

Preliminary evaluation of the WHO Special Programme on Primary Health Care



Tajikistan Case Study

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Abbreviations and Acronyms

BCA	biennial collaborative agreement
CME	continuous medical education
CSO	civil society organisation
DCC	Development Coordination Council
DCC-Health	Health Development Coordination Council
DP	development partner
EHG	Euro Health Group
EPW	European Programme of Work
EU	European Union
GIZ	German Development Cooperation (The Deutsche Gesellschaft für Internationale Zusammenarbeit)
GPW	General Programme of Work
HH	Health Houses
HLMA	health labour market analysis
HRH	human resources for health
KI	key informant
KII	key informant interview
MoF	Ministry of Finance
MoHSP	Ministry of Health and Social Protection
NDS 2023	National Development Strategy 2030
NHS	National Health Strategy
NPO	National Professional Officer
PHC	primary health care
RHC	Rural Health Centers
SDG	Sustainable Development Goals
SDG3 GAP	The Global Action Plan for Healthy Lives and Well-being for All
SP-PHC	WHO Special Programme on Primary Health Care
UHC	universal health coverage
UHC-P	Universal Health Coverage Partnership
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Purpose of case study

This case study in Tajikistan was conducted as part of the Preliminary Evaluation of the WHO Special Programme on Primary Health Care (SP-PHC).

The overall purpose of the case study was twofold:

1. Generate evidence for the evaluation questions including opportunities to strengthen the SP-PHC support to countries, to achieve the objectives and mandate
2. Generate learning on the how SP-PHC support to countries to operationalize selected strategic and operational levers of WHO/UNICEF PHC operational framework¹ is working in practice, and/or has applied an innovative approach or best practice, which could be learned and replicated elsewhere.

This case study focused on the following four strategic levers of the WHO/UNICEF PHC Operational Framework² during the implementation period 2020-2023: “Political Commitment and Leadership,”; “Governance and Policy Frameworks,”; “Engagement of communities and other stakeholders”; and “Primary health care workforce”, including, how support from the three levels of WHO (WHO headquarters, WHO Europe Regional Office and WHO Tajikistan Country Office) has been coordinated and operationalized.

2. Methods and approach

2.1 Data collection and analysis

The case study used a mixed methods approach. An initial document and data review was complemented by primary data collection through in-country key informant interviews (KIIs) and focus group discussions conducted from 28 August to 1 September 2023, with key national and sub-national stakeholders involved in PHC. Virtual follow-up interviews were also conducted in September 2023.

Key stakeholders were purposely selected to take part in KIIs and focus group discussions to collect relevant evidence, information and encourage experience sharing for learning. Representatives from the Ministry of Health and Social Protection (MoHSP) - Division on reforms, PHC and International Relations, Ministry of Finance (MoF) - health specialist of the Interagency Expert Group, the Republican Training and Clinical Centre for Family Medicine, PHC facilities, development partners (DPs) – (WB, UNICEF, USAID, GIZ) and the WHO Country Office) staff were interviewed. Altogether, 20 one-on-one interviews and four focus group discussions (with 4, 2, 2, and 25 participants respectively) were conducted, altogether 48 key stakeholders shared their experiences. The list of key informants (KIs) is available upon request to the WHO Evaluation

¹ WHO and UNICEF 2020. Operational framework for PHC: transforming vision into action.

² <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>

office. KIIs were conducted using a semi-structured interview guide that listed a predetermined set of questions related to the themes of this country case study.

Data from KIIs and focus group discussions were recorded in notes, analysed, and organized according to themes and content. Analytical approaches included data triangulation and content analysis.

The best practices and learnings were explored with emphasis on key enablers, critical factors, specific results, and their potential for replication, scale-up and sustainability.

2.2 Limitations

The number of KIs was limited as well as the time dedicated to undertaking this case study. The study used a purposive sampling strategy by which KIs were selected to bring forward perceptions from a variety of stakeholders on the selected themes and learnings to be documented. This approach however has an inherent risk of bias- particularly observer bias³ and selection bias. The study applied standardized tools for data collection and triangulated evidence as an effort to limit bias, however bias might not have been eliminated.

The availability of KIs during the consultant's in-country visit was furthermore limited as some KIs were out of the country at the time. There were also challenges in scheduling the remaining online interviews and obtaining documents, which extended the time required for data collection. The lack of awareness among most KIs, both within and outside WHO, of the SP-PHC programme and of the activities being implemented under the SP-PHC (Universal Health Coverage Partnership (UHC-P) and the PHC Accelerator/Sustainable Development Goal - Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) further limited data collection and availability.

Interpretation of report findings should take into consideration these limitations. Nevertheless, important information, learnings, opportunities, and gaps are presented in this report.

³ Observer bias: researcher's expectations, opinions, or prejudices influence what they perceive or record in a study

3. Background

3.1 Government of Tajikistan's progress on PHC for UHC

During the Soviet era, Tajikistan had a highly centralized, hospital-based health system. Following independence in 1991 efforts were made to create a system based on strong PHC, focusing on family medicine. Since 1998 an Order envisaging the gradual transition of PHC towards a system based on general practitioners was in place. The National Health Strategy (NHS) for 2010–2020 reaffirmed the importance of developing family medicine. Together with the new NHS for 2021–2030 and the Programme for Health Care and Social Protection embedded in the National Programme of Development of the Republic of Tajikistan up to 2030, the Government of Tajikistan has initiated a range of health care reforms to implement its vision for family medicine based PHC.

In 2008, a decree was passed obliging cities/districts to devote at least 40% of their budget to PHC. This led to an increase in spending for PHC from 31% in 2010 to 36% in 2016. The NHS 2010–2020 which laid out the vision for family medicine-based PHC guided the priority areas of the National Programme on the Development of Family Medicine 2011–2015 and the subsequent Strategic Plan for the Development of Family Medicine-Based Primary Health Care in the Republic of Tajikistan, 2016–2020. The development of the strategic plan was guided by the European Framework for Action on Integrated Health Services Delivery⁴. The strategic plan sets out to align with global and regional health and development commitments, including the SDGs, the drive towards UHC, and the European health policy, Health 2020.

Tajikistan joined the UHC Partnership in 2016 with health systems structured around input-based financing and significant out-of-pocket payments. Over the past decade, major reforms (supported by SDG GAP in recent years)⁵ have been initiated to advance UHC and strengthen PHC, including the development of a state-guaranteed Basic Benefit Package, the introduction of a per capita health financing approach for more equitable distribution of resources at the PHC level, the piloting a performance-based financing mechanism, case-based hospital payments and legislation to establish a Mandatory Health Insurance Fund. Improving the access, availability, quality, and efficiency of PHC is one of the strategic goals of the "Plan for the development of PHC based on principles of family medicine in the Republic of Tajikistan for the period 2021–2025". Ongoing activities to improve PHC include efforts to strengthen the material basis of PHC facilities and improve the qualifications of PHC workers through training programmes, and reward performance.

According to the MoHSP⁶ data, funding for the National Health Service has increased nine times in the last 10 years (from 15.9% in 1998 to 40.7% in 2022).⁷ Around 80% of PHC facilities were constructed/repaired and 89% equipped.⁸

COVID-19 negatively impacted all three UHC goals. Access to health services were affected by interruptions in care, particularly for noncommunicable diseases, delays in non-urgent services, shortages and stock-outs of drugs and medical

⁴ WHO Regional Office for Europe. the European Framework for Action on Integrated Health Services Delivery: an overview. Health Service Delivery Programme, Division of Health Systems and Public Health, 2016

⁵ Global Financing Facility and WHO helped to support development of the health financing chapter of the new NH 2021–2030 in which reform of the existing health financing system is regarded as an essential step towards improving the efficiency of health service delivery and addressing issues related to equity, access, and affordability of PHC. In 2019, the WB and Gavi joined forces to co-finance activities to increase coverage and quality of basic PHC in selected districts and support the nationwide roll-out of per capita financing for PHC. WHO has been supporting health system governance, public financial management and roll-out of the Basic Benefit Package. the European Union has funded a new programme supporting health systems strengthening with a focus on capacity development in the Ministry of Health and planning and delivery mechanisms for primary health care.

⁶ By the Presidential Decree No. 12 Ministry of Health was transformed into the Ministry of Health and Social Protection (MoHSP) in November 2013.

