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Disclaimer
The views and ideas expressed are those of the author and the review team and do not necessary imply or reflect the opinion of the Agency

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Acronyms

CME	**Continuing Medical Education**
FD	**Family Medicine Doctor**
FN	**Family Medicine Nurse**
FM	**Family Medicine**
FMC	**Family Medicine Center**
GP	**General Practice/practitioner**
KGZ	**Kyrgyzstan**
KSMA	**Kyrgyz State Medical Academy**
KSMIRCME	**Kyrgyz State Medical Institute for Continuing Medical Education**
MEP	**Medical Education Reform Project (Tajikistan)**
MER	**Medical Education Reform Project (Kyrgyzstan)**
MoHSP	**Ministry of Health and Social Protection**
NCD	**Non communicable diseases**
PGME	**Post-graduate Medical Education**
PGMI	**Post-graduate Medical Institute**
PHC	**Primary Health Care**
PUST	**Post-university Specialty Training**
RCFM	**Republican Centre for Family Medicine**
RHC	**Rural Health centers**
TSMU	**Tajik State Medical University**

Executive summary

Since 2009 the medical education reform project MEP I then MEPII have been working at all three levels of the medical education: pre-graduate, post-graduate (PGME) and continuing medical education (CME). At pre-graduate level, the curriculum has been revised, reducing the number of teaching hours, reorienting the content towards a family medicine/primary care approach and strengthening the teaching of clinical skills capacity of faculty members. Clinical skill labs have been set-up and the reform is implemented in its 4th year. The reform is moving as planned under the strong leadership of the Rector of TSMU and a committed and efficient working group leader. Year 5 and 6 are being developed. Year 6 will be a full clinical year. TSMU is facing the difficult situation of chronic public underfunding and is compensating it by enrolling a large number of students, over a thousand every year, which is beyond the teaching capacity of the institution for clinical skill development. The majority of students pay tuition which covers three quarters of running costs of TSMU. It also lacks sufficient access to medical facilities to provide adequate access to patients for students. A similar situation is encountered in Kyrgyzstan.

MEP is implementing with local partners an innovative 2 year post-graduate pilot program, PUST, in different districts. Overall 52 residents are being trained by practicing FM in local RHCs and FMCs under the supervision of trained tutors, with one day a week of courses given by the PGMI according to a revised FM curriculum. The majority of new interns don't have any alternative but to take a one year *internatura* as initial basic post-graduate training. This is insufficient and leads to a large number of undertrained doctors practicing in the regions, contributing to the poor quality of care provided and the continuous need for retraining such practitioners. The interest in FM remains very low due to the lack of status, poor retribution and difficult working conditions. MEP is working at improving the image of FM by proposing the PUST program and diffusing its positive results. In 2014 a study tour to Switzerland was organized for a delegation of high rank personalities to promote FM.

MEP has been very active in CME, contributing to the revision of retraining and CME curriculum and strengthening the teaching capacity of PGMI and RCFM, and in providing financial support to retrain 49 doctors and 60 nurses. It contributed also to strengthen family nurses' training both contributing to the 4th year of FN training and retraining programs. 34 peer review groups are active for both doctors and nurses in several districts and clinical mentoring by Swiss family medicine doctors are conducted regularly, but neither is recognized as CME by PGMI or RCFM.

This review was a mutual learning exercise for all participants with experience transfer on both the regional and international level. The relevance of this type of exercise in this phase of the project as well as the composition of the team which led it, were confirmed. It allowed to identify the numerous activities and outputs of the MEP four components and discuss them with the different actors involved. A wealth of concrete and innovative experiences has been gained in training professionals, capacity building of local institutions and new program development. **Now is the time to put them together and develop with all the stakeholders a national PGME-CME strategy**. This will help defining the various components which needs to be addressed to develop a sustainable medical education

improving the quality of care and responding to the population needs. Much needs to be done in coordination with other stakeholders to develop an effective primary care base in the country. The medical education is only one part of it, but an essential one. The health care reform underway needs to provide the necessary environment and working conditions to help better trained doctors and nurses to practice effectively.

The chronic underfunding of the health sector and the lack of leadership and strategic vision of the MoHSP make up the main obstacles of the project. A policy dialogue on the basis of the technical progress of the program was initiated with the health authorities, and benefits have already been observed. However, it is essential to strengthen the dialogue and structure it more, through joint activities implementing partner/SCO, in order to go from a technical to a more political dialogue at a higher level, aiming at systemic changes such as designing a comprehensive strategy on medical education and on FM implementation or allocating sufficient resources to public services. The respective roles of the SCO and of the implementing partner in conducting this dialogue should be further clarified. The SCO has the lead in conducting the dialogue, as its mandate in the matter is clear. As such, SDC HQ should give the SCOs more tools and a clearer definition of what is meant by political dialogue, as well as what is expected as a result. This is a general problem which should be the subject of an internal reflection within the SDC.

Despite efforts made by the project, it is nonetheless clear that some structural obstacles are beyond the influence of the program. This is particularly the case for the salary scale and the incentives for family doctors, as well as for keeping the *internatura* for 1 year for specialization.

At each of the three levels of medical education there are areas to be reinforced and further developed in a next phase of the project. MEP has the technical expertise to help the various stakeholders to develop and implement them. Decentralization of training and diversification of the stakeholders involved in PGME and CME need to take place, with more capacity being developed in the regions, closer to the practitioners. The role in training of medical professional associations and of hospitals should also be defined.

A MEP III phase is needed to complete the medical education reform and have a comprehensive strategy developed and implemented. Stopping now would leave the job unfinished. The under-graduate reform would not be completed and the post-graduate reform strategy not even defined. A third phase should concentrate much more on the strategic level, with much less on pilot testing operations. It would help the MoHSP and all the partners to define and implement all three main sectors of the medical education reform in a coordinated and effective way. The focus will be more at post-graduate and CME level than pre-graduate. Investing more in a nursing component is also recommended to better prepare Tajikistan to respond to the increasing burden of NCDs. Improved chronic diseases' management in health care facilities is essential and requires the full involvement of nurses.

There is a good collaboration with the MOHSP and other stakeholders. All highly appreciate the project and consider it as most successful. This should facilitate MEP in leading more strategic initiatives towards the development and implementation of a national PGME-CME strategy. The project needs to use the experience gained in the pilot interventions to translate them into the strategy. How can PUST be implemented or adapted to other regions

where MEP doesn't work and become the national standard basic post-graduate training in family medicine? More strategic attention and support need to be given to chronic diseases' management, both in developing sufficient training capacity and in the practice of long term care.

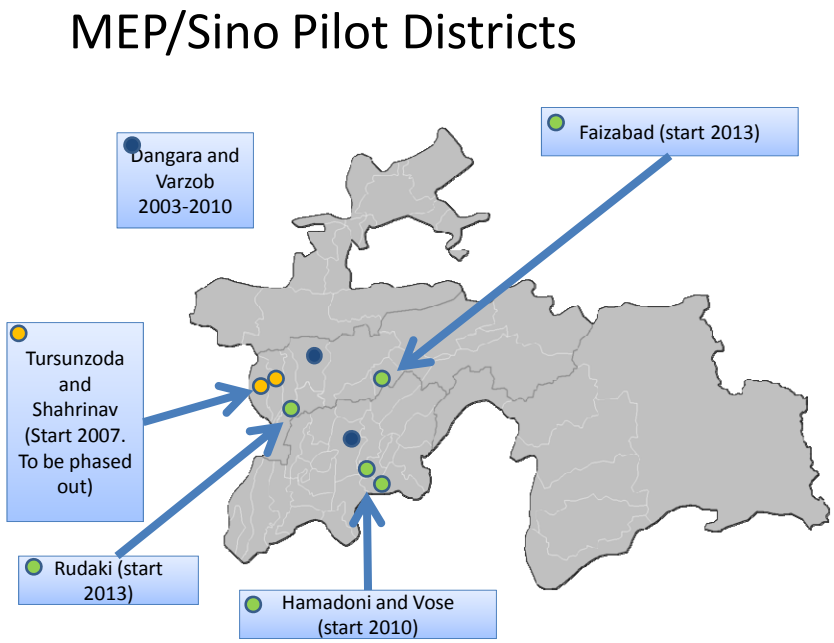
The main recommendations are the following:

1. Finalize the under-graduate curriculum reform
2. Reinforce clinical training and strengthen TSMU – hospitals partnership
3. Diminishing the number of students to be more in phase with the training capacity and increase the quality of clinical training
4. Reinforcing the implementation of enrolling more students from rural areas
5. Developing a comprehensive strategy in PGME and CME
6. Integrating PUST approach into a national PGME strategy
7. Upgrading/ retraining of practicing physicians will continue
8. CME needs to be diversified and decentralized
9. Developing an accredited CME system
10. Family nursing becomes an essential component of family medicine
11. Pushing the agenda for the development and implementation of a comprehensive PGME-CME reform and strategic developments
12. Developing more interactions between the Medical Education Reform projects in Tajikistan and Kyrgyzstan

As discussed in this report, almost all of the recommendations have a technical and a political dimension. MEP can work with the partners to prepare the technical part to facilitate a political decision with the support of the SDC office.

1. Introduction

The Medical Education reform Project (MEP II) implements activities in different districts of Tajikistan. Some started during the previous phase of the project (2009-2012) or even during previous Sino project phases. In the frame of the present peer review, the team visited Rudaki, Hamadoni and Vose districts.



Source : Dr E. van Twillert

The MEP II is involved in 4 domains of activities leading to 4 different outcomes, forming a continuum, from under-graduate education, to post-graduate education and continuing medical education. In order to maintain the coherence of the project contribution to the development of medical education to strengthen the Tajik capacity in providing primary care services, a fourth component to strengthen policy dialogue has been included. They are all summarized and listed below with their main outcome.

1. Under-graduate education – TSMU
   - Students at TSMU in year 1and 2 have improved their knowledge and practices through new curriculum and better teaching approach
2. Post-graduate education – PUST
   - FM residents/interns have improved their knowledge and practices through the implementation of PUST and a functioning mentoring system
3. Continuing Medical Education – CME
   - Family doctors and nurses have improved their knowledge and practices through a functioning CME&L system that is steered and managed by Tajik institutions
4. Policy dialogue
   - Roles and responsibilities of different institutions as well as financing of medical education are clarified through policy dialogue

The present report looks at the key findings of the peer review, putting them in perspective with the overall reform, their relevance, their sustainability, their potential expansion at the national level and in view of the similar project implemented in Kyrgyzstan.

The report reviews the project's activities and results following the continuum of medical education from under-graduate to post-graduate and continuing medical education. It then discusses some of the findings and suggestions about outcome 4 on policy dialogue and the added value of the peer review for both medical education reform projects in Tajikistan and Kyrgyzstan. The detailed responses to ToRs review questions established by the SDC HQ-OZA Health Advisor is included at the end of the general report. The present synthesis of the results and recommendations was established based on this document

2. Methodology

The four purposes of the peer review were
1) to review the new components such as PUST and the cooperation with the medical colleges,
2) to deepen the reflection on CME&L models developed and define what steps are needed for their institutionalization,
3) to define what strategic orientations should be taken in the project implementation according to challenges and risks
4) to define how to develop more synergies between SDC health funded projects in Tajikistan and Kyrgyzstan to further develop SDC vision and improve performance in medical education reform.

This peer review was carried out as a formative assessment undertaken in a very interactive and participatory way. This was not intended to be a formal evaluation but a learning exercise where many stakeholders involved in the project were met and involved in active discussions about the project achievements, the participatory processes used to develop the various domains of its activities and their sustainability. Numerous meetings and interviews gave the team the opportunity to challenge the current strategies or activities underway, leading to lively discussions on new opportunities to be explored.

