hospitals. % patients declaring informal out-of-pocket payments for hospital treatment	MoH (Survey) MoH (Survey)	Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: ↘ 2017: ↘ 2020: ↘	Average % of BBP resources going to drugs purchasing Average % of BBP resources going to maintenance	MoH (official reporting) MoH (official reporting)	Baseline: 2013: 2017: 2020: Baseline: 2013: 2017: 2020:		
					Average financial burden for patient in facilities applying BBP Ratio of individual health spending to average salary.	MoH (Survey) MoH (Survey)	Baseline: 2013: ↘ 2017: ↘ 2020: ↘ Baseline: 2013: ↘ 2017: ↘ 2020: ↘					

ANNEX TO THE IMPLEMENTATION PLAN AND MATRIX ON MONITORING AND EVALUTION OF NHS RT

NHS RT IMPLEMENTATION PARTNERS

Code number	Agencies and Organizations	Code number	Agencies and Organizations
MZ	1. Ministry of Health: Headquarters and Affiliated Entities		
MZ-1	Office of the Minister's of Health	MZ-12	Department of Emergency Relief and Health Services
MZ-2	Health Policy Analysis Unit	MZ-13	Internal Audit Department
MZ-3	Health Service Delivery Department	MZ-14	Department of Record Keeping and Document Control
MZ-4	Department of Research and Medical and Pharmacy Education	MZ-15	Personnel Department
MZ-5	Department of Reforms and International Cooperation	MZ-16	Service for Government Supervision of Pharmaceutical-related Activities
MZ-6	Department of Maternal, Children's and Family Planning Services	MZ-17	Service for Government Supervision of Health Care Provider
MZ-7	Economy and Budget Planning Department	MZ-18	National Disease Surveillance and Epidemiological Control Service
MZ-8	Department of Pharmacy and Medical Equipment	MZ-19	Department of Construction
MZ-9	Department of Disease Surveillance and Epidemiological Control	MZ-20	National Center for Statistics and Medical Information
MZ-10	Department of Accounting and Book-keeping	MZ-21	Editorial Board of 'The Health Care of Tajikistan' journal
MZ-11	Legal Department	MZ-22	Editorial Board of the 'Shifo' magazine
		MZ-23	Republic Centre of Accreditation of Health Care Facilities
RE	2. Oblast Health Administrations		
RE-1	Health Administration of Gorno-Badakhshan Oblast	RE-3	Health Administration of Sogd Oblast
RE-2	Health Administration of Khatlon Oblast	RE-4	Health Administration of the City of Dushanbe
LU	3. Health Care Provider Facilities		
LU-01	National Medical Center	LU-24	National Clinical Center for Traditional Medicine
LU-02	National Diagnostic Center	LU-25	National Clinical Center for Orthopedics and Traumatology
LU-03	National Center for Reproductive Health	LU-26	National Children's Sanatorium 'Karatag'
LU-04	National Center for the Monitoring and Prevention of Drug Use	LU-27	National Children's Sanatorium for Cardio-rheumatology Conditions 'Gushari'
LU-05	Tajik Institute for R&D in Obstetrics, Gynecology and Perinatal Health	LU-28	National Center for Medical-social Rehabilitation "Tangai"
LU-06	National Clinical Center for Pediatric Medical & Surgical Care	LU-29	The Nurmatov National Hospital for Physical Therapy
LU-07	Tajik Institute for R&D in Preventive Medicine	LU-30	National Center for Training and Clinical Research in Family Medicine
LU-08	National Research Center for Cardio- and Thoracic Surgery	LU-31	National TB Control Center
LU-09	National Research Center for Hematology	LU-32	National Clinical Center for Endocrinology
LU-10	National Clinical Center for Dental Medicine	LU-33	National Center for Nursing [Research and Training]