⁷ MoHSP Presentation on the SDG3 GAP PHC-Accelerator meeting on 19 September 2023

⁸ Ibid.

supplies, and increased patient flow to PHC facilities. The pandemic also affected financial protection with negative economic impact and higher risk of financial catastrophe and impoverishment. In addition, the quality of care was compromised with increased risk of health care acquired infections among health workers, use of medicines with no evidence on efficacy and safety and falsified medical products and adverse effects of experimental medicines.⁹ Although COVID-19 challenged current models of service delivery with PHC, which need to be strengthened, it also demonstrated the importance of PHC and the need for a paradigm shift in health systems for which good governance to enhance health system performance is very important.

A recently conducted PHC situation analysis showed the progress as presented in Table 1 below.¹⁰

Table 1 The Situation in PHC in the Republic of Tajikistan, 2023

Indicators	2010	2015	2022
% of population that have been covered by PHC services	82%	92%	97%
% of PHC facilities which are provided with the equipment	76%	85%	92%
Average number of visits to PHC	4.8	5.5	7.6
% of public expenditure for PHC from total public budget for health	34.6%	35.1%	40.7%
% of PHC facilities which are working according to the family medicine principles	56%	74%	88%
% of PHC facilities using evidence-based clinical protocols	67%	79%	93%
Number of doctors and nurses trained in family medicine	MD: 271 (4.4%) Nurse: 327 (3%)	MD: 4154 (77%) Nurse: 6652 (62.3%)	MD: 4597 (82.3%) Nurse: 9669 (73.4%)

Source: MoHSP presentation, September 2023

According to the 2023 sustainable development report for Tajikistan¹¹, there are moderate improvements with major remaining challenges related to the achievement of the SDG3, good health and well-being¹². (Table 2)

⁹ WHO, UNICEF, EU, GIZ, H. Olmon. The Situation in PHC in the Republic of Tajikistan, 2023

¹⁰ Ibid.

¹¹ Sustainable Development Report 2023: Implementing the SDG stimulus, page 39 (2023 SDG dashboards for Eastern Europe and Central Asia (levels and trends)

¹² According to the Sustainable Development Report 2023, Tajikistan ranks 85 out of 166 countries in terms of overall performance on the SDGs, with a country score of 69.2.

Table 2 SDG3 indicator performance

SDG3 – Good Health and Well-Being				
Maternal mortality rate (per 100,000 live births)	16.6	2020	●	↑
Neonatal mortality rate (per 1,000 live births)	13.6	2021	●	↑
Mortality rate, under-5 (per 1,000 live births)	31.4	2021	●	↑
Incidence of tuberculosis (per 100,000 population)	88.0	2021	●	→
New HIV infections (per 1,000 uninfected population)	0.1	2021	●	↑
Age-standardized death rate due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30–70 years (%)	28.3	2019	●	→
Age-standardized death rate attributable to household air pollution and ambient air pollution (per 100,000 population)	203.8	2019	●	●
Traffic deaths (per 100,000 population)	15.7	2019	●	↑
Life expectancy at birth (years)	69.5	2019	●	→
Adolescent fertility rate (births per 1,000 females aged 15 to 19)	45.6	2019	●	↑
Births attended by skilled health personnel (%)	94.8	2017	●	●
Surviving infants who received 2 WHO-recommended vaccines (%)	97	2021	●	↑
Universal health coverage (UHC) index of service coverage (worst 0–100 best)	66	2019	●	↗
Subjective well-being (average ladder score, worst 0–10 best)	5.2	2022	●	→

● SDG achievement ● Challenges remain ● Significant challenges remain ● Major challenges remain
 ↑ On track ↗ Moderately Increasing → Stagnating ↓ Decreasing ● Data not available

Source: Sustainable Development Report 2023

Despite notable improvements in health reform, including PHC and UHC, Tajikistan continues to face significant challenges related to the human resources for health (HRH), particularly in terms of labour migration of medical workers and significant shortage of personnel along with geographical inequality. In addition, the results of the PHC situation analysis survey¹³ revealed a growing concern related to the availability of competent medical workers and a lack of sufficient qualifications and certifications related to the family medicine especially at the level of rural health centers (RHC) and health houses (HH).. Insufficient financial resources in the health sector and investment in infrastructure and equipment, fragmented health information system, slow integration and management skills were also identified as major constraints to achieving UHC.

3.2 WHO Tajikistan structure, strategy and workstreams in relation to health systems, PHC approach, UHC, health security

Established in 1992 as the focal point for WHO activities in the country, the WHO Country Office in Tajikistan provides technical assistance to the MoHSP in Tajikistan to strengthen the public health system in the country. The WHO country team consists of 24 staff members (2 in recruitment), including 12 professional officers/experts¹⁴ (5 international and 11 national) of whom 3 are temporary. There are 2 new positions (digitalization and vaccine-preventable diseases and immunization) funded by the EU within the Central Asia COVID-19 Crisis Response – phase 2 programme, which are currently being recruited. PHC is one of the areas under the portfolio of the public health national professional officer. There

¹³ WHO, UNICEF, EU, GIZ, H. Olmon. The Situation in PHC in the Republic of Tajikistan, 2023

¹⁴ Professional officers/experts in the fields of health policy and financing, immunization and surveillance, epidemiology, communicable diseases, disaster preparedness and response, family and community health, nutrition, food safety and food security, mental health and environment and health.

is no position dedicated solely to PHC. Seven staff work directly on PHC and sit on the Coordinating Council for the Development of PHC in Tajikistan.

The position of the health policy adviser was introduced in July 2020 under the UHC-P funding to provide policy advice to the Government and the MoHSP to “strengthen its health system for moving towards UHC, manage, coordinate and enhance the health system team efforts in the WHO Country Office and align activities with the UHC country support strategy within the framework of the UHC-P to achieve greater effectiveness of country level work”.¹⁵ After one year, the funding of the health policy advisor position was taken over by the EU Health Development Programme (2020-2025).

Since 2021, there has been a position of Technical Officer on Communications and Partnership Management in the WHO Country Office, with a mandate to strengthen communications capacity in the WHO Country Office, as well as bilateral relations with various partners and donors. This position also includes serving as the main focal point for the Development Coordination Council on Health (DCC-Health) - central to WHO's work in the SDG3 GAP, which promotes strengthening coordination and collaboration with partners. This position is currently filled by an international expert, whose role is also to build the capacity of the national expert to take over/continue this work in the future.

The priorities for the WHO Country Office are set out in the Biennial Collaborative Agreement (BCA) between the MoHSP and the WHO Europe Regional Office. Programmatic priorities for collaboration in BCA 2020/2021 and BCA 2022/2023 are agreed in response to public health concerns and reflect the country NHS and focus/shift on PHC. Four strategic priority areas are identified with 11 outcomes which aim to strength PHC in Tajikistan. The programmatic priorities in the period 2020-2023 (BCA 2020/2021 and 2022/2023) for Tajikistan are presented in Annex 2.

WHO Country Office staff (WHO Representative, health policy advisor and national professional officer (NPOs)) engage in various national health coordination platforms and working groups supporting strategic developments and advocating for health systems strengthening, the PHC approach and UHC. WHO is also an active member of the general DCC, the DCC-Health, and several DCC subgroups that facilitate technical discussions, each of which addresses and supports one of the key pillars of UHC-PHC/service delivery, health financing, health information system and digitisation, HRH, and emergency and nutrition. For example, WHO Country Office co-chairs (with the EU) DCC-Health, an important working group/platform for exchange of knowledge and information and aligning development partners' activities in the health sector. As one of the key players in PHC, WHO Country Office representatives sit on the National Coordinating Council for the Development of PHC, while seven WHO Country Office representatives are members of the DCC PHC subgroup.

3.3 Support received from WHO SP-PHC to Tajikistan since 2020

The UHC-P and SDG3 GAP global platforms which are part of the SP-PHC, have provided multi-year support to Tajikistan for the efforts on PHC driven by the WHO Country Office, spanning from before the creation of the SP-PHC to date.

Tajikistan is one of the 20 global pilot countries for the national implementation of the SDG3 GAP, with a focus on strengthening health financing as an accelerator towards achieving SDG3 on health and well-being for all. However, to date, Tajikistan has not received direct funding from the PHC Accelerator.

“WHO is our main partner in PHC. Brings all together to discuss issues and problems. Provide strategic advice and support (documents, visions, initiatives), coordinate and make bridge between MoHSP and other development partners, helping to mobilize resource.”

“Resources of WHO are not big, but WHO helps with resource mobilization and work with government”.