There is also an important dimension of such peer reviews which can be considered as capacity building, capacity building from the suggestions made, from international standards and also grained from other similar projects' experiences, such as the MER in Kyrgyzstan. The review being less formal than an evaluation, it allows for more open and less threatening discussions suggesting new ways of tacking current constraints or problems to be solved. This was particularly the case when meeting with the head of the Health Policy Analysis Unit at the MoHSP.

Overall the peer review should be considered as a learning process of partners involved which goes far beyond the findings reported in this report. The issues raised during the discussions by the team members, bringing an outside look at the project's realizations,

hopefully should continue to generate further questioning and help the partners to reorient some activities and develop new solutions.

As SDC is actively involved in a similar project on medical education reform in Kyrgyzstan and in the development of primary healthcare services in other Eastern European and Central Asia countries, the peer review team constantly shared experience and ideas about similarities, differences and lessons gained from other projects which could be useful for the Tajik project and vice versa. The participation of the SDC Health Advisor for Eastern Europe and Central Asia to the review was particularly useful and effective in bringing and comparing the MEP achievements and issues with other SDC health projects underway in the region.

The team first reviewed the numerous documents available (annual reports, mission reports, project document, etc) and contacted technical experts involved in the project: Prof Renato Galeazzi who established and provide regular support to peer review groups of doctors and nurses, Prof Clarence Günther and Prof Heather Baxter from the University of Calgary, Canada who assist the pre-graduate medical reform at TSMU and Dr Didi Burkhardt, representative of the Swiss Family Medicine Association. During the peer review, Dr Kaspar Wyss from the Swiss TPH and Dr Erik van Twillert- the representative of the Swiss TPH in Tajikistan - were present, allowing for immediate feedback and complementary information on project's achievements or on the general health situation in Tajikistan. This was extremely valuable and helped having productive discussions. Similarly, the participation of the Senior Program Manager of the Swiss Cooperation office in Dushanbe as a team member, was also very valuable in bringing important perspectives many projects are facing in the local context, on constraints and opportunities, giving also the inter-institutional relationships influencing the project implementation and the historical dimension of the project development.

The mission included meeting the major stakeholders and partners actively involved in the project at all four levels the project is active in: MoH, Health Policy Analysis Unit, SDC, WHO for policy dialogue aspects, Rector and head of the reform working group at TSMU, including very fruitful discussions with students, professors involved in the pre-graduate medical reform, the directors of PGMI and RCFM and colleagues active in post-graduate training, in retraining and CME courses, attending courses and seminars and having an opportunity to meet with doctors and nurses participants, Directors of Medical colleges and nurses students and attending four peer review groups (two for doctors, two for nurses) and meeting with the participants, and meeting with FM doctors and their mentors in the PUST training program. The team visited 3 different districts where young interns are being trained as FM doctors under the daily supervision of one tutor. Visiting a good sample of the MEP2 project activities and meeting partners, from key decision and policy makers to students, nurses and physicians practicing in the field, gave the team a good overview of the project achievements and allowed to link more effectively the experiences, successes and difficulties encountered to the overall achievements and goals of the project as a key contributor to the reform in medical education.

The interviews offered ample opportunities to discuss on current realizations but also on possible new developments which could be envisaged. This was particularly the case with

the advisor to the MoHSP, with the head of the Health Policy Analysis Unit on what the unit could do to help the MoHSP plan the development of primary care services in the country and also with the directors of the PGMI and RCFM on what each institution should propose as a unique selling offer. On the last day of the mission, a debriefing followed by a discussion, gave the opportunity to present a summary of the peer review findings to the main stakeholders of the project and get also their feedback on the findings reported.

The peer review team, with no exception, has been welcomed by all partners visited. All stakeholders accepted to be interrupted, questioned and challenged in good faith by the review team. This suggests that the project is well accepted and integrated into the different services, institutions and geographical locations it is active in. This shows that trust and participative collaboration have been established with the project partners, key ingredients to develop sustainable activities. The team had access to all needed documents provided by the project local members. This has facilitated greatly the peer review team's work. The team is very grateful to all for their availability, the time and efforts made to contribute to the outcome of this review.

3. Findings

3.1 General considerations

- Overall, the Peer-review went very well and represented, well beyond the present report, an important moment of mutual learning and experience transfer on both the regional and the international level. The relevance of this type of exercise in this project phase, as well as the composition of the team which led it, were also confirmed.
- The learning and the exchanges focused not only on the technical aspects of the project, but also on the management, monitoring, policy dialogue, and peer-reviews as process. The exercise was especially beneficial and energizing for the Tajik health authorities, both at the MoHSP and the TSMU level, as well as for the students who sometimes had to answer unexpected and even unusual questions…
- The main difficulties encountered lie in the limited time available for interviews, as well as in the treatment of sometimes incomplete or event contradictory information, which required some work to harmonize the data.
- Overall, the program is evolving as initially planned and the results at this stage are encouraging, especially in view of the strategic context and the lack of leadership from the MoHSP. Given that the program operates at the level of the medical training system as a whole and that the various curricula are being developed or have recently been introduced, it is essential to continue the project beyond the current timeframe in order to consolidate the results and avoid jeopardizing the achievements.
- However, priorities will have to be established for subsequent phases. Indeed, the program operates on several levels and includes many components that require careful consideration and prioritization based on the potential for sustainable and systemic changes which they present.
- The chronic underfunding of the health sector and the lack of leadership and strategic vision of the MoHSP make up the main obstacles of the project. A policy

dialogue on the basis of the technical progress of the program was initiated with the health authorities, and benefits have already been observed. However, it is essential to strengthen the dialogue and structure it more, through joint activities implementing partner/SCO, in order to go from a technical to a more political dialogue at a higher level, aiming at systemic changes such as designing a comprehensive strategy on medical education and on FM implementation or allocating sufficient resources to public services. The respective roles of the SCO and of the implementing partner in conducting this dialogue should be further clarified. The SCO has the lead in conducting the dialogue, as its mandate in the matter is clear. As such, SDC HQ should give the SCOs more tools and a clearer definition of what is meant by political dialogue, as well as what is expected as a result. This is a general problem which should be the subject of an internal reflection within the SDC.

- Despite efforts made by the project, it is nonetheless clear that some structural obstacles are beyond the influence of the program. This is particularly the case for the salary scale and the incentives for family doctors, as well as for keeping the *internatura* for 1 year for specialization.
- The support and collaboration with the University of Calgary and the Swiss Association for Family Medicine are very much appreciated and largely contributed to the success of the program.
- The lack of trust of the population in the family doctors is still a reality in Tajikistan. However, the project has implemented significant measures to form better FM doctors, to make the profession more attractive and to provide better working conditions. These efforts should be continued and even intensified in subsequent phases.

3.2 Undergraduate medical education reform at TSMU

Following the MEP I the first 4 years of medical school curriculum has been revised and implemented, giving much more emphasis on the basic training needs of primary care. Year 4 is currently implemented and the curriculum of year 5 is being developed for 2015-1016. A testing center to run written MCQ has been set up, evaluation of courses by students has been introduced and quality assessment procedures developed. Teachers' pedagogical capacity has been improved by ToT courses and clinical skills lab has been set up and is fully used. Resistance to change among faculty members is decreasing as they see the positive effects of the curriculum reform. There has been some set back happening independently from the Rector's will, with the reopening of a faculty of pediatrics independent from the faculty of general medicine. This illustrates that some political decisions are made independently from the main actors. Ways have been found so that it should not affect the teaching capacity of the institution to provide the necessary courses in pediatrics of students. Overall the undergraduate medical education reform is moving on schedule, with unsolved major challenges which are beyond the project influence such as the exceeding number of students and the difficulty of having access to patients in clinical sites.

The reform at undergraduate level is well established, it has a national impact, TSMU being the only school of medicine in Tajikistan. The first 4 years of the curriculum have been changed with a significant reduction of hours and focusing more on the necessary knowledge future doctors need to acquire. These changes in curriculum need to be regularly

reviewed, evaluated and adapted, but the ground work has been done and the project activities can concentrate more on the clinical years (Y4-Y6).

The Medical Education reform Project benefits from a strong leadership and support from the TSMU Rector. The head of the working group is a dynamic and very energetic professor of surgery who works closely with the Rector. The curriculum has been revisited with priority given to meet primary care competencies development. During phase 1 of the MEP project, teaching clinical skills was introduced early in the program, starting with communication skills and a clinical skills lab was established. Strengthening the teaching capacity in clinical skills is a strong asset of this reform and should continue to be implemented. While many interventions of the MEP are conducted on a pilot basis, the TSMU reform has a global national impact.

Gaining clinical competencies at under-graduate level

Under-graduate medical education is characterized by 6 years of studies. These include 3 pre-clinical years and 3 clinical years. During these last 3 years medical students will develop clinical competencies and skills, by having contacts with patients. Gaining access to patients is a bottleneck that all training institutions face. This is the main reason why the number of students has to be limited according to the size of available clinical sites. If not, as it is in Tajikistan and Kyrgyzstan, students end their studies with very limited clinical experience. Some clinical skills can be acquired with mannequins in clinical labs and simulation centers. However this doesn't replace the full contacts and experience gained with real life patients.

Access to clinical sites (mainly hospitals) to see patients remains a major challenge for medical schools. There is no more formal coordination with hospitals and often no more paid dual professorial positions for professors working in hospitals and teaching at the university, as it used to be during the Soviet time and is now in European countries. Schools of medicine need to negotiate with the hospitals to reach agreements of collaboration. The situation is less critical in Tajikistan, where there is only one school of medicine. In Kyrgyzstan, there are 6 medical schools, all competing for the limited number of clinical sites, with no coordination nor planning on the number of students to be trained in relation to the capacity of clinical sites to train them.

Key point: Access to patients to gain clinical experience remains a major challenge. Clinical skills lab cannot replace the experience with real patients. Number of students should be reduced and the selection process more strict. The affiliation conditions with clinical sites should be reviewed. These are major political decisions which need to be taken by the MOHSP. The project with its partners can provide some technical proposal, but the government needs to act accordingly.

The continuity in medical education: the need for better planning between pre- and post-graduate training

Many faculty members agree that there are too many medical students, but no one knows how many should be accepted and trained to fill the available positions in the health care system. The situation is much more critical in Kyrgyzstan, due to the number of medical schools. Because of insufficient governmental subsidies and to survive financially, TSMU and Kyrgyz schools of medicine accept too many students, the majority paying tuitions (contract students). According to the Rector, this income represents 75% of the TSMU's budget in

Dushanbe. This has many consequences: not sufficient access to patients to gain clinical experience, double standard in training among students paying stations (contract) or those benefiting from state grants (budget), those paying may have better access and better training, not enough post-graduate training positions, many young interns with no future after 6 years of medical studies, not to mention the waste of financial expenditure. The Rector assured us that the number of students should not increase and will remain around 900 -1000 per year in the faculty of general medicine. He is also working hard at maintaining equitable access to quality of training for all students being on contract or benefiting from public grants.

Key point: policy dialogue needs to be established at higher level (MoHSP) to coordinate much more tightly the planning and the development of human resources in the medical field. How many doctors should be trained every year at primary care level and as specialists? How many students can be accepted every year to respond to the needs of the country? The continuity between the pre- and post-graduate levels needs to be established and planned accordingly. One way of reducing the number of students and meeting the financial needs of TSMU would be to increase tuition fees and offer 20% of student positions with governmental study grants, targeting in priority candidates from rural areas.