Code number	Agencies and Organizations	Code number	Agencies and Organizations
LU-11	National Research and Training Center for Restorative Surgery	LU-34	National Center for Highly-communicable Diseases
LU-12	National Center for Oncology	LU-35	National Center for Vaccine Prevention
LU-13	National Clinical Center for Psychiatric Diseases	LU-36	National Center for HIV/AIDS Prevention and Control
LU-14	National Child and Adolescent Mental Health Center	LU-37	National Center for Tropical Diseases
LU-15	National Clinical Hospital for Psychiatric Diseases	LU-38	National Center for Healthy Lifestyles Promotion
LU-16	National Inter-regional Center for Neurology and Psychiatry in Tursunzade	LU-39	National Center for Forensic Medicine
LU-17	National Clinical Hospital for Tuberculosis	LU-40	National Center for Integrated Management of Childhood Illnesses
LU-18	National Clinical Center for Skin Diseases and STDs	LU-41	National Center for Nutrition Research
LU-19	The Gulyamov National Clinical Center for Narcology	LU-42	National Center for Health Care Support of Pasture-based Husbandry
LU-20	National Clinical Center for Eye Diseases	LU-43	National Center for Children's Rehabilitative Care
LU-21	National Clinical Center for Cardiology	LU-44	National Center for Preventive Disinfections
LU-22	National Clinical Center for Urology	LU-100	Health Care Provider Facilities of Oblast, City and District Levels
LU-23	National Clinical Center for Spinal Disease		
PK	4. Institutions of Basic and Continuing Education of Physicians and Health Professionals		
PK-1	Tajik National Medical University named after Ibn Sino	PK-10	Rasht District Nursing College
PK-2	Tajik Institute of Postgraduate Medical Training	PK-11	Yavan District Nursing College
PK-3	National Medical Library	PK-12	Dangara District Nursing College
PK-4	National Nursing College	PK-13	Kanibadam City Nursing College
PK-5	Kurgan-Tyube Nursing College	PK-14	Istaravshan City Nursing College
PK-6	Kulyab Nursing College	PK-15	Pendzhikent City Nursing College
PK-7	Khudzhand Nursing College	PK-16	Khorog City Nursing College
PK-8	Gissar District Nursing College	PK-17	Tursunzade City Nursing College
PK-9	Vakhdat City Nursing College		
MK	5. Health Care Logistics and Capital Construction Services		
MK-1	National Center for Pharmaceutical Research	MK-5	National Warehousing Facility for Special Medical Supplies
MK-2	National Center for the Procurement of Pharmaceuticals, Health Supplies, and Other Health Care Goods	MK-6	National Wholly-owned Government Entity 'Ronanda'
MK-3	National Wholly-owned Government Entity 'Tadjpharmindustries'	MK-7	National Medical Transport Depot
MK-4	'Tadjik Adjanta Pharma, Ltd' joint venture	MK-8	Construction and Maintenance Department of Kulyab
GU	6. Government Agencies other than the Ministry of Health		
GU-1	Chancellery of the President of the Republic of Tajikistan – Department of Women's, Family and Health Care Affairs	ГУ-13	Вазорати нақлиёт ва коммуникатсия

Code number	Agencies and Organizations	Code number	Agencies and Organizations
GU-2	Parliament of the Republic of Tajikistan – Committee for Welfare, Family, Health Protection, and Environment	ГУ-14	Агентии омори назди Президенти Ҷумҳурии Тоҷикистон
GU-3	Ministry of Finance	GU-15	Tax Committee
GU-4	Interior Ministry	GU-16	Committee for Youth, Sport, and Tourism
GU-5	Ministry of Justice	GU-17	Committee for Women and Family
GU-6	Ministry of Economic Development and Trade	GU-18	TV and Radio Committee
GU-7	Ministry of Education	GU-19	Committee for Emergency Situations and Civil Defense
GU-8	Ministry of Labor and Social Protection	GU-20	Customs Administration
GU-9	Women's and Family Affairs Committee of the Government of RT	GU-21	Land Use, Survey and Cartography Agency
GU-10	Ministry of Agriculture and Environment	GU-22	Construction and Architecture Agency
GU-11	Ministry of Irrigation and Water Resources	GU-23	Agency for Standardization, Metrology, Certification and Trade Oversight
GU-12	Ministry of Energy and Industry		
PO	7. Professional and Membership Organizations		
PO-1	Trade Union of Health Sector Workers	PO-10	"Avicenna" NGO [Comprehensive support of poor families; a project to prevent water-borne infections]
PO-2	Medical Societies, by clinical specialties	PO-11	«Sudmand» NGO [Support of the elderly, disabled, orphans, low-income families, families with many children, people with psycho-behavioral disorders]
PO-3	The RT Nursing and Midwifery Association	PO-12	«Buzurgmekhr» NGO [Protection and advocacy of rights, medical and social rehabilitation of war veterans and disabled servicemen, street youth, women and children– victims of violence, and other vulnerable groups]
PO-4	Society of People with Disability	PO-13	«Nasli Navras» NGO [Work with socially vulnerable and high-risk populations]
PO-5	"Khamdilon" NGO [Support of psychiatric patients]	PO-14	*Women's Association of Tajikistan "Expert" [Comprehensive support of women, children, and youth]*
PO-6	«Most» [Bridge] NGO [social rehabilitation of drug users and HIV+ positive persons]	PO-15	«Central Asian Gerontology Center» [Comprehensive social, psychological, community and home-based support of senior citizens, including their social re-integration and healthy lifestyles]
PO-7	"Samo" NGO [maternal and children's health, HIV/AIDS, drug addiction, health worker agendas]	PO-16	Bureau for Human Rights and Rule of Law [Prospectively, could work in the area of patient rights protection and advocacy]
PO-8	"Center of Psychiatric Health and HIV/AIDS Patient Support" NGO	PO-17	The Open Society Institute – Foundation in Support of Tajikistan: Public Health Program
PO-9	«Mekhri Vartan» NGO [Comprehensive support of women: health, education, development, protection from home violence]	PO-18	National Family Medicine Association
MP	8. International Development Partners		
MP-1	WHO	MP-9	USAID
MP-2	UNICEF	MP-10	GTZ
MP-3	UNFPA	MP-11	KfW
MP-4	UNDP	MP-12	JICA

Code number	Agencies and Organizations	Code number	Agencies and Organizations
MP-5	The World Bank	MP-13	Global Fund
MP6	EU	MP-14	UNAIDS
MP-7	SDC	MP-15	CDC
MP-8	SIDA		