KIs

¹⁵ Health policy advisor terms of reference/Job description.

Since its introduction in Tajikistan, the SDG3 GAP funding has been used to:

- Strengthening WHO leadership in Tajikistan to maintain its leading role as a technical agency and to be able to better disseminate findings and recommendations around the work being done.
- Improving internal communication (links to WHO leadership) to strengthen WHO Country Office to be a stronger office in general.
- Strengthening coordination between partners for better health system governance by strengthening both the DCC-Health platform and its use to improve coordination and collaboration in the health development sector in Tajikistan.
- Organizing high level dialogues, retreats, roundtables, and workshops that have been instrumental in advocating for health, promoting the PHC approach, facilitating discussions, resource mobilization and achievements of UHC (Section 4.4 “Engagement of communities and other stakeholders”).

Under the UHC-P platform, the WHO Country Office with support from the WHO Europe Regional Office has initiated, facilitated, contributed to, and/or implemented various activities to support: evidence base decision making (e.g. Health Labour Market Analysis – HLMA¹⁶, PHC situation analysis¹⁷; analysis of current achievements and gaps in delivering and financing health services¹⁸, MedMon survey¹⁹); learning and exchange of experience (e.g., study visits to Türkiye and Kazakhstan²⁰); development of high-level political documents (e.g., Joint statement on PHC, Joint statement in support of the health financing transition) and policy documents; capacity strengthening of national counterparts through trainings, seminars and/or workshops. More detailed information on the above support is provided in Sections 4.2 – 4.4.

Table 3 Overview of SP-PHC support to Tajikistan from 2020-2023

Timing of start of activity and status of implementation of activity	Related to which lever	Description of activities and actual or potential achievements and results	Potential funding source, and amount
01/01/2022 - 10/12/2024	Political commitment and leadership. Governance and policy frameworks. Funding and allocation of resources. Engagement of communities and other stakeholders	Advocacy, raising awareness, working meetings on PHC strengthening, workshops (e.g., PHC demonstration platform), internal meetings with WHO Europe; events on advancing Tajikistan’s Health Financing System towards UHC; Basic Benefit Package monitoring and evaluation.	US\$ 125 000 (Funds accommodated under SP 01, UHC - Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards UHC).
01/01/2023 - 10/12/2024	Governance and policy frameworks.	Study visit (2 nd visit to PHC demonstration platform in Kazakhstan)- 22-25 May 2023;	US\$ 100 000 (Funds accommodated under SP 01, UHC - Countries enabled to

¹⁶ Undertaken to understand health workforce needs in the context of ongoing health system reforms, to drive legal and political commitment to the development of health workforce policy.

¹⁷ A comprehensive PHC analysis, done by the WHO in partnership with the Republican Training and Clinical Family Medicine Center and GIZ, within the frame of the EU-funded Health Development Programme. The analysis confirmed the need for further prioritization of PHC and family medicine principles in the country: (i) development of model for integrating vertical programs and ambulance into PHC facilities at the district level; (ii) stronger governance arrangements; (iii) infrastructure modernization; (iv) introduction of e-health and distance learning; (v) strengthening prevention and treatment of non-communicable diseases, which pose a growing threat to public health in Tajikistan with the aim to decrease patients’ financial hardship and increase effectiveness of primary care services.

¹⁸ WHO conducted analysis of current achievements and gaps in delivering and financing health services as part of State Guaranteed Benefits Programme (SGBP) and persuaded the Government in favor of regular revision and improvement of SGBP in the country. Also Supported revision of the State Guaranteed Benefit Package (SGBP) and prioritization of the most essential services, especially services delivered at the PHC-level, for poor households and other priority groups.

¹⁹ MedMon survey - survey on prices, availability, affordability of medicines.

²⁰ Organized under the WHO PHC Demonstration Platform for national key stakeholders to learn and share experiences on various approaches to strengthening and maintaining the quality of services at the PHC level.

	Engagement of communities and other stakeholders	Summer school on public health policy	develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage).
06/03/2021 - 06/03/2025	Governance and policy frameworks. Funding and allocation of resources	Strengthened health sector governance and financing mechanisms with an emphasis on primary health care (upgrading health governance, strengthening health sector public finance management and programme budgeting capacities strengthened, nation-wide roll-out of improved Basic benefit Package.	1 450,000 (VCS S DEVCO TJK HLTH GOV FIN) (This is the sole EU funded programme. However, the proposal and programme components have been strongly influenced by the results and achievements of UHC-P and SDG3 GAP support).

4. Key findings

Key findings are reported against the high-level evaluation questions.

4.1 Design of the SP-PHC - relevance and coherence

1: Design (relevance and coherence):

These questions are concerned with the design of the SP-PHC and the extent to which the SP-PHC's design and objectives respond to global, regional, country and partner needs, and support the achievement of the SP-PHC's mandate. Also, to be examined is the coherence of the design, objectives, and interventions of the SP-PHC and the degree to which this supports the PHC approach internally within WHO and with external partners.

1.1 How relevant and appropriate is the design of the SP-PHC for achieving its aims and objectives and for supporting the wider aims of the General Programme of Work (GPW)13?

Finding 1: There is a general lack of knowledge about SP-PHC among internal (WHO) and external KIs at the country level. Few KIs had heard of the SP-PHC, and some of them said that they had only learned about SP-PHC after being informed about this evaluation. Documentary and KI evidence suggest that the SP-PHC was mainly communicated at a higher level, and not to the country level. KIs also reported a lack of knowledge about the design of the SP-PHC, and none of them could recall any communication about the SP-PHC or participation in webinars, meetings, or briefings, indicating limited or no involvement of the WHO Country Office in the design. On the other hand, KIs are aware of and actively involved in partnership platforms and activities under the UHC-P and SDG3 GAP being implemented in Tajikistan through the SP-PHC.

Finding 2: While the GPW13 was found to be in line with the Government's goals for achieving UHC through PHC, it was also found to be too broad and lacking in detailed guidance on how to operationalize it. Several KIs reported that the GPW13, promoted by the WHO Country Office, was used to guide the Government in the process of developing the new national health strategy (NHS 2030). Some KIs described the GPW13 as a tool that provides a broad vision for the

Government but lacks clear direction and guidance for countries such as Tajikistan²¹ that are undergoing major reform and transition and have a demonstrated lack of capacity. KI quote: “Weak links and WHO documents to GPW13 to support countries”

1.2 How coherent is the design of the SP-PHC (its objectives, activities, products) “internally” across WHO at global, regional, and country levels?

Finding 3. There is close collaboration between the WHO Regional Office for Europe, WHO European Centre for PHC and the Tajikistan Country Office, with established coordination mechanisms, including an internal share-point platform. However, there are no clear mechanisms for sharing the strategic and overall programmatic initiatives (such as SP-PHC). Documentary and KI evidence suggest that there are regular missions by WHO Europe staff to Tajikistan to discuss progress on PHC and UHC-P, to assess MoHSP interest, and to support the organization of roundtables and high-level discussions in the country. The appointment of a technical officer on communication and partnership management²² in the Country Office since 2021 significantly improved the coherence of communication and information sharing within the Country Office and across the different organizational levels. Although many KIs highlighted close collaboration and coordination on the PHC approach and UHC-P, evidence suggests that there has been limited to no communication on the SP-PHC and its objectives. There are no systematic updates on SP-PHC and none of the KIs reported reading information on SP-PHC in the existing internal sharing platform.

Finding 4. Fragmentation in WHO work limits both inter-agency PHC collaboration and alignment, and between WHO organisational levels. KIs highlighted the cross-cutting nature of PHC, with different areas falling under the portfolio of different NPOs in the WHO Country Office. This, coupled with the reported fragmentation of the WHO work, limits coordination and inter-agency PHC collaboration and alignment. Fragmentation is also reported between WHO organisational levels. There is a documentary and KI evidence that NPOs communicate mainly with their focal point at the WHO Regional Office for Europe, within their specific portfolio (e.g., health policy, health systems, public health, sexual and reproductive health, non-communicable diseases, immunization, emergency, and preparedness) further limiting coordination and organizational PHC collaboration and alignment. This is recognized by the WHO Country Office and internal sharing platform was established to strengthen cross organization collaboration and information sharing.

KI partner quote: “WHO is sometimes quite fragmented. We are approached from different sides with similar requests related to PHC which might touch each other, but in practice we are responding by different colleagues who may not always be communicating amongst themselves”.