Faculty development program and improvement of the teaching of clinical skills

One of the strong points of the MEP is to strengthen the teaching capacity of the faculty of TSMU, particularly in the area of clinical skills development, a key area in medicine. The Calgary consultants have organized over the years several clinical skills training seminars and workshops for the faculty responsible for clinical skills training. They had the opportunity to observe small group teaching sessions “practicals” and bedside teaching in several departments. They have observed much improvement. The peer review team was told on several occasions by different faculty members how these workshops were much appreciated and have raised much enthusiasm among them, facilitating the acceptance of the reform. Recently a continuing training unit (ToT) has been established at TSMU for its faculty members. This should help provide long term development of the initial efforts provided by the Calgary University consultants.

Key point: The contribution of the project has been critical in identifying training needs for faculty members. By strengthening their teaching capacity it has played a key role in facilitating the reform and showing the benefit of the curriculum changes. It will also have some impact in Kyrgyzstan**.** The experience gained and reported during the peer review has convinced the consultant Louis Loutan that similar training activities should be developed in Kyrgyzstan. Following the review, discussions took place in KGZ with faculty members at KSMA raising much interest in mastering these interactive methods of teaching to be implemented soon.

Promoting GP/FM at pre-graduate level

Family medicine is not perceived as a very attractive specialty. There are many reasons to that: broad field of activities, second rank status of doctors, confusion between fully trained FM doctors and doctors with only one year *internatura* training, poor working conditions in rural areas, etc. In the academic cycles, the concept of *family medicine* is not understood as a proper specialty, it is also perceived as being imported from outside since many projects more or less imposed it. The concept of *general practice* would be much more recognized and accepted. In Kyrgyzstan, in order to avoid institution blockage, primary care doctors are

now referred as GP/FM. The promotion of GP/FM needs to start at pre-graduate level. It is the case at TSMU as the curriculum has been revised towards this objective. In KGZ in year one a full course is given around "patient, disease and society". This is not sufficient and all along the pre-grad training 6 years reference and illustration of GP/FM need to be done both in courses and by exposing students to FM practice. This could be done by inviting GP/FM practitioners to give course and case studies presentations and having also the possibility for students to work in FM centers. But more important is establishing a policy and a strategy which gives priority to GP/FM positions over the specialties. These are major political decisions the MoHSP needs to make, which are beyond the project responsibilities.

Key point: The curriculum has been reformed with a special focus on meeting the training needs of primary care providers. Students should be regularly exposed to FM practice during their entire 6 years under-graduate medical education to become familiar with GP/FM practice. But, without a clear policy to give priority to GP/FM, the promotion of GP/FM will remain very difficult. A national debate needs to take place, which should also include nurses. This is the responsibility of the MoHSP.

The need for decentralization of clinical training

Currently most if not all of the training during the clinical years (Y4-Y6) takes place in the capital city Dushanbe. As a consequence students do not have sufficient access to patients. The situation is very similar, even worse due to the higher number of students in Bishkek. This also means that during the 6 years of the medical studies students do not work in a more rural environment. No wonder that they all want to practice in the capital city at the end, thus participating to the chronic lack of medical professionals in rural areas. Decentralization of clinical training is a necessity and has several advantages. First students would have much more access to patients and gain more clinical experience. Second, they would develop contacts with local health facilities and their staff, facilitating post-graduate training in the facility after graduation. Third, this would allow for students coming from these regions to maintain regular contacts with their region of origin and encourage them to return and practice there. TSMU should establish a network of collaborating clinical sites in all regions (oblasts and rayons) with working agreements and supervision mechanisms developed to be able to send a substantial number of students during their clinical years. The Rector plans to send to their regions' hospitals 6th years students for 10 months.

In Kyrgyzstan, KSMA has already started to send students in oblast hospitals for their summer internships. A survey is underway to compare the students' satisfaction and clinical experience gained in Bishkek hospitals vs oblast hospitals. TSMU is planning similar exchanges.

Key point: As TSMU is planning Y6, as a year of full clinical experience, decentralized internships should be encouraged. As early as possible students should spend some time in regional hospitals and RHC during their studies, certainly during the last three clinical years. Monitoring and supervision mechanisms need to be developed, possibly using much more the capacity of the local hospitals' staff.

Selecting students from rural regions

In both KGZ and Tajikistan newly formed doctors stay in the capital city, thus aggravating the imbalance between cities and rural areas, which remain underserved with an aging doctors' population. There is no easy solution to this long lasting problem. Tajikistan has established quotas of students from rural areas, but they are not fully filled and implemented. As the

average level of education is lower, upgrading courses or even a full year of extra education may be needed. Mechanisms need to be developed to encourage candidates from rural areas. These could include local municipalities which may provide financial support to candidates to pay for their studies providing the come back to their province of origin. Contract should be signed accordingly. Regular contacts with their home region should be maintained during the 6 years of medical school working in the local hospitals and RHC. As project Sino and the Aga Khan are actively working with local health services, testing innovative programs should be implemented with MEP.
Key point: To increase the number of doctors working in rural areas, more candidates need to be selected from these regions. Different mechanisms and synergies need to be developed and close contacts with their home region during their medical education need to be maintained.

3.3 Post-graduate medical education – PUST

PUST is gaining very valuable field experience in Post Graduate Medical Education (PGME) and residents gain clinical skills.
In 2013 PUST started a pilot program in PGME in Family Medicine for 20 residents. In 2014, 32 new residents started this two year residency program. It is fully implemented in ambulatory settings, in rural health centers and in policlinics. In doing so, young residents are immediately immerged in the reality of family medicine practice. Local tutors have been trained to supervise one or two young residents. This contributes to increase the competences of the local staff. They work in the local RHC 4 out 5 days a week and have a day of training provided by PGMI. Facilitators and residents get some financial incentives provided by the project. Residents interviewed and the 2014 survey conducted by MEP shows that 93% of the residents rate the learning environment good or excellent. Currently this program is implemented in 12 different locations, mainly where project Sino is active. Compared to the present one year *internatura* post-graduate training, PUST provides full access to patients to gain clinical competencies and skills under close supervision for two years. This is certainly a great improvement in comparison to the present system where interns are given limited clinical responsibilities, this being the case both in Tajikistan and Kyrgyzstan. Another important point is that training is provided by Tajik institutions (PGMI and local physicians) with the financial support of the project. In doing so PUST contributes to build the local training capacity.
Key point: Gaining field experience is very important for the project. It allows identifying the strength and weaknesses of FM training in rural areas in ambulatory setting (RHC). MEP is documenting the experience gained which will be very useful in the design of a full scaling up of FM training and a national strategy.

Building on the PUST innovative approach to post-graduate medical training
The approach of PGME training in family medicine is very innovative: two years basic clinical practice training, fully ambulatory, field based, in RHC with daily supervision by the retrained local staff, residents in charge of patients, reinforcing RHC capacity and visibility. Several questions arise though: To what extent this model can be deployed in the whole country and should become the standard? Should other specialties follow a similar model or is FM training format unique? Who should be in charge of PGME in Tajikistan: PGMI, RCFM, TSMU, the hospitals? What role for the medical associations? Who should pay for PGME? These are some of the urgent questions to be answered.

Of course, there are no easy answers to these questions. A debate needs to take place soon so when the new generation of students comes out of TSMU in two years, a new PGME strategy is in place. MoHSP and the other stakeholders need to agree on what PGME will be in Tajikistan. Is PUST the model of PGME the country wants to adopt for family medicine? Should the training be only ambulatory or a combination of hospital and RHC based training should be developed? In Kyrgyzstan, the model the strategy proposes is based on one year in hospital followed by one year in an ambulatory facility (Family Medicine Center). The combination of one year in-patients and one year out-patient training gives more flexibility and facilitates the acquisition of competencies in difference domains such as basic surgery, pediatrics, internal medicine and obstetrics. It may also facilitate the understanding of the continuity of care. The competencies to be acquired are not defined yet, the learning objectives, the rotation in different services, the supervision modalities and monitoring of progress need to be defined. This is where the PUST experience is very valuable.

Key point: PUST provides a wealth of experience which needs to be documented. It should trigger now a national debate around PGME and explore how its model can be expanded or modified to fit the national needs.

Develop a comprehensive PGME-CME strategy for Tajikistan

While the under-graduate medical education reform is well underway, it is unclear how the PGME will be implemented. PUST is providing very interesting results, but the vast majority of interns still have only one year *internatura* of PGME. This year of training has no standardized content and format defined and provides a very uneven set of competencies depending on where the training has taken place. Many colleagues interviewed agree that one year training is insufficient to gain basic clinical competencies. PUST provides an opportunity to test how much competencies can be gained in two years of ambulatory clinical training, the capacity of local staff regarding supervision, the necessary upgrading of the facilitators, etc. The strategy to be developed under the auspices of the MoHSP should define who are the stakeholders involved, their responsibilities, the accreditation of the training institutions, thereby assuring full independence of a future accredidation agency, the length of basic training, the competencies to be gained, the educational standards, the financial and organizational aspects of the PGME, the supervision and monitoring of the training, the final examination process, etc. The World Federation of Medical Education provides very useful guidelines to establish such a strategy (also in Russian). A PGME-CME strategy has been elaborated in Kyrgyzstan and needs to be approved, with two postgraduate years of basic training. The experience gained in this development could be shared with colleagues in Tajikistan. KRZ colleagues would gain also very much from the ongoing PUST experience.

Key point: Developing a national strategy will help all the stakeholders active in the field to define more clearly their competencies and responsibilities and design a PGME vision to which everyone needs to adhere. If this is not done soon, there will continue to be different types of basic training, different qualifications of general practitioners or FM doctors, some with two years well supervised training, some only one year *internatura* leading to more confusion within the professional circles and in the population, discrediting even more family medicine/general practice. The MoHSP should convene soon a working group, with MEP participation/support to develop this strategy.

Towards the development of an effective and rewarding PGME environment for interns and residents

Most human resources positions in the health system are long term. Doctors and nurses are employed for many years, for all their professional life. Hospitals and RHC have very few short term positions to hire young interns or residents for one or two years to gain experience and being paid for their work. As they contribute to the income of the medical facility by seeing patients, they should be paid. In oblast or rayons' hospitals, and RHC there are vacancies which often are not declared. These financial resources made available by these vacancies could be used to pay young interns and residents, unless extra financial means are available by the MoHSP.

Key point: Most interns and residents do not have a salary while working in hospitals or RHC. Giving access to patients and being responsible for them under supervision is essential to train competent clinicians. Ways need to be found to develop paid post-graduate training positions.

3.4 Retraining and continuing medical education, including family nursing

MEP is actively involved in strengthening the CME & L

MEP has significantly contributed to the revision of the 6 months training programs for family medicine doctors and nurses. The training programs in both CME institutions (PGMI and RCFM) have been harmonized. These programs are quite dynamic, combining formal training to gain knowledge with clinical practice at the local policlinics. This harmonization of the curriculum, more oriented towards NCD management in family medicine, is a progress and provides a more standardized approach at national level. Retraining of doctors in FM/GP will have to continue for many years to upgrade practicing doctors' knowledge and skills. This should also translate into an increase in salary. MEP also contributed to the retraining of PGMI and RCFM trainers. It is important to strengthen the training capacity of these two institutions, as they will remain key actors in CME. No doubt the medical associations should become more involved in PGME and CME, but it will take a long time until they gain sufficient resources to play an important role.