Some KIs indicated that the structure and approaches of the MoHSP to PHC related activities follow the WHO Country Office fragmentation with different persons (immunization, maternal-newborn-child-health, PHC, health emergencies etc.) and the MoHSP family planning that correspond to NPOs in the WHO Country Office.

1.3 How coherent is the design of the SP-PHC (its objectives, activities, products) “externally” with wider development partners and country partners (e.g., UNICEF, other UN agencies, Global Fund, GAVI, World Bank, governments; non-governmental organisations, civil society organisations (CSOs), other)?

Finding 5: WHO, through its SP-PHC (UHC-P and SDG3 GAP) work and processes, enables, and ensures good collaboration and complementarity among national stakeholders and DPs, facilitates synergies, and helps the country

²¹ Tajikistan has a very centralized political system and strong government ownership is key. To make something sustainable, there needs to be a government mandate (приказ) and WHO's role is essential in a country context like Tajikistan. WHO in Tajikistan has a very close working relationship with the MoHSP and other government partners and it is important to ensure that any programmes initiated should result in relevant agreements, legislation and/or regulations.

²² Technical officer on communications and partnership management in the CO with the role of strengthening the capacity on communications in the WHO Country Office, but also bilateral relationships with different partners and donors and serving as the main focal point for the DCC-Health) - central to WHO's work in SDG GAP, because SDG GAP is of course all about strengthening coordination and collaboration with partners.

to better prioritize and address country strategic needs and gaps in PHC. Many KIs emphasized the role of WHO in improving partner coordination and information sharing under the umbrella of SDG3 GAP in Tajikistan. This has helped to better position local and international health partners towards the common vision on PHC. Evidence from KIs and documents suggests that the WHO Country Office in Tajikistan is well respected and recognized by key national stakeholders and partners²³ as the lead agency in coordinating activities and mobilizing resources for health reform in Tajikistan. WHO is seen by DPs and key stakeholders as a key organization that primarily supports the MoHSP, assists the ministry in setting priorities (including strengthen PHC) and developing/formulating strategy and policy frameworks, and engages other sectors and the Government in responding to and addressing priorities. Some DP informants indicated that they are lacking a direct dialogue platform with the Government as WHO is the one who has direct/daily contact with the Government, while national stakeholders reported that they prefer to have one leading partner (WHO) to coordinate DPs in providing the support to the country.

Finding 6: The health coordination platforms, initiated by WHO Country Office, provide an effective mechanism for coordination and collaboration on PHC. The SharePoint platform initiated and facilitated by WHO, and the DCC-Health are seen by all KIs as key to coordination and synergy among partners. Multiple KIs described DCC-Health as one of the most active working groups under the general DCC which serves as a main platform for exchange of knowledge and information and aligning development partners' activities in the health sector. KIs pointed to the DCC-Health as a key instrument to achieve the objectives of the SDG3 GAP. KIs also emphasized the WHO Country Office role in advocating and initiating the establishment of the DCC-Health subgroups to support five pillars of the national strategy and achieving UHC.²⁴ The PHC subgroup was established under DCC-Health in May 2022 with the role in building a common vision among all stakeholders on moving towards comprehensive PHC, advising and engaging to support relevant operational activities (e.g., provide technical advice, analysis, training, capacity-building) upon request of the governmental institutions.²⁵

KI quote: "In DCC -Health we sit together, just the partners, and talk about how we can strengthen collaboration - How can we increase the knowledge exchange? How can we avoid duplication? How can we identify gaps? How can we ensure that all our efforts are aligned to support the Government of Tajikistan and MoHSP in implementing the national health strategy? And then we act as one voice".

KI quote: "In some countries there is a competitive environment, but in Tajikistan there is a division of labour, joint work – WHO, WB, EU, partners, WGs. Lots of discussions, platforms, topics."

KIs also highlighted the support and contribution of the PHC subgroup members in monitoring the implementation of the PHC Action plan for 2021- 2025 and providing DCC-Health with an understanding of progress made on, and activities relevant to PHC. Although the PHC subgroup is co-chaired by GIZ and WB, some KIs described WHO as the third co-chair as one of the key players in PHC.

Finding 7: There is strong WHO and DP engagement and consultation with key national stakeholders through national platforms and policy and high-level dialogues. The WHO Country Office has played a crucial role, using its convening power to strengthen overall leadership, governance, and advocacy for health. KI and documentary evidence shows the presence of the WHO staff and development partners in different national health platforms, including the recently established (December 2022) Coordination Council for the Development of PHC (Decree № 894) and their strong engagement in consultation with key national stakeholders (MoHSP, Ministry of Education, MoF, Ministry of

²³ MoHSP, government agencies, health facilities, CSOs/non-governmental organisations, development partners.

²⁴ The DCC working group has subgroups on the key pillars of the national health strategy: PHC/service delivery, health financing, HIS and digitisation, HRH, and emergency and nutrition to facilitate technical discussions. The first meetings of these subgroups took place in early May 2022, and during this meeting they developed terms of references for each of the subgroups, including the PHC subgroup, led by the subgroup co-chairs. According to the terms of references, they meet approximately every quarter and/or on an ad hoc basis.

²⁵ Objectives of the PHC subgroup: An increased exchange of information and knowledge relevant to PHC among health development partners; Improved planning and coordination among health development partners working on PHC; more strategic and increase (joint) resource mobilization efforts (financial, human resources, materials, and supplies).

Foreign Affairs, the Republican Training and Clinical Centre for Family Medicine, etc.). The WHO Regional Office for Europe, the WHO Country Office and partners are engaging with the Government through policy and country dialogues, roundtables, and workshops to plan directions and activities based on country needs and agreed BCA, and to promote stronger and deeper engagement with civil society groups to sustain their support and services in PHC.

4.2 Implementation – efficiency and effectiveness of the SP-PHC

2: Implementation (efficiency and effectiveness):

These questions are concerned with the implementation of the SP-PHC, including the efficient use of funds, progress implementing the SP-PHC activities, results achieved, and key factors that are helping or hindering SP-PHC performance.

2.1 What evidence is there to suggest that resources are adequate for the SP-PHC to achieve its mandate?

Finding 8: Funding within the SP-PHC (UHC-P and SDG3-GAP) is perceived to be low and insufficient, which in the long run may negatively impact WHO's leadership role in supporting the country to achieve UHC through PHC.

Documentary evidence suggests that there is an increase in DP investments with a shift towards PHC, guided by a clear MoHSP vision on PHC and a clear DP vision on areas for investment to support PHC. However, several KIs reported that WHO resources (human and financial), provided through SP-PHC (UHC-P and SDG3-GAP), remain very limited placing a burden on the current WHO Country Office staff. For example, the WHO Country Office in Tajikistan does not have an NPO or focal point for PHC, which is now particularly important for WHO's role in supporting the MoHSP to achieve its vision for PHC. Several KIs indicated that the national public health officer, who is currently responsible for health system support including PHC, is overburdened. KIs also indicated that limited WHO resources in the long run may affect the implementation of activities and the ability to address some of the issues that need attention, thus undermining the WHO leadership role.

2.2 To what extent are SP-PHC activities being implemented as intended and achieving or expecting to achieve their objectives and results?

Finding 9: Funding from UHC-P and SDG3-GAP is seen as highly beneficial in supporting government (MoHSP, MoF, etc.) and other key stakeholders in formulating PHC related policies and strategies and facilitating high-level policy dialogues. There is strong evidence that UHC-P and SDG3-GAP funds and the health policy advisor position (initiated under the UHC-P) have been instrumental in supporting MoHSP in developing key PHC related documents and agreements. This support has also included organising high-level policy dialogues and roundtables to advocate for health, promote the PHC approach, facilitate discussions, resource mobilisation and achievements on UHC. For example, with UHC-P funding, the Joint Agreement on PHC was signed by the Minister of Health and DPs in 2022. All KIs highlighted the importance of this high-level political document which outlines the shared vision of the MoHSP and DPs for strengthening PHC in Tajikistan, and the important role of the WHO Country Office and WHO Europe in advocating, developing the document, and organizing a high-level policy dialogue event on PHC, during which the document was signed²⁶. The Joint Agreement on PHC resulted in a number of actions in line with the shared vision of the MoHSP and

²⁶ The joint statement on PHC identifies five key areas for stronger collaboration and coordination: 1) Strengthening governance mechanisms for PHC; 2) Prioritising financing and resources for PHC; 3) Addressing the critical shortage of health workers; 4) Supporting the integration of vertical programmes into the PHC system and 5) Investing in infrastructure development and renewal.