Key point: Strengthening and diversifying PGMI and RCFM capacity is important. The offer of CME courses and trainings needs to be widened, including peer review groups. Other stakeholders should also become involved: associations, hospitals, RHC

To develop a CME&L strategy integrating new forms of professional development

As for PGME, there is a need for developing a national strategy on CME. The needs of the Tajik population are evolving, the practice of medicine, the diagnostic and therapeutic means are changing and doctors need to update their knowledge and skills regularly. CME training courses done every 4 to 5 years are useful but respond only partly to new needs. A more integrated approach of CME, becoming part of weekly activities, needs to be developed. Part of the training could be provided by the traditional actors (PGME, RCFM) in organizing short courses on specific topics, particularly in the field of NCD management, but some should be provided on site, at local hospitals and RHC. E-learning is also coming and on line programs could be developed facilitating the access to training and upgrading skills of practitioners locally. PGMI and RCFM have gained a lot of experience in CME. They should continue to contribute in the development of this field by diversifying more the training options offered. On-line interactive courses are certainly a promising area. More coordination between the two competing institutions should be encouraged. Each could

develop also some unique specificities and offer more focused expertise and services. In Kyrgyzstan, there is only one CME centre (KSMIRCME). This simplifies the coordination and contacts.

Local health facilities can also provide seminars, case presentations and workshops for the local practitioners being working at the local hospitals or RHC. Experts from the capital city could be invited, but most of the work could be organized locally, reinforcing also the local capacity. These types of CME activities also participate in creating links between the various actors of the local medical sector and facilitating their interactions in the management of cases. In the development of these new approaches of integrated CME, incentives and an accreditation system needs to be put in place.
Key point: CME will play an increasing role in upgrading the qualifications of practicing doctors to meet the new standards of FM/GP practice. It should diversify and part of it should become much more integrated and provided locally, closer to the doctor's practice.

Peer review groups.
Project SINO and MEP have developed over the years a very valuable experience in organizing peer review groups, under the guidance of Prof Galeazzi. Very high coverage/enrolment of family doctors and nurses in the rayons covered by the project has been achieved. The review team has attended three sessions, which illustrated the real value of such groups of discussion. These sessions were very lively, all participants sharing their ideas and opinion on the cases presented and discussed. These create solidarity and allow practitioners to share their practical experience. It breaks isolation and helps practitioners to discuss together about their problems. It is valuable and provides some on site activities. The peer group leaders, who had benefited from a training course were both excellent. Up to now the project provides funding to cover transportation costs.

So far, the peer-review groups have been organized independently from the traditional CME channels, i.e. PGMI and RCFM. Both institutions do not recognize the concept as valid. Is it because they perceived it as replacing or competing with the traditional training courses? As a consequence, PRG are not recognized as CME. This should not be. It is complementary to other forms of CME (courses, conferences, workshops, seminars, etc) and are not replacing them. A possible way to break this odd feeling could be to empower PGMI and RCFM and train their staff to teach doctors how to organize peer review groups.
Key point: Peer review should become a recognized type of CME. This means involving more the local stakeholders in CME such as PGMI, RCFM, medical associations.

Clinical mentoring
Twice a year, 4 doctors from the Swiss Family Medicine Association conduct a 3 weeks mission to train local mentors in districts and at RCFM. The team met some of these doctors who had benefited from this clinical mentoring. They really appreciate it and the fact that Swiss doctors come to visit them gives them credit and enhances their reputation. No doubt this type of onsite support and training is new and very valuable. It is a type of peer to peer exchange of problems and practice which has its value. Obviously, the Swiss doctors involved are very committed and provide respect and motivation of their local colleagues. For doctors working in remote areas this is invaluable and provides recognition of the work they do. At this stage it is not clear to what extend trained Tajik colleagues can provide the same

services and how such decentralized training can be maintained and further developed at national level. Should it continue to be part of the MEP or should the Swiss and Tajik societies of FM develop an independent partnership are areas to be explored.
Key point: Valuable and positive experience, but seems difficult to maintain and expand to the rest of the country. Explore possibilities of training of trainers locally at PGMI or RCFM.

Promoting CME and its accreditation. The role of medical associations
Promoting CME is a priority, if we want to continuously upgrade the doctors' competencies and knowledge. It implies finding incentives and rewarding those who make the effort to train and improve the quality of practice. Accreditation mechanisms developed should much more work as incentives to upgrade knowledge and skills than at sanctioning doctors who do not comply. The strategy should establish rules and mechanisms of accreditation, being voluntary then becoming mandatory. Accreditation rules should be created, defining the number of certified credit-hours each medical doctor needs to collect every year and how these should be gained and recognized. Collecting credit-hours should also lead to formal recognition of the efforts made, either to maintain the physician certification to practice and/or to upgrade his salary. The process of accreditation should remain under the MoHSP authority, which can delegate some responsibilities to the associations and/or CME institutions.

Internationally, medical associations are responsible for providing quality control of CME training proposed to their affiliated members. They review the conference or seminar programs and decide how many credit hours are recognized and delivered. In most countries however, CME institutions such as PGMI or RCFM, do not exist. In Tajikistan these institutions continue to play an important role and provide competencies which should be used. The CME strategy could propose a combined approach, strengthening the role and responsibilities of associations in CME and linking them with PGMI and RCFM. The specialty associations can provide the expertise in their field and the two institutions could provide the administrative and logistical support for the accreditation. This process is underway in Kyrgyzstan.

Medical associations exist in Tajikistan, but do not have a strong membership base, have limited resources and are not yet recognized as important partners by the MoHSP. Defining the role of associations in post-graduate and CME is a process which should be encouraged and implemented rapidly. Professional associations by definition have the expertise in their specific field. When given responsibilities and authority they can become very important and useful partners for the MoHSP and governmental services. They represent their constituencies, a large number of doctors, they can promote quality within their members, establish codes of ethics to be respected by their members, promote good practice and regular upgrading of their members' competencies. Strengthening associations' role is also a way to broaden the base for decision making in the medical and health sector.
Key point: CME in place in Tajikistan needs to be revisited, further developed and diversified. An accreditation system should be established and the role of new stakeholders such as medical associations and hospitals explored.

E-learning and telemedicine.

In a country like Tajikistan where transportation may be expensive and time consuming for those living and working in remote areas, e-learning and telemedicine offer an attractive way of maintaining professional contacts and giving access to training. While telemedicine with distance consultations may be very attractive and much needed for those practicing far away from medical centers, it is not so easy to develop, the main limiting factor being the availability of the experts in the reference hospitals. At this point in time reliable access to the internet is not be available everywhere, but it is expanding and should continue to improve. To establish a well-functioning system needs a well-organized network with resources to compensate the experts and well-trained providers. It is easier to start with a distance-learning program which provides access to on line training courses, which are validated and can count as credit-hours in CME. PGMI and RCFM could develop such capacity and technical expertise, which would be very complementary to the CME and retraining courses they run presently. RCFM and TSMU are currently involved in such development with some Central Asian partners. KSMIRCME has already a significant experience in this field which is developing rapidly. Training courses for the teachers designing on line courses are available in Kyrgyzstan.

By developing such connections between central Dushanbe based institutions and the periphery, some aspects of regular supervision at distance with weekly courses and interactions could be worked out for medical students and young interns doing a residency in oblast or rayon hospitals and RHC. This would significantly reduce transportation time and fees for the supervisors and/or the interns and still allowing for regular contacts and monitoring knowledge and skills acquisition. The MEP could already explore such means of communication on a pilot basis with the PUST sites.
Key point: e-learning is a very useful tool in training and teaching which could prove very cost-effective in Tajikistan, where practitioners are located far away from learning centers. Pilot testing the use of e-learning where PUST is active would be very valuable. Key CME providers should be actively involved in the process.

The Family Nursing (FN) concept is being developed and implemented
The MEP main goal is to contribute actively to the medical education reform to strengthen PHC in Tajikistan, family medicine in particular. Reinforcing the role of nurses in the health system is of prime importance at a time where NCDs represent an increasing burden, as the management of chronic diseases mobilizes different health professionals. Doctors and nurses are bound to work together, having shared and coordinated responsibilities to meet the patients' needs. This implies major changes in both professions' cultures and practices. MEP addresses some of these changes in outcome 3, by providing support and training for nurses as part of the project activities in continuing medical education. MEP has not the mandate to reform the nursing system in Tajikistan. Most of the efforts of MEP concentrate on the reform for doctors.

Today, MEP is active in family medicine nursing in 6 districts of the country. Over the past years 305 FN were retrained, 60 in MEP II, as well as nurse tutors. The retention rate of retrained nurses in the districts remains high at 96%. At the end of training they are supplied with a medical bag and a book on nursing is provided. A total of 15 peer review groups have been created for nurses, representing 71% of nurses retrained FN. Overall, medical colleges

train some 600 FN per year and PGMI retrains on average 31 nurses in FN per year (FN training approach report, 2013).

MEP has been actively supporting the development of a 4th year FM specialty training in medical colleges, revising the retraining curriculum giving more importance to FM and NCD priorities. It also provides financial support to the retraining of nurses and the training of trainers. MEP provides support to medical colleges in Dushanbe and Kulob by renovating FM buildings in Kulob and providing books to students in MEP pilot districts. ToT for nurse trainers has started in October 2014.

Retraining of FNs

The quality of retraining has improved with the revision of the 6-months retraining programs run by PGMI and RCFM, although both programs do not match completely (2013 report). A total of 60 nurses have been retrained in FN. MEP provided some support to review the curriculum. The training adresses better current health needs of population, by improved teaching through adult learning skills training. This allowed also to expand its activities in new pilot districts Rudaki and Faizabad.

On several occasions doctors interviewed mentioned the growing role of nurses, particularly those who had been retrained in FM. Some then sent nurses to be retrained to increase their competencies and knowledge to help them as partners (Hamadoni RHC). Doctors discover the benefits of working closely ("tandems") with nurses (Peer review group of doctors in Hamadoni). Without FN retraining they were having difficulties to understand the concepts of FN and putting them into practice. This illustrates the need for combining the re/training of both professionnals in the field. Actually developping a joint doctors-nurses retraining course where both interact together would make a lot of sense. This had been implemented more than 10 years ago in Bosnia& Herzegovina to develop FM teams.

A fourth year in FN to strengthen nurses' training is a positive step towards the development of FM.

Since 2006 an optional 4th year of training in family medicine is taught in medical colleges, being offered after the 3 initial years of basic nurse training. This allows rolling out FN on a large scale. At the moment this fourth year FN training is offered in some of the 15 medical colleges (nursing schools), with an average of 600 FN trained per year. The curriculum of this 4th year could not be reviewed, existing only in Tajik language. This analysis would be useful to further improve its content and format. The 2013 report mentioned that communication and computer skills could be improved and that some of the training did not meet the needs of FN practice in rural areas. Less in class teaching and more exposure to field practice conditions by more in-service training could be developed to better prepare FN to their future profession. It would also strengthen the links between the schools and the RHC allowing for more interaction and more adapted training. Internships in rural facilities need to be developed.

An evaluation of the retraining courses and of the 4th year outcomes among the recently trained FN would give first hand information on the strengths and weaknesses of the FM training in Tajikistan. The evaluation should also be done among the teachers. This would

help improving the FN training in the future and suggest areas of development and support for a MEP III phase.