DPs on PHC (e.g., tailor-made study visits to Kazakhstan and Türkiye to equip mid-level policymakers and health managers with the knowledge, skills, and capacities to improve health service delivery and the health workforce in the country).

Another example is a high-level intersectoral dialogue with the MoHSP and the MoF to strengthen their cooperation and common understanding on the PHC (facilitated by the WHO Country Office). There is also strong evidence on the SDG3 GAP funds importance in strengthening WHO leadership in Tajikistan and strengthening communication and coordination between partners for better health system governance (see Finding 6).

Finding 10: SDG3 GAP and UHC-P implemented through the SP-PHC has been instrumental in bringing together and better aligning multilateral health and development partners, enabling them to better support the government in moving towards UHC. There is strong evidence from documentary review and KIs of strengthened collaboration between key health DPs²⁷ which has allowed partners to align and coordinate their technical and financial support with the government's agenda. The contribution of UHC-P to improving coordination between partners for better health system governance has played an important role in strengthening policy dialogue and has had a positive impact on the multisectoral dimension of health interventions and on partner alignment. One of the examples highlighted by several KIs was the development of a joint statement in support of the health financing transition and the commitment of DPs to support the implementation of key health financing reforms. WHO coordinated the development of a Joint Statement in Support of the Health Financing Transition, which was signed in 2021 by all major DPs supporting this area.

Finding 11: WHO support through the WHO PHC Demonstration Platform facilitated development of a clear country direction for investment in PHC. There is a strong documentary and KI evidence that the WHO PHC Demonstration Platform, designed to show what efficient PHC looks like in practice, played an important role in developing the Tajikistan direction on PHC, and at the same time, a clear vision for partners on where to invest in PHC. Two study tours in Kazakhstan were organized jointly by WHO and GIZ. The learnings from the first study tour to Kazakhstan were discussed in a WHO-facilitated roundtable/workshop and resulted in a clear vision of what the country/MoHSP wants to achieve in PHC. The second study tour visit to Kazakhstan was organized for the government officials and DPs interested in investing (WB, GIZ, USAID, UNICEF) and led to development of a joint action plan on PHC. It also led to the new MoHSP initiative and agreement with DPs to establish the "District of Excellence" in Tajikistan where DP investments will be made with coordination of all approaches and complementary support from partners. The identification of the "District of Excellence" is currently underway.

KI quote: "Now imagine that in the "District of Excellence" we have WB and WHO supporting health financing, GIZ supporting improvement of accessibility and quality of integrated PHC and human resource workforce capacity building, UNICEF prevention and control system across health care – each of the partners will do something in there leading to PHC and integration/vertical programmes".

2.3 How efficiently are SP-PHC resources being utilised (e.g., activities are being implemented in a timely and economic way)?

Finding 12: SP-PHC engagement and the flexibility of UHC-P and SDG3-GAP funds generate synergies between the SP-PHC workstreams. Several KIs described the UHC-P and SDG3-GAP funds as flexible, allowing WHO to respond to ad-hoc requests arising from the MoHSP or the WHO Regional Office for Europe. Despite the relatively small amount of these funds, they are valued by the government as in some cases they act as a catalyst for other partners to invest. The flexibility of the funds also allows synergies to be created between the SP-PHC workstreams, with "requests" from the PHC Accelerator being brought to UHC-P for funding. Many KIs highlighted that the flexibility and catalytic nature of the UHC-P and SDG3-GAP funds also allowed for the creation of synergies between partners (see Findings 5, 6 and 16).

²⁷ WB, Global Financing Facility, Islamic Development Bank, EU, ADB, the Global Fund, Gavi, the Vaccine Alliance.

Finding 13: Reporting for UHC-P and SDG3 GAP has taken place in a timely manner. However, there are no standardised reporting procedures and templates provided by WHO for reporting on SP-PHC. The UHC-P funds are reported using a template reporting on key milestones, narrative and number, visibility, and communication. There were no reports that summarised activities under the SP-PHC. This makes it difficult to separate the work done under SP-PHC from that of other programmes, especially when these funds complement each other or initiate support from DPs' own or other funds allocated to PHC. All interviewed stakeholders agreed that results and achievements under the SP-PHC need to be systematically recorded and documented.

2.4 How is the SP-PHC adding value to the work of WHO and external partners at country levels?

Finding 14: UHC-P and SDG3-GAP funding has been instrumental in elevating PHC within the MoHSP and partners, as well as the Government's strong commitment to health financing reform. Multiple KIs highlighted an increased investment in PHC and a clear MoHSP and development partners vision with areas for investment, as the main achievements of the UHC-P and SDG3 GAP funding in Tajikistan, reached through the coordination platforms, high level dialogues and roundtables initiated, established and facilitated by the WHO Country Office. Strengthened cooperation between MoHSP and MoF is another achievement attributed to the WHO support by several key KIs, with MoF staff now better understanding PHC and its importance, and active engagement of PHC departments to better understand PHC financing.

In addition, according to the documentary evidence the “support in pilot introduction of health financing reform in Sughd Oblast of Tajikistan was of paramount importance to accelerate Government efforts for implementation of health financing reform in the country” (started with UHC-P support and then transitioned to the EU Health Development Programme since 2022)²⁸. To further improve efficient resource allocation and strategic purchasing in Sughd Oblast, guide the implementation of the health financing reform in the region, and support the achievement of UHC, the new Health Financing Mechanism Unit was established and equipped with staff and necessary IT infrastructure. Managers at different levels were trained to improve their knowledge and skills in health governance and financing.

Finding 15: The SP-PHC catalytic support (through UHC-P) was notable in scaling-up health systems strengthening activities. Despite of limited resources the added value of the UHC-P was recognized by key partners who highlighted an increase in WHO support for PHC (technical, political, and financial) in Tajikistan over the past three years with governance and resource mobilization activities resulting in large investments in PHC and a clear MoHSP/DP vision with next steps and areas for investment. The SP-PHC catalytic support (through UHC-P) was noted as particularly important in relation to scaling up health systems strengthening activities such as evidence-based and informed decision making (data/evidence creation), monitoring financial protection for policy-making in Tajikistan (e.g., development of awareness and capacity and skills of local stakeholders, building family planning team, and producing data for family planning results); and financial protection work, that resulted in the new financing mechanism in Sughd Oblast pilot, revision of Basic Benefit Package capacity building activities. However, it is difficult to assess the added value of the SP-PHC alone, as the UHC-P and SDG3 GAP funds were available/implemented in Tajikistan before the SP-PHC was established.

2.5 How sustainable are the interventions of the SP-PHC?

Finding 16: The strong leadership and engagement of the WHO Country Office, the synergies created across DPs and national stakeholders, the supportive environment in the country for change to take place in PHC, and the encouragement of innovative approaches to planning and implementation (all with support by SP-PHC) are seen as

²⁸ EU funded EUR 52.2 mill support “Health Development Programme” (2020-2025) is being implemented jointly by WHO, GIZ and UNICEF. WHO is implementing Component 1 - Strengthened health sector governance and financing mechanisms with an emphasis on primary health care. GIZ in Tajikistan implementing component 2 - Improved accessibility and quality of integrated primary health care service delivery and UNICEF is implementing Component 3 - Effective Infection prevention and control system across the health care delivery system, including COVID-19 crisis response.

key factors in achieving and sustaining PHC reform results. KIs and documentary evidence suggest that SP-PHC support, building off on previous support, was instrumental in building political commitment for a PHC oriented health system in Tajikistan, and in supporting the health financing reform in the country to enable financing of such a system. KI quote: "*The way things are set up (in the government system and not in parallel) and with all development partners together, speaks to sustainability*". KIs highlighted that the strengthening of the health sector governance and financing mechanisms piloted in Sughd oblast, initially supported through the UHC-P, and now being rolled out through the EU-Health Development Programme with emphasis on PHC (WHO leading this component), is directly focused on achieving sustainability. All KIs pointed that allocation from the government to the health sector, although increasing, is still very low and pointed to the need for increasing national expertise (both in the MoHSP and at the regional level) in policy and other areas, including support to the health financing unit to build critical capacity and develop a model for sustaining PHC efforts.

4.3 Gender, equity, and human rights considerations

3: Gender, equity, and human rights.