Most important also would be to review the basic 3 years of nursing training, looking at how much is already taught on family health and NCD management, on hospital based practice compared to ambulatory RHC based practice, and on developing a team work approach of medical care and defining new responsibilities for nurses. Introducing and including the concepts and some of the practice of FN during the basic 3 years certainly needs to be developed. This maybe beyond MEP II scope of work now, but certainly needs to be addressed for the development of FM.
Key point: An evaluation of the retraining courses outcomes and to the 4th year in FN among the re/trained nurses would help to identify what needs to be improved in their content and format. Strengthening the teaching capacity of trainers needs to continue and be reinforced. Giving more importance to FM and NCD management skills during the first basic 3 years of nurses' training would be welcome. Propose combined doctors and nurses courses to develop team work approach to chronic diseases management is needed.

Strengthening inter-professional collaboration
While the task shifting terminology gives the wrong feeling of doctors delegating to nurses and other professionals what they don't want to do, inter-professional collaboration reflects more what needs to be developed: working together, each having its roles and defined responsibilities in the management of patients and responding to his/her needs. This is a change in the professional culture of both doctors and nurses. It takes time and needs to be implemented by a step by step approach. Guidelines and protocols are being developed for chronic diseases. They offer a unique opportunity to put doctors and nurses together and define each others' roles. As chronic diseases imply long term care and continuity of care, both doctors and nurses have to work together. This is a simple and pragmatic way of developing this partnership. AKHS is leading the protocols development working group. It should push for such a joint inter-professional approach. More joint doctor-nurses discussion around case presentation and management in RHCs should be proposed. During the PRGs run by doctors and nurses the team observed, participants were asked if joint PRG sessions could be organized. Nurses were feeling uncomfortable with the proposal and expressed the need for keeping their own groups. Doctors were ready to try it. This should be discussed further and could be organized independently from PRGs as joint cases discussion where both parties come with their views.
Key point: develop inter-professional collaboration around protocols and guidelines and at local facilities around chronic diseases case management. Competencies have to be identified and acquired by both doctors and nurses. This will allow gaining practical experience to be then conveyed at central level and ultimately in a comprehensive strategy around nursing in the health care system.

Family Nursing challenges and opportunities
These are not within the scope of the MEP II phase. These are areas which need to be developed in the medium to the longer term. They are still worth mentioning as they condition very much the development of a stronger FN.

More in-service, in-the-field training and supervision of FN students and trained FN in the field. As most of FN activities take place out of hospitals in RHC and in the communities, it is essential that the training reflects this reality of practice. A general difficulty in nurse training is the focus in in-class training, at the expense of in-service or clinical based training. On top of that hospital-based clinical training is easier compared to clinical training in rural outpatient settings where transportation and accommodation, absence of supervisors, difficulties in communication may be a problem. The profiles of patients seen in hospitals, the organizational and hierarchical structures, the roles of nurses and the required activities are quite different from ambulatory practice in RHC and health promotion activities in the communities. To develop FN, not only an in depth revision of the curriculum needs to be done, but the format and the organization of the overall training needs to be revisited. As for doctors and what PUST is currently implementing in some districts, the on- site training and supervision of FN students and FN in practice need to be developed. To what extent the MEP II can explore already some possible avenues would be helpful for the design of a next phase remains to be seen, but should be encouraged.
Key point: Nurses' training should have more in-service and field based practice to develop clinical and patient management skills.

Set up an internship program for FN (yr 4) in rural health facilities
To build a case for nurse-based PHC, the essential link is to combine the class-room teaching with field-work. To do this, there will be a need for special programs addressing the clinical preceptorship, with regular exposure of students to the field reality. This will also be a way to value to long experience of PHC clinicians (nurses and feldshers, as witnessed in Hamadoni), and to ensure that field experience can contribute to new FM concepts.
It is not clear if such field internship can be organized and tested during this phase of the project at a pilot stage. This needs to be explored by the MEP team. One pragmatic way could be to progressively and selectively include nurses in some of the PUST training process both in the RHCs and at PGMI. Because at the end, what is proposed is very similar to the doctors' training in FM, combining field clinical experience and in-class training. MEP has the opportunity to include nurses in some of the activities already underway.

Investing in training capacities of nurses needed
Currently most teachers in medical colleges (nursing schools) are doctors. Very few are nurse teachers. This needs to evolve over time and building up a nurse teacher workforce is a necessity. Since the core activities between nursing and medicine are quite different, nurses with training and practice need to become the trainers to relay properly the specificities and competencies nurses need to acquire. There will be a transition phase during which doctors will still be needed as teachers, but progressively nurse teachers should become in charge. In the long run a defined training curriculum and professional standards should be developed to become a fully recognized nurse teacher. To keep FN high on the agenda of training, a significant number of FN trained teachers should be part of the faculty of medical colleges and not only hospital trained nurses. In the shorter run, as MEP is promoting the training of nurse teachers at PGMI and in medical colleges, the experience gained can be very useful. Information should be collected on what needs to be done, what are the needs, the difficulties and the opportunities. Again this would help and give suggestions for the next phase potential activities.

Key point: Nursing has specificities and these need to be taught and acquired. Building teaching capacity in nursing with developing a whole core of nurse professors is required.

Focusing on Chronic Diseases Management

Most concepts of FN (communication, continuity of care, collaboration with doctors, etc.) can be introduced by chronic diseases management such as diabetes or hypertension. This is the best way to convince the actors of the health system, doctors included, that responding to the needs of patients with chronic diseases requires the collaboration of all and a diversification in health care provision. Doctors are no longer the sole actor in charge. They need to work with nurses, physiotherapists, pharmacists, social workers, the family and the community. Inter-professional collaboration becomes a necessity and progressively all actors see the added value of working together. The Chronic Care Model has been found to be an adequate answer to address the epidemic of NCDs. This shift in priorities in the nursing and also doctors professions need to be reflected in the training curriculum and the competencies to be developed. Again, the team could not review the curriculum of both the 4th year and the retraining courses. This should be done by the MEP team with the local partners to already see what can be done now to improve its content and format. Simultaneously in RHC where MEP and project Sino works testing ways of inter-professional collaboration around specific chronic diseases management could be achieved. The project could start with hypertension and diabetes, reviewing the existing guidelines and protocols and discussing them with the RHC staff, including nurses to develop simplified and pragmatic approaches of case management. This could lead later to the development of a broader strategy at national level.

Key point: Nurses play a key role in the management of chronic diseases. FN need to be trained accordingly and gain experience competencies in inter-professional collaboration. Clinical protocols and guidelines offer a unique opportunity to include a nurses' dimension.

Reinforcing the status of FN professionals

Family nurses need to be recognized, gain a defined status and benefit from them with an increase in salary and recognized responsibilities. This is a long term goal. In the short term, MEP can explore how legally FN retraining and 4th year FN training are financially rewarded and how the FN association can play an increasing role in promoting FN in Tajikistan. Currently the nurses' association is a joint association of doctors and nurses in family medicine, the president being the head of PGMI. Are the nurses' specificities and interests well represented? An independent nurses' association with specific roles and responsibilities delegated by the MoHSP, could give them a stronger voice in the family medicine debate. MEP can explore further what can be done.

Key point: As the role and responsibilities of nurses increase, their status should be much more recognized. Nurses' professional associations need to be developed and strengthened.

Here are some recommendations which can be implemented this year and which would help the design of this component of the next phase:

1. FN is an essential component of family medicine development. It needs to remain part of the MEP mandate, although there are limited resources dedicated to in this phase. This component should be increased in the next phase. In the meantime, strengthen the nurse training coordinator position within the MEP II, providing some resource person in nursing from a Swiss or international nursing institution to help build up the nursing arm

in areas suggested in the chapter. Consider organizing a workshop on FN by the end of the year to identify with partners priority areas to be developed in the future.
2. Evaluate the outcomes of the retraining and 4th year training among FN trainees after 6 months of post training practice by conducting a survey .
3. Document activities initiated by MEP in the area of CME&L for family nurses (PRG) and explore others to be conducted at RHC (short courses, joint doctors-nurses case discussion, etc).
4. Continue to strengthen the 4th year specialty training program in FMN: review of curriculum on NCD management, develop more interactive formats, in-service training and field based training.
5. Evaluate the 6 months re-training program in FMN: strengthen content on NCD management, in-service training, inter-professional sessions included, PGMI and RCFM equivalent program, develop shorter more specific courses
6. Develop more training of trainers courses for FN teachers: identify the key priority areas teachers should be trained for: mastering interactive teaching skills, NCD management, inter-professional
7. Select two clinical protocols/guidelines and develop with a working group the FN component. Take diabetes and hypertension as starting point. The exercise should promote inter-professional collaboration, meaning that at some stage nurses and doctors should work together to create it. From there examine all project activities where inter-professional doctors-nurses interactions can be developed and implemented (pre-, post-graduate/PUST and CME) to identify possible initiatives.
8. Explore what role of nurses' professional association should play in FN CME and training and how to reinforce it.

3.4 Policy dialogue

The MEP is involved in all three phases of medical education: pre- and post-graduate education and Continuing Medical Education. This gives the project a comprehensive overview of the reform process and access to all stakeholders. MEP has been quite successful in developing close contacts with the main partners, at all levels from decision makers to practitioners in the field. Through regular meetings with individual partners and working groups it keeps them informed on progress and problems waiting for a solution. Critical issues such as the excessive number of students compared to the training capacity, the lack of sufficient public funding at TSMU and other medical institutions or the absence of a real political and financial commitment to develop family medicine with the proper incentives, have been raised and are being raised regularly at MoHSP level and to donors at the Joint Annual Review, with little impact. The policy dialogue exists but is not very effective. It is quite effective at the technical level to change the curriculum and reform the pre-graduate education thanks to the strong leadership of the Rector and its team. PUST gets the green light to implement an innovative post-graduate program and the project can strengthen the PGMI and RCFM capacity for CME. Clearly the MoHSP has very little strategic vision on the reform and demonstrates no leadership power, both technically and politically as if the real decision makers are located in other ministries such as the Ministry of Finances or at the Presidency. For many years efforts have been done by several donors to improve the MoHSP capacity, with little success. The Health Policy Analysis Unit created to this effect has not been able to make a difference. One can only suggest that the SDC local office and other donors should coordinate more their interventions and explore other channels of

communication with the government to increase the political commitment in the health sector. In Kyrgyzstan, having a SWAP facilitates the coordination of interventions, the creation of a health sector reform strategy and its implementation.

The health policy analysis unit at the MoHSP should be strongly encouraged and supported to play its role in providing data on the country's needs in human resources development for the coming years. So far, it is not concentrating on the key priority questions and has no clear vision on its role. Technical support to the unit is needed to collect the data and conduct operational research for planning the reform according to needs. MEP and other stakeholders involved in the health sector should coordinate their efforts to strengthen the unit capacity.

Broadening the vision of the reform and creating a strategy

MEP I and II have gained a wealth of experience gained with partners at all along the continuum of medical education, from under-graduate to post-graduate and continuous medical education. Some of its activities are more focused on pilot activities, some have a more national impact, such as the reform at undergraduate level. Partner institutions welcome further involvement of MEP-SDC support.

The challenge now is how can all these initiatives and reforms be put into a coherent global continuum of the medical education with a common vision, integrating the pre-, post-graduate and CME dimensions. Under the leadership of the MoHSP, it is time now to put all stakeholders together to design this vision and strategy. If not done the country will have to continue to face multiple types of trainings and re-trainings with no clear job descriptions and mandates given to each institution involved, leading to undue competition and confusion. Soon there will be FM doctors with two years training (PUST) with others having only one year *internatura* and others with 6 months retraining, all having more or less the same title and responsibilities, but very different skills and competencies. GP/FM expertise and competencies need to be defined and the needed training programs certified.

In between now and the time when the new generation of students having been trained with the new curriculum (fall 2017) a comprehensive strategy on postgraduate education and CME should be created and implemented. MEP should play a key role in facilitating this process with all the key stakeholders, under the authority of the MoHSP. This will have to combine policy and technical dialogue approaches. The creation of a working group with MEP participation bringing its rich experience and providing the necessary support to get the agenda moving would be very valuable. The role and responsibilities of each organization need to be defined, the number of years of minimum basic training has to be defined to obtain a certificate of GP doctor. A new PGME training curriculum and training process need to be defined to reach the expected competencies. The role of medical associations in medical education has also to be identified. Who should monitor progress and be in charge of the quality control of the training? There will be a transition phase with newly trained doctors and practicing doctors who need to be retrained to reach similar standards of qualification. is the time to start the process by creating a working group in charge of the design of the strategy. At this stage the MoHSP has no real strategic vision on medical education. The TSMU Rector has a clear vision for undergraduate medical education, but the role of TSMU and other institutions such as PGMI, RCFM, hospitals and medical associations in PGME needs to be clarified.

The promotion of family medicine – general practice

For more than 10 years family medicine has been promoted with full support of external donor agencies. Training, retraining and specialty development of doctors and nurses to become competent FM professionals have been implemented both in Tajikistan and Kyrgyzstan. To some extent, the academic cadre of professionals has never really endorsed the FM concept nor its implementation. In some instance, they have not been involved actively in these initiatives. To many doctors family medicine doesn't correspond to a well defined medical field, while general practice is much more appealing. This has lead to a lack of support and promotion of the field by medical schools. The continuing medical education (CME) institutions (PGMI, RCFM and in Kyrgyzstan KSMIRCME) have played the main role and benefited most from the financial support given by international donors. This was much less the case for TSMU and medical schools in KGZ. As a result, there has been little support provided by the academic institutions. GP/FM needs to be put on the agenda, including the academic world, if the MoHSP wants to develop a strong primary care system.

More than 10 years of FM programs can't be erased that easily, but some solution need to be found to promote the concept of FM/GP, as there is a need to train much more FM/GP to respond to the healthcare needs of the country. This is becoming particularly urgent as the continuity and long term care of patients is critical in the management of patients with NCDs, one of the major causes of morbidity and mortality in the region, adding to the burden of infectious diseases being still quite significant. If general practice is more attractive to the medical profession, a phase of transition could combine the two notion of FM with GP, as one profession. This could reduce the resistance from some influential faculty members to engage in the development of FM/GP. The debate needs to take place to be able to move forward.

Key point: To develop FM/GP in Tajikistan and Kyrgyzstan implies much more commitment and investment than just a medical education reform. First, there should be a clear political decision that the nation needs a much higher proportion of FM/GP doctors. This means that the number of specialists needs to be controlled and reduced and that financing mechanisms have to be developed to favor FM/GP practice. Good initial PGME training to gain clinical competencies has to be created with due recognition of the status. Access to CME is also needed to maintain and continue to develop competencies. Then good working conditions with adequate salaries are implicit. The medical education reform plays an important role, but needs to be accompanied by appropriate health care and policy reforms.

Creating incentives to innovate and promote FM/GP

The medical education reform towards more FM/GP will only be effective if simultaneously there is a reform of the healthcare system promoting FM/GP. The under-graduate reform should "produce" students with better knowledge and skills. These will have higher expectations in the profession and the working conditions. If postgraduate training doesn't bring a higher level of qualification and competencies grained the risk of disillusion and moving away from FM/GP will be high. The team could see the interest and pride of extra training opening up for new skills and knowledge for the physicians and better recognition by the population. However, these efforts should also lead to financial incentives and promotion by the health system. Proper mechanisms of upgrading salaries and retribution according to skills development need to be put in place. This is out of the medical education reform stricto sensu, but absolutely crucial to make it successful and sustainable in the long run.

Key point: In the future the MEP should concentrate much more on the strategic level, and much less on pilot testing activities. A whole list of domains is given in the recommendations chapter. The project needs to use the experience gained in the pilot interventions to translate them into an effective national strategy development. How can PUST be implemented or adapted to other regions where MEP doesn't work and become the national standard basic post-graduate training in family medicine? The discussion can start already now by creating a working group analyzing PUST experience and results to develop recommendations for a national strategy. All stakeholders, including practitioners, should be included in this working groups. MEP should provide technical and financial support to it.

4 Main recommendations

Under-graduate medical reform

4.1 Finalize the under-graduate curriculum reform.

By the end of MEP 2 the 5th year should be underway and year 6 in preparation. Year 6 is fully clinical and should be implemented in a number of hospitals and RHC. It can be seen as a bridge to the PGME years. By then the main goals of the under-graduate reform should have been achieved. MEP 3 should be less involved at under-graduate level. It could continue to provide some support strengthening training competencies, in monitoring and upgrading processes and continue to advocate for FM and inter-professional competency development.

4.2 Reinforce clinical training and strengthen TSMU – hospitals partnership

This is crucial for Y6 but also during the clinical parts of Y4 and Y5. There are technical parts of this implementation (supervision, quality control, definition of competences and skills to be gained, control of skills acquisition) where the future project can provide significant support. There are also policy and political decisions to be made for structural changes with legal and financial implication to link TSMU with hospitals (creation of dual professor positions, financing hospitals for their contribution, legal binding agreements). These are part of the MoHSP and MoE responsibilities. The project could facilitate these developments by providing technical and financial support to the preparation of this new strategy.

4.3 Diminishing the number of students to be more in phase with the training capacity and increase the quality of clinical training

The selection of students should be reinforced at the beginning and at the end of Y1 according to criteria responding to needs and the training capacity of TSMU. The revenue brought by students tuitions should not determine the number of students to be accepted. If no extra funding is provided by public budget, then the tuition should be increased and the number of students reduced. Public funds should provide grants for at least 20% of students who need it. Again this is a political decision to be taken by the MoHSP.

4.4 Reinforcing the implementation of enrolling more students from rural areas

The mechanisms to increase the number of students from rural areas to access medical studies need to be revisited and an effective strategy developed. This is the only way to increase the number of doctors in the region. MEP3 could provide support to this strategy development, though its implementation depends on MoHSP willingness.

Post-graduate medical education

4.5 Need for a comprehensive strategy in PGME and CME

A national PGME program has to be developed defining:

- The number of basic training year 2 to 3 years and moving away from 1 year *internatura*
- The content of these basic training years according to competencies and skills needed at primary care level with a special emphasis on NCD management and inter professional competency development
- What institutions should be in charge of PGME (TSMU, PGMI. RCFM, hospitals, medical associations)?
- Decentralization of PGME to clinical training sites in the regions
- Where should the training take place: in- or/and out-patient health care facilities
- Monitoring the acquisition of skills, examination and certification mechanisms
- Interns and residents responsibilities and remuneration

4.6 Integrating PUST approach into a national PGME strategy

The PUST needs to be integrated into a national PGME strategy. Discussion should be initiated soon to see if it should remain fully based on ambulatory training or should it be modified according to national standards? As part of the PGME strategy development a working group and a national debate should be organized with the support of the MEP.

Continuing medical education and retraining

4.7 Upgrading/ retraining of practicing physicians will continue

Many practitioners have only one year *internatura* post-graduate training. This is insufficient and justifies retraining and upgrading. The MEP should continue to maintain some support to promote access for those who need upgrading their competencies. Retraining could become more focused on NCD management. Retraining will be phased out when all newly trained doctors are in practice

4.8 CME needs to be diversified and decentralized

Currently CME is fully centralized to PGMI and RCFM, with the exception of peer review groups. These need to become accredited and other CME options developed. The PGME-CME strategy should identify other options of CMI, more decentralized and locally implemented. PGMI and RCFM need to diversify also their offer with more short courses, seminars, specialized courses. Local hospitals and RHCs should also offer accredited CME (seminar, conference). E-learning and telemedicine are new tools to be used for CME, connecting the periphery with academic centers.

4.9 Developing an accredited CME system

CME is part of maintaining and upgrading the quality of medical practice. Accreditation of CME is essential to promote it, to encourage practitioners to use it, provided it is relevant and is benefiting practitioners by improving their competencies and their status. CME should become an incentive for practitioners. The CME bodies in charge of CME need to be defined. Currently these are PGMI and REFM. What role given to medical associations, hospitals and FM facilities? This should be defined and developed. In the long run CME should become financially sustainable by asking the practitioners to participate financially.

Family nursing becomes an essential component of family medicine

NCD management implies the involvement of multiple actors around the patient. Nurses are key partners to doctors. Strengthening inter-professional collaboration is essential and could be initiated around the protocols and guidelines development of a selected number of chronic diseases such as diabetes and hypertension. In the next phase MEP should become more involved in developing FN activities by strengthening:

- FN training during the first 3 years of basic nursing education and 4th year FN education with increased in-service and internship training in rural facilities
- Retraining and CME in FN to upgrade competencies of practicing nurses. The current 6 months retraining should be more standardized and other shorter retraining options offered
- FN teachers training with full standards specified to become professor in nursing to develop a critical mass of FN professional teachers
- Building joint doctors –nurses activities around chronic disease management by introducing the Chronic Care Model, including the prevention and control of NCDs, joint doctors – nurses diseases management protocols development, team work competency development
- The status of FN, its recognition as a specialty, developing educational standards, accreditation of training, degrees and specialties in community nursing, home care and palliative care
- The role and responsibilities of nurses associations in training and CME

Policy dialogue

4.11 Pushing the agenda for the development and implementation of a comprehensive PGME-CME reform and strategic developments

The PGME-CME reform is an essential part of the health care reform and restructuring of the health system in Tajikistan. Better initial training combined with continuing training is essential to improve the quality of care. Many of the recommendations made have a technical and a policy dimension. MEP is quite effective in developing innovative activities and strengthening the technical dimension of the reform components. More emphasis should be put on the policy and strategic development of the medical education reform by integrating more the three different components pre-, post-graduate and CME.

Understanding the difficulties encountered to mobilize the decision makers at MoHSP and in government, MEP could work at developing the various parts of the overall strategy from a technical angle to prepare and facilitate the policy orientations and decisions. Joint efforts should then include other actors such as the SDC local office, other donors and international agencies to move the agenda and get the policy decisions implemented. Here is an non exhaustive list of domains to be considered:

- Human resources needs and planning in the health sector
- Number of medical students to b accepted every year according to training capacity and responding to the health system needs
- TSMU – hospitals agreements and contracts to give access to proper clinical training
- Post-graduate minimum basic training requirement of 2 -3 years
- Defining who should be in charge of the of PGME
- Defining the role of medical associations in PGME and CME

- Decentralizing PGME and CME: what needs to be done
- Developing a CME accreditation system
- Pushing the FM/GP agenda by creating the necessary conditions and political decisions to be taken to implement it
- A comprehensive approach of NCD management from prevention to care, the human resources needs and the organization reform of health care services
- Strengthening the role and mandate of nurses as key actors in primary care: curriculum and training reform, teachers and trainers development, inter-professional activities and competencies development, responsibilities and status reinforced, nurses' professional association becoming a contributing actor

4.12 Developing more interactions between the Medical Education Reform projects in Tajikistan and Kyrgyzstan

The review is a first step to more interactions between the two projects. Each can contribute to the other's development. A plan of shared activities needs to be established in the coming months with a joint meeting in 2015.

Some of the present recommendations can be initiated in the coming months, most of them should be addressed in the following phase of the MEP.