This question is concerned with how well the SP-PHC is addressing the most vulnerable populations in its promotion of PHC.

3.1. How well has the SP-PHC supported the inclusion of gender, equity and human rights considerations across their core functions and technical products? (examples and reflections)

Finding 17. WHO supports gender, equity, and human rights in PHC mainly through technical products, while SP-PHC activities are very limited and focused on advocacy. Documentary evidence suggests that gender equality, as one of the key cross-cutting issues that plays a significant role in ensuring equity in health, is high on the agenda of the MoHSP. This focus on gender and equity is attributed in part to WHO as a key advisor and supporter of the MoHSP in developing related policies and strategies. Gender equality and equity are included in the National Development Strategy 2030 (NDS 2030) regarding achievements of the SDGs, the Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030,²⁹ and PHC related documents. On the other hand, there is documentary and KIs evidence to suggest that gender-specific SP-PHC activities are very limited and mostly relate to support for national events and active participation of WHO staff (gender focal point) in Gender Thematic Group³⁰ meetings. For example, the national roundtable with civil society (November 2020), supported by the WHO Country Office, provided a platform for an in-depth discussion on the role and capacity of civil society in accelerating the achievement of the health-related SDGs, including gender equality, and included recommendations for improvement from the perspective of civil society organizations. According to documentation, no funding has been allocated to the WHO Country Office for gender-specific activities since 2020. KI quote "*There are no funds even for the roundtable on gender*".

The KIs' views on the country's progress on gender equality are polarised. Some stated that gender is a sensitive issue in Tajikistan, and that "gender is only addressed on paper", with "the gender lens not visible enough in health" and

²⁹ Improving delivery of quality PHC services, reducing the level of gender inequality and elimination of any discrimination by age in provision of services; PHC services should not be limited only to treatment of patients but should focus on disease prevention and maintenance of good health, provision of rehabilitation and palliative care, taking into account gender differences; Promote equity in the allocation of financial resources, etc.

³⁰ The gender thematic group in Tajikistan is led by UN Women: facilitate dialogue on gender issues and encourage gender mainstreaming among partners; undertake activities supporting women's human rights and empowerment in general and providing support for national policies and action plans; focus on training, production of gender briefing kits, and inputting into the Common Country Assessment/United Nations Development Assistance Framework(UNDAF) processes, as well as work involving the Millennium Development Goals and Poverty Reduction Strategy Papers.

"strategies not fully implemented in practice". Others reported that there has been progress in addressing gender, with MoHSP staffing policies including gender balance, and that the vast majority of PHC staff being women.

4.4 Lessons learned and best practices related to advancing selected PHC levers in Tajikistan

Engagement of communities and other stakeholders³¹

Introduction/Background

UHC-P and SDG3-GAP funds have been used for addressing country strategic priorities and focus on PHC and jointly identified gaps and needs in national responses through, among others, engagement of key national partners and strengthening national and intersectoral coordination and coordination between partners for better health system governance.

Results/expected results

Evidence points to the important role of WHO in facilitating the engagement of key stakeholders from all sectors including CSOs and communities through policy and high-level dialogues to define problems and solutions and prioritize actions. Some of the examples are listed below:

- WHO organized a high-level dialogue with MoHSP and MoF. The result is a better understanding of PHC and its importance among MoF staff. Also, there is active engagement of the MoHSP departments to better understand funding for PHC.
- WHO organized a roundtable allowing more discussion and reflection of the lessons learned from the study tour in Kazakhstan that resulted in a common vision of the MoHSP and DPs for PHC.
- High-level intersectoral policy dialogues between national and regional health and finance authorities were organized to advance pilot implementation (in the Sughd oblast) of the health financing reform and increase efficiency of Government spending on health.}
- WHO also supported the national roundtable on the role and capabilities of civil society in accelerating the achievement of the health-related SDGs in Tajikistan involving representatives of the civil society. This event provided a platform for a detailed discussion on how to harness the capabilities of civil society to contribute to progress towards the achievement of SDG3 (20 November 2020).

All KIs reported that the following documents/statements, initiated, developed, and facilitated by the WHO Country Office, with support from the WHO Regional Office for Europe, were the most important achievements made possible by UHC-P:

- A Joint statement on PHC - outlining the MoHSP's and DP's common vision on PHC, priorities, and way forward to strengthen PHC. This high-level political document was formally signed by the MoHSP and over 18 UN agencies and DPs at an official ceremony in Dushanbe on 27 May 2022. The document provides guidance and support the

³¹ Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue.

Republic of Tajikistan in its efforts to strengthen PHC as the foundation for improving health and wellbeing across Tajikistan and achieving the highest level of health and health protection.

- A Joint Statement in support of the Health Financing transition which was signed by all key DPs in this area. The Statement urges the country to modernize budgeting and payment systems, increase domestic funding for health and distribute resources equitably.

Gaps and challenges

Gaps are mostly described in relation to the still limited involvement of civil society and communities in defining problems and solutions and in setting priorities for action. Documentary and KI evidence suggests that there is limited direct engagement of civil society, non-governmental organisations, and communities with government. Some KIs reported that dialogues with CSOs are often organized as separate events, citing the example of the national consultations organized in November 2020, when a roundtable led by the MoHSP was organized with partners to present progress and discuss strategies, while a national roundtable with CSO representatives was held separately (the next day) to discuss the role and capacity of civil society in accelerating the achievement of the health-related SDGs.

Key enablers, critical factors and lessons learned

Documentary and KI evidence suggest that the following factors helped the achievement of results:

- **Strong commitment, leadership and engagement of the WHO Regional Office and Country Office staff in Tajikistan** (recognised as the leading agency in coordinating activities and supporting government and MoHSP in reforming PHC).
- **Good collaboration and coordination among WHO and national stakeholders** through various channels and platforms (e.g., work under the DCC-Health and PHC subgroup led to development of the joint statement on PHC; the Health Financing Platform, formed under the accelerator working group, led to the development of a joint advocacy statement for health financing reforms presented to the MoHSP and MoF and the executive office of the President).
- **Supportive environment for change to take place.** High policy dialogues, joint planning process, collaboration and discussions through roundtables and workshops, shared experience through WHO demonstration platform, initiated and facilitated by the WHO Country Office within the SP-PHC, have created a supportive environment for changes, and built the consensus between DPs and other key actors on gaps to be addressed, as well as priorities and directions to support the PHC.
- **Encouragement for innovative approaches in planning and implementation** under the SP-PHC with some activities that have been catalytic (improved, accelerated, innovative, resulting in resource mobilization, etc.) - see Findings 9-11.

The following was found as a challenge in achieving results:

- **Limited WHO resources (human and mainly financial), provided through SP-PHC (UHC-P and SDG3-GAP).** Several KIs indicated that WHO Country Office would benefit from a position entirely focused on PHC because the national public health officer, who is currently responsible for health system support including PHC, is overburdened, which coupled with the limited SP-PHC resources may affect the ability of WHO to continue its leadership and coordination role with the MoHSP.

Potential of replication, scale up and sustainability aspects

- The created synergies across national stakeholders and DPs, the supportive environment, and the encouragement of innovative approaches to planning and implementation are seen as key to sustaining reform results and achieving UHC through strengthened PHC.
- Support for the establishment of a health policy framework in Tajikistan that focuses on PHC, and consensus reached among MoHSP, MoF and DPs on priorities to be addressed, with areas for investment, was described by KIs as one of the most sustainable forms of support provided by WHO.
- The existing health platforms and the way they are structured, together with clear coordination mechanisms, have created a well-functioning model that has been replicated in the Eastern Mediterranean region.
- Community health workers and community health volunteers and teams established under previous projects/programmes are now being used in other projects, creating a sustainable approach.

Primary health care workforce³²

Introduction/Background

HRH is recognized in the “Strategy on Healthcare of population of the Republic of Tajikistan up to 2030” as a key/priority area for advancing towards accessible, affordable, and quality health services. UHC-P and SDG3-GAP funds have been used for providing evidence-based data for HRH policy formulation and, in coordination with partners, to mobilize resources to support HRH capacity building.

Results/expected results

Following the high-level Policy Dialogue in March 2022, WHO conducted the HLMA in October 2022 with the support of the WHO Europe Regional Office (health workforce division) and the WHO Country Office in Tajikistan to assess the situation of health workforce in the country, identify gaps and challenges, and provide policy recommendations towards strengthening health workforce in PHC. The HLMA results were discussed at the High-level Policy Dialogue on Human Resources for Health: Health Labour market analysis to inform policies, held on 28 April 2023 and led to the identification of key issues in HRH to be addressed and support to be provided to the MoHSP.

KIs also reported UHC-P support to the Republican Training and Clinical Centre for Family Medicine in Tajikistan for organisation of trainings of PHC staff which resulted in PHC workforce gaining the confidence to raise issues and become proactive in seeking further support. Some KIs highlighted the WHO role in advocacy and resource mobilisation for HRH, resulting in the allocation of EU funding under Health Development Programme Component 2, implemented by GIZ, for improving the accessibility and quality of integrated PHC services (Output 1: Mechanism of integrated PHC) for medical education of family doctors including training of residents in the 2 Years Post University Specialty Training and six months training programmes with a focus on continuous medical education/continuous professional development postgraduate education of family doctors; postgraduate education of nurses/midwives and continuous professional development/continued medical education.

Some of the results of strengthening the national capacity are listed below:

- More than 125 health care workers/statisticians have been trained to report COVID-19 cases through ICD-10 coding to DHIS2 system
- More than 200 PHC managers/specialists trained in COVID-19 case management, including prevention, rehabilitation, and mental health
- More than 200 employees of the MoHSP and the MoF were trained on health financing reform mechanisms

³² Adequate quantity, competency levels and distribution of a committed multidisciplinary PHC workforce that includes facility-, outreach- and community-based health workers supported through effective management supervision and appropriate compensation.

- More than 500 specialists were trained in the basics of pharmacovigilance and reporting of adverse drug reaction, including those after COVID-19 vaccination
- More than 500 medical students were trained and involved in promoting healthy lifestyle campaigns (World Health Day, World Hand Hygiene Day etc.)³³
- Development of the relevant part of the Strategy of the Republic of Tajikistan in the field of science, technology, and innovation for the period up to 2030
- Provision of opportunities for students of medical and pharmaceutical universities to improve their practical skills
- Increase in the number of doctors (576 people) and paramedical personnel (1715 people) and other personnel, including a reduction in the number of vacancies and a concentration in the number of certified specialists
- Increase in the number of specialists participating in retraining courses, especially abroad
- Increase in the number of qualified doctors and an increase in the quality of education in universities and colleges were highlighted as the country's main achievements³⁴.

According to the documentary and KIs evidence, WHO will continue to advocate and support the MoHSP in strengthening PHC workforce by improving the planning (and equitable distribution) of medical school/college graduates, improving the quality of medical services through the introduction of continued medical education, self-training systems, and reforming medical education by introducing a bachelor's degree for mid-level health professionals and a residency for specialists.

Gaps and challenges

Despite notable improvements in health reform, including PHC and UHC, Tajikistan continues to face significant challenges related to HRH. The high-level Policy Dialogue³⁵ (as part of the Joint Annual Review) held in March 2022 highlighted the labour migration of medical workers and significant shortage of personnel, geographical inequalities, lack of funds for advanced training, shortage of doctors in some specialties, and the need to enhance the efficiency of educational activities as key challenges. In addition, KIs also highlighted that the low interest in family medicine due to the increased workload and responsibilities of family medicine doctors (e.g., 16 vertical programmes, reporting requirements, paperwork, home visits, etc.), coupled with salaries that are lower than the national average, as a growing concern affecting HRH in PHC. A challenge related to HRH capacity building, reported by KIs, was the high turnover of staff, including health managers, who are often removed from their positions after training.

Key enablers, critical factors and lessons learned:

The following are described by KIs as key enabling factors in achieving results related to HRH:

- The synergies across national stakeholders and DPs created through WHO-initiated and coordinated platforms (within the SP-PHC)
- High level policy dialogues that led to the initiative for conducting HLMA and facilitated discussions on HRH and the identification HRH issues to be addressed with supported to be provided to the MoHSP
- The supportive environment in the country and the growing interest in strengthening HRH capacity in PHC, including among health policy makers and health managers.

Potential of replication, scale up and sustainability aspects

Support for the establishment of a HRH strategy in Tajikistan, development of the relevant sections of the Strategy in the field of science, technology, and innovation for the period up to 2030, consensus reached among MoHSP, other key stakeholders and DPs on the gaps to be addressed and areas to invest, was described by KIs as one of the most sustainable forms of support provided by WHO and partners. However, much remains to be done. Several KIs

³³ WHO Country Office internal documents and reports.

³⁴ Report on the Policy Dialogue as part of the Joint Annual Review of the first year of implementation of the National Health Strategy of the Republic of Tajikistan for 2021-2030, March 2022

³⁵ The high-level Policy Dialogue, as part of the Joint Review of the First Year Implementation of the National Health Strategy of the Republic of Tajikistan up to 2030 was organized by the World Health Organization (WHO) in Tajikistan, in collaboration with the MoHSP of the Republic of Tajikistan and the MoF of the Republic of Tajikistan.

highlighted the need to strengthen technical capacity and units within the MoHSP for the ongoing health reform process, including HRH for PHC.

5. Conclusions and opportunities for SP-PHC support to Tajikistan

5.1 Summary conclusions

- **The WHO Country Office in Tajikistan is well respected and recognised by key national stakeholders and partners as a key organization** that primarily supports the MoHSP and assisting the Ministry in setting priorities (including the shift to PHC), developing/formulating strategy and policy frameworks, coordinating activities and mobilizing resources for health reform in Tajikistan. This is evident through WHO policy level advisory and advocacy, organisation of high-level dialogues and consensus meetings engaging other sectors and the government in responding to and addressing identified priorities in PHC, and coordination and facilitation through different platforms to ensure synergy among DPs in their support to achieving UHC through strengthen PHC. Limited human resource capacity (particularly the absence of a PHC focal point in the WHO Country Office) places a burden on the current WHO Country Office staff to focus on PHC.
- **The cross-cutting nature of PHC, with different areas falling under the portfolio of different NPOs, requires better coordination of PHC activities** within WHO organizational levels, and the establishment of a focal point for PHC in the country office. Overall, KIs reported fragmented WHO work, which limits cooperation and coordination on PHC within WHO organizational levels and between agencies.
- **There is no systematic approach and adequate mechanisms in place for promoting SP-PHC to country level or in supporting countries in operationalizing them.** This is evident through a general lack of knowledge about SP-PHC among internal (WHO) and external KIs at the country level, and the difficulty they have in separating/identifying activities being implemented under the SP-PHC (UHC-P and SDG3 GAP) and other programmes/projects.
- **SP-PHC is a welcome initiative which enables country to address needs and gaps in achieving UHC through strengthened PHC and motivate DPs to be more focused on PHC.** There is positive feedback from key stakeholders in Tajikistan, and appreciation of the UHC-P and SDG3 GAP support.
- In general, **the UHC-P and SDG3 GAP funds have clearly contributed to elevating PHC within the MoHSP, have been instrumental in building political commitment for a PHC-oriented health system in Tajikistan, and have supported the country's health financing reform to enable the financing of such a system.** UHC-P and SDG3 GAP funding was found to be highly beneficial in supporting the government (MoHSP, MoF, etc.) and other key stakeholders in formulating PHC-related policies and strategies, and in facilitating high-level policy dialogues that led to the clear MoHSP vision on PHC with areas for investment (considered the main achievements of UHC-P and SDG3 GAP funding in Tajikistan).

- **The interventions/activities under SP-PHC are largely designed to add value and achieve some sort of “catalytic” outcome.** UHC-P and SDG3 GAP funds have led some DPs to raise and invest additional funds for PHC (e.g., the EU-funded Health Development Programme, which allows for a significant scaling-up of technical assistance on health financing previously provided under UHC-P), or have helped them to maintain their focus and investment on PHC (e.g., the new World Bank project will support financing system changes and digitalisation; the new EU project will continue to support PHC). However, as the UHC-P and SDG3 GAP global platforms also provided support to Tajikistan (for PHC efforts) prior to the establishment of the SP-PHC, it is difficult to assess the value added of the SP-PHC alone.
- **UHC-P and SDG3 GAP funds, although perceived as low, are encouraging and provide a safe space for exploring innovative approaches.** Their flexibility allows activities and plans to be quickly adapted to emerging and other programming needs and allowing synergies to be created between the SP workstreams and between partners. However, many KIs feel that if they remain low, in the long term they may limit WHO's ability to address some of the issues that need attention, and thus undermine WHO's leadership.
- **There has been insufficient clarity on quality assurance of reporting and missed opportunities to document and record SP-PHC interventions and contributions in a systematic, structured, and standardized manner.** Although reporting on UHC-P and SDG3 GAP takes place in a timely manner there are no standardized reporting guidance and templates provided by WHO to report on SP-PHC implementation in the country. There is an identified need for a more guided, standardized, and structured reporting on results and achievements under the SP-PHC.
- Strong commitment, leadership and engagement of the WHO Country Office in Tajikistan, the synergies across national stakeholders and DPs created through WHO-initiated and coordinated platforms, the supportive environment in the country for change to take place, and encouragement for innovative approaches in planning and implementation are the main factors contributing to the achievements in Tajikistan to date and are considered key to sustaining the reform results and achieving UHC through strengthened PHC.