5 Added value of the Peer Review

The peer review is not a formal evaluation of the project. The review of the project activities was meant to be also a learning process with all the partners to raise issues and questions, bringing suggestions and possible innovative approaches and to strengthen the partnership between the different actors.

5.1 The review: an interactive learning exercise.

The whole 9 days of the review were dedicated to understand the activities of the project, their strengths and weaknesses, their potential to be expanded further in other parts of the country, how existing institutions were involved and their perception of the project achievements and how sustainable they were in the middle and long term. But even more important were the discussions with the partners, taking this opportunity to involve them in the reflection about the medical education reform. This was done at all levels: physicians benefiting from mentoring sessions, medical colleges' teachers and students, nurses and doctors retrained, RHC managers, professors and the rector of TSMU, the directors of RCFM and PGMI, and MoHSP representatives and the Head of the health policy analysis unit at MoHSP.

The discussions were regularly referring to the project underway in Kyrgyzstan, comparing activities, experiences and initiatives, highlighting the strengths and weaknesses of each project and potential developments.

The team was quite impressed how open and critical the discussions were. Partners were ready to speak freely about the problems and the needed changes in their activities and in the health care system. This lead to very lively discussions, sharing ideas, opening new ways at looking at activities and hopefully leading later to changes in their practice.

All partners in their own field see the added value of the reform. It was fascinating and very encouraging to listening to the nurses and doctors participating in the peer review groups

and sharing ideas and knowledge. One could see the need to break isolation and share experience on patient management. The emulation of medical students gaining more clinical skills at the skill lab at TSMU or young FM interns becoming in charge of patients under the supervision of facilitator were other illustrations of changes in practice and interaction that MEP is bringing. There is obviously a need to develop new skills and improve performance and gain more recognition and respect. The challenge is how to translate the medical professionals' commitment and interest at MoHSP level, to reform the healthcare system towards promoting and rewarding those who engage and improve services to the population.

5.2 Impact of the peer review on the Kyrgyz Medical Education Reform project (MER)

As the peer review leader went to Kyrgyzstan after the mission, a detailed debriefing was given to the SDC National Health Program Officer and to the IME MER project implementation team in Bishkek.

Improving the teaching of clinical skills. Involving the Kyrgyz MER project director in the peer review conducted in Tajikistan is having a direct impact on the project. The under-graduate reform component is being revised with paying much more attention on reinforcing the capacity of KSMA faculty to teach clinical skills. As the project is planning the clinical years (Y4-Y6), strengthening the pedagogical skills of teachers is of key importance and is coming at the right time. Lessons learnt from the Tajik MEP project at TSMU particularly in organizing interactive workshops are being used in KSMA. A review of needs will be conducted by direct observation of courses run by Kyrgyz colleagues at KSMA and two workshops will be organized during this one week mission by two experts from UNIGE-HUG.. Local faculty members at KSMA and also at OSH University are asking for it, when mentioned as a possible support provided by the project. At undergraduate level strong support has been provided to help local faculty to get organized in working groups to revise the curriculum, integrate the various departments into a more comprehensive approach of the teaching of various matters around organs with a much more systemic approach. Not enough attention has been paid in providing direct support for teaching methods. The Tajik experience inspires the Kyrgyz project directly.

Gaining more field experience to feed policy and the reform process. The strength of the Kyrgyz MER project in post-graduate and continuing medical education is to have designed a global strategy for the country involving the major stakeholders, under the leadership of the MoH. This strategy gives a vision and an overview of what needs to be developed in medical education. This is still in its early stage and the strategy needs to be officially approved. The various steps to be implemented have all a national framework component which helps all parties to adhere and follow the same orientation and structure. This is the case for the number of basic residency years, finding ways of paying residents, the educational standards, the development of medical associations, the standardization of clinical protocols, an integrated management of NCDs involving doctors and nurses, etc. The MER project tries to develop with the MoH and the stakeholders a general framework to be applied to all medical specialties and then will concentrate mainly on general practice/family medicine developments.

Linking this strategic development with field based experience to test interventions is missing. Field interventions allow to gain a more practical view on what works and what does not, what are the constraints and how to overcome them. PUST and the CME experience gained in Tajikistan are extremely valuable for MER. How much supervision for young interns is needed? Who should provide this supervision and how to strengthen it? What is the capacity of local institutions in rural areas to provide supervision and clinical training? What part for in-patients and out-patients training in GP/FM? PUST has a lot of experience to share, even if the project is working in a different environment. MER in its 2015 activities and budget planning will develop some pilot field-based activities in the Naryn oblast in central Kyrgyzstan and possibly in a rural district town in Osh oblast. These will concentrate on the creation of a two year basic training program for GP young post-graduate residents, putting much emphasis on a patient centered approach and NCD integrated management. This will also involve an integrated approach with nurses in the management of 4 chronic conditions considered as a priority (CVD, diabetes, chronic pulmonary diseases and palliative care).

For CME, the MER project plans to work with the local partner, KSMIRCME, to introduce peer review groups for doctors and nurses in Kyrgyzstan, building on the Tajik experience, but very closely linked with the Kyrgyz PGMI-RCFM to avoid resistance in its development. MEP experts will be contacted.

5.2 Future interactions between the Tajik and Kyrgyz medical education reform projects

No doubt informal contacts exist already and will continue to develop. More formal ways could be developed. Concretely, MER could contribute in the strategy development process in Tajikistan and the MEP could share its experience in reinforcing training and supervision of interns in ambulatory care in the regions. These are two areas where each project can bring some added value to the each other. Regular bilateral or multilateral workshops could be organized on specific topics (strategic development and promotion of GP/FM in the region; under-graduate medical education challenges (private vs public system, quality control); priorities in human resources development; responses to urban-rural divide; role of e-learning in CME). They would allow both countries to share their experience and to gain from each other's successful initiatives. Maybe they could promote joint efforts or initiatives towards the development of a common strategy at all three levels of medical education. There could be also joint training seminars and courses to develop closed links and joint projects in training or/and in research. Joint publications in medical journals would also promote cooperation and visibility of the reforms underway. An annual or bi-annual regional conference could be also organized to measure progress and regularly address new challenges.

6 Conclusion

This review was a learning exercise for all participants. It allowed to identify all the numerous activities and outputs of the MEP in the four components of the reform and discuss them with the different actors involved. A wealth of concrete and innovative experiences has been gained in training professionals, capacity building of local institutions

and new program development. Now is the time to put them together and develop with all the stakeholders a national PGME-CME strategy. This will help defining the various components which needs to be addressed to develop a sustainable medical education improving the quality of care and responding to the population needs. Much needs to be done in coordination with other stakeholders to develop an effective primary care base in the country. The medical education is only one part of it, but an essential one. The health care reform underway needs to provide the necessary environment and working conditions to help better trained doctors and nurses to practice effectively.

MEP is working in the medical education reform for many years. It is the concrete demonstration of a SDC long term commitment to health care reform in Tajikistan. Project SINO continues also to provide very valuable inputs in the health care reform. MEP is well known, it is a reliable partner to the local institutions and partners have developed trust with its team members and realizations. It is not working independently of local institutions, on the contrary it reinforces them and strengthens their capacity. It can then take a major role in promoting the development of a comprehensive strategy in post-graduate and CME. It can provide the technical backstopping to meet international standards and bring some financial support to help the local partners to work and create such a strategy. Now is the time to move and do it if we want that the newly trained students can benefit from it in the fall of 2017.

A MEP III phase is needed to complete the medical education reform and have a comprehensive strategy developed and implemented. Stopping now would leave the job unfinished. The under-graduate reform would not be completed and the post-graduate reform strategy not even defined. A third phase should concentrate much more on the strategic level, with much less on pilot testing operations. It would help the MoHSP and all the partners to define and implement all three main sectors of the medical education reform in a coordinated and effective way.

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7 Annexes

7.1 Terms of reference

7.2 Detailed responses to ToR review questions

7.3 Mission program

Terms of Reference

Peer Review of Medical Education reform Project

October 13- 22, 2014

I. General Context in Tajikistan and contextual patterns related to the health sector and medical education.

Despite of showing annual growth of 7.4 (WB data, 2013) the economy of Tajikistan remains to be fragile as 49 percent of its GDP is made by labor migrants working in Russia. The volume of aluminum production (the second contributor to country's GDP) has decreased by 30% in 2014.

Besides, continued vulnerabilities to external market shocks, susceptibility to natural disasters, underexploited economic diversification potential, limited arable land, and landlocked location make Tajikistan one of the poorest countries in the Europe and Central Asia region, with a GNI per capita of US$800 in 2011.

In spite of a remarkable decline this last decade, poverty is still very high. According to the WB latest data, a third of the population of Tajikistan lives below the poverty line.

The state allocation for health care in Tajikistan amounts to 1.7% of GDP or 14 USD per capita, the 2nd lowest worldwide. Management of these limited resources is inefficient and professional training is outdated, resulting in health services too often of low quality and provided unequally between regions. The overwhelming majority (70%) of health care funds comes from private, out-of-pocket payments, making health care services less and less accessible to the poorest.

Health indicators in Tajikistan are amongst the lowest in the Central Asian region. However, some key indicators, such as the infant mortality rate, nearly halved from 89 per 1,000 live births in 2000 to 49 per 1,000 live births in 2012, and a similar decrease occurred in the under-five mortality rate (UNICEF data, 2007).

Since 2000 the health care system in Tajikistan is undergoing profound systemic changes endeavoring to adjust the scare financing of the sector with commitments made in the main strategic policy documents (in particular the Health Sector Strategy 2010 -2020) to make health care services affordable and accessible to the population, particularly the poorest. One of the main objectives of the health reform is to refocus health services from hospital to primary health care level and restructure primary health care level to be based not on expensive narrow specialists but family medicine practitioners.

Up to 2010 preparation of family medicine practitioners had been done mainly and in a limited number of districts with support of international projects. Narrow specialists working at primary health care level were retrained into family medicine specialists during six month courses. This approach was based on the urgent need to implement objectives of health care reforms by gaining evidences that family medicine is accepted by the population. The training capacity of this approach is however limited with 70 doctors per year whereas the need for family doctors is substantially higher[1].This is due to limited capacities of the two institutions involved into re-training (Post Graduate Medical Institute PGMI and Republican Center for Family Medicine RCFM, high cost (US 2'500 per re-trainee) and almost no co-funding from governmental side for this retraining. In consequence, without a structural changes in medical education and a strong involvement of the Tajik State Medical University TSMU, the only university preparing medical doctors for the country at the undergraduate level and in investing in Post University Specialty training for family medicine, it will still take decades to roll out the family medicine model nation-wide.

[1] Since 2000, 3800 (out of 5833) family doctors have been retrained.

The concept of Medical Education Reform endorsed in 2010 provided a legal frame to review and improve standards of medical education at the TSMU to respond to the health needs and reforms of the country. The Law on Family Medicine ratified by the Parliament of Tajikistan in 2010 re-confirmed the Government's commitment to continue health care reforms at primary health care level and opened opportunities to prepare family doctors in a more sustainable way.

Within the frame of the Concept of Medical Education the teaching curriculum started to be reviewed from 2011 onwards and two faculties of the TSMU - pediatric and treatment faculty for adults - were united allowing undergraduate medical students to study one common program. However, influential pediatricians of older generation directly approached presidential administration in 2013 asking to redevise pediatrician and adult treatment faculties with the argument that children compose 40% of the Tajik population and child health issues are among key priorities. As a consequence, in 2014 following the Decree signed by President of Republic of Tajikistan the medical faculty was again divided into two making obvious that there is no common understanding regarding the main objectives of reforms.