5.2 Opportunities for SP-PHC support to Tajikistan

5.2.1 Opportunities for the global level/WHO

- **Strengthen efforts to improve the way SP-PHC intent is communicated, and information shared and understood at the country level (WHO Country Office and key stakeholders) by:**
 - Defining mechanisms that will strengthen SP-PHC promotion and ensure adequate and timely communication and information sharing across operational levels.
 - Utilizing existing share point platforms to promote SP-PHC and establish systematic updates on SP-PHC.
 - Organisation of webinars/workshops on SP-PHC for internal WHO staff at all operational levels to create a common understanding.
 - Provide much clearer guidance and mechanisms for operationalizing SP-PHC. This also includes the WHO/UNICEF PHC operational framework, how the framework is translated at the regional and country level and the tools used to do so.
- **Develop a standardized and structured, but simple, reporting system on results and achievements under the SP-PHC at the country level.** Clear guidance standardized and appropriate reporting processes and forms/templates are needed for documenting and keeping records of SP-PHC activities at the country level. They may also include narrative sections of implemented activities, sharing good practices and lessons learned.

- **Consider and further explore ways to reduce fragmentation.** The establishment of an SP-PHC focal point at headquarters level and of PHC focal points at Country Office level would allow for better coordination between WHO organisational levels, reduce fragmentation and strengthen inter-agency cooperation and alignment on PHC.
- **Consider introducing incentives for countries that demonstrate strong commitment, a clear vision and tangible results in achieving UHC through strengthening PHC,** in the form of additional funding to support sharing of best practices, lessons learned, participation in regional workshops, etc.

5.2.2 Opportunities for Tajikistan

- **Capacity assessment, including mapping of WHO Country Office capacity against country needs** and country goal of achieving UHC through PHC (based on principles of family medicine), should be undertaken, followed by joint advocacy to fill gaps where a priority mandate is not being fulfilled (e.g., WHO PHC focal point who can also serve as SP-PHC focal point).
- **SP-PHC results and achievements at the country level should be better recorded and documented.** Standardized and structured reporting systems for documenting and keeping records of SP-PHC activities (with narrative of implemented activities and lessons learned/good practices) should be used.
- **More attention should be given to the existing internal Share Point platform and its use should be strengthened to promote and share information and updates on the SP-PHC,** including the PHC implementation support mechanism, guidance on how to implement the PHC operational framework and tools for its translation at country level. The SharePoint platform could also serve as a main platform for exchanging different initiatives, opportunities, and activities under the SP-PHC and other programmes/projects implemented by NPOs within their portfolio to reduce existing fragmentation and support the cross-cutting nature of the PHC.
- **Consider developing a PHC dashboard** showing the status of implementation of the PHC country vision, which can be used as a tool to support resource mobilization, identify areas for investment and attract new investment (e.g., forthcoming new EU and WB projects).
- **Consider prioritising support to national counterparts to improve their capacity for planning and data-driven decision-making** to ensure implementation of the existing health policy framework and country priorities for achieving UHC through strengthened PHC. WHO should continue to support data-driven decision-making through advocacy, resource mobilization and technical assistance to the MoHSP and other key stakeholders in management, planning, data analysis and interpretation, and use of data in decision-making and prioritization. Consideration should also be given to extending technical assistance to the regional and district levels.
- **Continue to support the MoHSP to pursue the idea of “District of Excellence” and use this as an opportunity to build more capacity in MoHSP by strengthening PHC related units.** WHO should provide technical expertise and support to the PHC related unit, which would then gain greater legitimacy through WHO standing.
- Building on the success of the development and adoption of joint statements on PHC and health financing, WHO should **continue to support the country in identifying gaps, setting priorities and addressing challenges in HRH, and support the MoHSP in developing the joint position statements outlining the shared vision on HRH,** presenting high-level guidance to Tajikistan, and in aligning and coordinating DP technical and financial assistance with the Government's vision and the country's needs (clear vision on areas for investment to support HRH).
- **Communicate and share** – Further strengthen strategic communication (linked to WHO leadership), promotion of the achieved results, initiatives, and recommendations, to maintain the leadership and coordination role among DP in the country.

- **Innovations, positive experience, platforms, and new models** emerging from the SP-PHC support should continue to be widely applied – where relevant – and shared across the region through existing forums and platforms.

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Annex 2: High and medium priorities within framework of GPW13 and EPW

The following high and medium priorities within framework of General Programme of Work 2019–2023 (GPW 13) and European Programme of Work 2020–2025 (EPW) have been chosen for collaboration:

Table 4 Programmatic priorities in the period 2020-2023 (BCA 2020/2021 and 2022/2023)

Strategic Priority 1. One Billion More People Benefiting from UHC	
1.1 Improved access to quality essential health services	<p>Output 1.1.1 Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>Output 1.1.2 Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>Output 1.1.3 Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course</p> <p>Output 1.1.4 Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness, and empowerment of communities</p> <p>Output 1.1.5 Countries enabled to strengthen their health and care workforce</p>
1.2 Reduced number of people suffering financial hardship	<p>Output 1.2.1 Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage</p>
1.3 Improved access to essential medicines, vaccines, diagnostics, and devices for primary health care	<p>Output 1.3.1 Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists</p> <p>Output 1.3.3 Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved*</p> <p>Output 1.3.5 Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices</p>
Strategic Priority 2. One Billion More People Better Protected from Health Emergencies	
2.1 Countries prepared for health emergencies	<p>Output 2.1.1 All-hazards emergency preparedness capacities in countries assessed and reported**</p> <p>Output 2.1.2 Capacities for emergency preparedness strengthened in all countries**</p> <p>Output 2.1.3 Countries operationally ready to assess and manage identified risks and vulnerabilities**</p>
2.2 Epidemics and pandemics prevented	<p>Output 2.2.1 Research agendas, predictive models and innovative tools, products, and interventions available for high-threat pathogens**</p> <p>Output 2.2.2 Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale*</p> <p>Output 2.2.3 Mitigate the risk of the emergence and re-emergence of high-threat pathogens and improve pandemic preparedness</p>

Strategic Priority 1. One Billion More People Benefiting from UHC	
	Output 2.2.4 Polio eradication plans implemented in partnership with the Global Polio Eradication Initiative
2.3 Health emergencies rapidly detected and responded to	Output 2.3.1 Potential health emergencies rapidly detected, and risks accessed and communicated Output 2.3.2 Acute health emergencies rapidly responded to, leveraging relevant national and international capacities Output 2.3.3 Essential health services and systems maintained and strengthened in fragile, conflict-affected, and vulnerable settings
Strategic Priority 3. One Billion More People Enjoying Better Health and Well-Being	
3.1 Determinants of health addressed	Output 3.1.1 Countries enabled to address social determinants of health across the life course 3.1.2 Countries enabled to strengthen equitable access to safe, healthy, and sustainably produced foods through a One Health approach
3.2 Risk factors reduced through multisectoral action	Output 3.2.1 Countries enabled to address risk factors through multisectoral actions Output 3.2.2 Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws, and fiscal measures**
3.3 Strengthened country capacity in data and innovation	Output 3.3.1 Countries enabled to address environmental determinants, including climate change Output 3.3.2 Countries supported to create an enabling environment for healthy settings
Strategic priority 4. More Effective and Efficient WHO Providing Better Support to Countries	
4.1 Strengthened country capacity in data and innovation*	Output 4.1.1 Countries enabled to strengthen data, analytics, and health information systems to inform policy and deliver impacts*.
4.2 Strengthened leadership, governance, and advocacy for health.*	Output 4.2.1. Leadership, governance, and external relations enhanced to implement GPW13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform*

* Only in BCA 2020/2021

** Only in BCA 2022/2023

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