To ensure results and sustainability in strengthening primary health care services with qualified staff it was envisaged by the current management of TSMU that after graduating a 6 year common program, approximately 70% of graduates will continue their education in a one year postgraduate course on family medicine. However, due to many factors, mainly related to governance and socio economic issues[2i], majority of medical graduates continue to choose and be distributed to become specialists such as surgeons, gynecologists, urologists etc.

I. History and latest development of SDC Health portfolio in Tajikistan

Health Care Reform has been recognized as a long term challenge related to social development. Therefore, the Swiss Agency for Development and Cooperation (SDC) has been supporting the health sector in Tajikistan since 1999. In the current Cooperation Strategy for the Central Asia (2012-2015) Health Care Reform remains a priority domain for intervention in the cooperation program in Tajikistan.

SDC has focused its efforts through a number of different projects improving the access to and quality of health services delivered at the primary level. In line with the national strategy and with the other donors active in this sector, SDC is making recognized inputs in the selected districts for the implementation of family medicine, including health financing mechanisms, training of medical staff, and the involvement of local communities for promoting healthy lifestyles: Community Based Family Medicine Project (phase 3, implemented by Aga Khan Foundation), Enhancing Primary Health Care Services Project (ex. Sino, implemented by the Swiss TPH in consortium with Save the Children) and health component in the Integrated Health Habitat Improvement Project (phase 1, Aga Khan Foundation).

Furthermore, to respond to the emerged challenge related to medical education SDC has launched in 2010 the Medical Education Reform Project which is presently in its second phase (2012-2015). Indeed, the principal source of new health workers in Tajikistan are the Tajik State Medical University (TSMU) in charge of training medical doctors, four medical colleges in charge of training nurses, midwives and pharmaceutics as well as nine medical schools, in charge of training nurses (including family nurses), laboratory technicians, sanitation and epidemiology workers, etc. Within MEP, SDC has in its first phase (2011 and 2012) been focusing its investments in the curriculum reform at TSMU. This is to be continued within phase II of the project, while the scope of the project was extended so to address also family nurse education, post-university speciality training for family medicine and Continuous Medical Education & Learning (CME&L).

In the area of family nurse training main challenges relate to the low professional status as well training status of this staff category. Indeed the some do refer to nurse as the "secretaries" of doctors while currently no political discussion is happening on this status and possible increased responsibilits assigned to family medicine nurses.

In the area of CME&L the system is constructed on classical tools and approaches thereby credits are given for structured courses to be taken at PGMI and other teaching institutions, conferences and peer-reviewed publications. Little recognition is given to low-cost and effective tools and approaches suitable and tailored to the family doctors (and nurses). In complement and so to improve skills of health workers working in primary care, specific 6 months retraining programs have been set-up in the last decade so to improve clinical knowledge of family doctors and nurses. These programs implemented by the Post Graduate Medical Institute (PGMI) and the Republican Centre for Family

[2] Narrow specialists have more income due to out of pocket payments

Medicine (RCFM) and supported by various donors including SDC, have retrained using so called Clinical Training Basis (CTBs) several hundred of doctors and nurses.

The project is designed to improve the quality of health care services provided by health care staff at primary health care level.

II. Expected Outcomes of the Medical Education Reform Project

The second phase of the Medical Education Reform project implemented by Swiss Tropical Public Health Institute (Swiss TPH) has the following four outcomes to be attained by 2015:

Outcome 1: Students at TSMU in year 1 and 2 have improved their knowledge and practices through a new curriculum and better teaching approaches.
Outcome 2: Family Medicine residents/interns have improved their knowledge and practices through the implementation of Post University Specialty Training program (PUST) and a functioning mentoring system.

Outcome 3: Family doctors and nurses have improved their knowledge and practices through a functioning Continuing Medical Education and Learning (CME&L) system that is steered and managed by Tajik institutions.

Outcome 4: Roles and responsibilities of different institutions as well as the financing of medical education are clarified through policy dialogue.

The MEP project is a complexe project involving many national stakeholders - Ministry of Health, Republican Family Medicine Center, Postgraduate Institute of Medical Education, Tajik State Medical University and medical colleges - each with its own interest.

III. Purpose and overall objectives of the review mandate

The current phase of the project is to come to an end in August 2015. Given that medical education reform is still in early stage of its implementation, it is planned to continue the project in the frame of a successive phase. It was decided **to review the project for 4 main purposes**: **1.** the second phase of the project has new components (PUST and cooperation with medical colleges) that were not yet reviewed **2.** to deepen the reflexion on CME&L aspects and most cost-effective model to be pushed for institutionalization[3] **3.** there are serious challenges and risks for the project implementation and success that need to be strategically thought about. **4.** to further develop SDC vision and improve performance in medical education reform by synergizing and engaging SDC-funded Health projects in Tajikistan and Kyrgyzstan in mutual experiences and knowledge sharing.

The format of the review is then a peer review. The review will not only focus on results so far but will also have a forward looking perspective (e.g. adaptations in project activities) informing the planning process of the third phase of the MEP.

IV. Scope, Review Criteria and questions

In accordance with DAC criteria for evaluating development assistance, the scope of the review will be enhanced by questions related to the project's relevance, effectiveness and, efficiency..

Therefore, the review will find out answers to the following questions[4]:

Outcome 1	**Review Criteria (DAC)**
• To what extent is the new curriculum **implemented** and showing **positive results** on students' knowledge and practices? • Is there a need to continue assistance to curriculum reform and strengthening pedagogical/teaching approaches at undergraduate level or is the agenda over? • Should the scope and range of activities at TSMU be narrowed down? If so what are priority areas for the future?	Effectiveness
• Does the **working group** in charge of overseeing the revision of the	Effectiveness

[3] This was recommended in the peer review conducted in Summer 2013 on the Community Based Family Medicine Project.
[4] The questions are sorted per outcome, but cross-checking with the other outcomes may be necessary.

curriculum at TSMU function well, in a participative process, and what are the main challenges faced?	Efficiency
• Is there any institutional **resistance** to the new curriculum? • What can be said about the improved formulation of learning objectives? • Have pedagogical and teaching skills improved at TSMU? • Are students today receiving better quality teaching? • Are most of the department heads and TSMU **supportive** to the revisions, including in relation to the necessary adjustments in the teaching hours?	Effectiveness
• Is the clinical skills **laboratory** adequately **operating** and being used to improve clinical skills? • To what extent have **clinical skills** of teachers, especially in areas of history taking and physical examination, been strengthened? • Is the idea of making the clinical skills laboratory gradually evolve towards a **clinical skills center**, still relevant?	Effectiveness, Efficiency, relevance
• Have qualitative and quantitative (**gender-sensitive) studies** and surveys in the area of family medicine on relevant epidemiological and public health topics, been conducted and their results adequately **disseminated by the** department for family medicine respectively the department of public health? • In which extend do the results of these studies feed decision- and policymaking?	Effectiveness, Efficiency, relevance
• Did the project enable **working relations** between the faculty/chair of public health with management training activities at **rayon level** (e.g. on the business planning tool) or with the medical statistics department of MoH. If yes, what are the results of these collaborations?	Effectiveness, Efficiency.

Outcome 2	**Review Criteria (DAC)**
• Have **advantages** and **disadvantages** of different approaches to **Post-university Specialty Training (PUST)** been assessed? • What were the main lessons learnt regarding the piloting of the concept? • How can the project build on initial positive experiences with PUST? What can/shall be carried forward and how to make sure the model is institutionalized and scale-up? • Are the PUST and the tutoring system showing **positive results** for interns?	Effectiveness, Efficiency.
• Has the **PUST working group** been **functioning well** and in a participative process? What were the main challenges faced?	Effectiveness, Efficiency
• Do **enough clinical training basis** (CTBs) collaborate at the PUST level (only in districts covered by Sino project?) and do they perform well in their new responsibilities?	Effectiveness, Efficiency
• Has the **interest** of students in the specialty of **family medicine** increased since the launching of the project? • How many **graduates** are currently followed up by the project (benchmark: 5% of graduated targeted in the first year)? • What kind of approaches and collaboration to **increase** the **interest** of the students in family medicine, have been identified and tested? What are the main findings?	Effectiveness, Efficiency
• Does the tutoring/teaching system focus on both **professional** and **personal development** of interns? • Is there an agreement on **minimal criteria** for professionals who act **as tutors/teachers?**	Effectiveness, Efficiency

Outcome 3	**Review Criteria**

	(DAC)
• Is the **concept for CME&L curriculum** for family doctors and nurses finalized and to what extent is it implemented? • To which extend is the developed concept cost effective and economically viable in the context of Tajikistan? • Is the CME&L system contributing to improve quality of care? • What is the potential of the developed system for being **scale-up** (and what kind of scale-up, geographical or vertical?) • Is the CME&L system producing **positive results** for family doctors and nurses?	Effectiveness, Efficiency, relevance
• Does the **CME&L working group function well** and in a participative process? What are the main challenges faced?	Effectiveness, Efficiency
• What are the challenges in improving the quality of nurses training when cooperating with medical colleges? • Should the assistance to nurse training and retraining be continued in this form?	Effectiveness, Efficiency, relevance
• Do enough **clinical training basis** (CTBs) collaborate at the CME&L level (only in districts covered by Sino project?)	Effectiveness, Efficiency
• Is the involvement of the **Swiss Association for PHC** and their institutional partnership with the RCFM relevant and the collaboration successful? Have complementary resources (non SDC funds) for extending the collaboration and mentoring functions, been identified so far? • In what direction the mentoring approach may evolve?	Relevance, efficiency, effectiveness
• Is CME&L done in **gender-sensitive way** (gender balance participation and training contents taking into account the differentiated health needs and care approach)?	Relevance
• Is the **teaching** within the retraining courses based on **adult learning theory** and **cognitive knowledge** acquisition and **up-to-date approaches** and techniques for medical education (use of effective lecturing techniques, appropriate use of audio-visual aids, feedback skills, and small group learning and facilitation)? • Is **communication skills** development included in the training modules? Are they resistances to this regards?	Effectiveness, Efficiency

Outcome 4	**Review Criteria (DAC)**
• Has a mechanism for a **regular dialogue** across key actors and institutions involved in medical education and human resource development, been set-up by the project and how is it functioning?	Efficiency
• Have the **roles, tasks and responsibilities** between TSMU, MoH, PGMI and RCFM been clarified? What are the main **difficulties**/**resistances**/oppositions encountered and is the project able to address these challenges? • Does **TSMU** still demonstrate a strong **leadership** and a strategic vision (commitment of the rector and other key persons)? • Is there an **agreement** on which one is **overseeing PUST**? • Is there an **agreement** on **training sites** overseen by TSMU, RCFM and PGMI, including polyclinic 8 in Dushanbe? • Has the **leadership** role of **RCFM** as the responsible institution for **CME&L** been strengthened?	Efficiency Effectiveness.
• Have **best practices** and **case studies** been documented, **capitalized**, shared and **disseminated** to MoH, MoE, and other stakeholders on a regular basis? • In which way strategic communication and capitalization feed the policy dialogue?	Efficiency
• Is there sufficient **political willingness** to address structurally the critical issue of available and qualified health staff at the PHC level?	Relevance, Effectiveness.

• Is the strong focus on medical education for medical doctors (vs. improving nurses' qualifications and tasks shifting in family medicine centers) still appropriate in the context of Tajikistan? • What is the influence of the project, the SDC health programme, the Swiss Cooperation Office and the other donors, in their respective roles in **advocacy and policy dialogue**, on the implementation of the medical education reform? • Is there potential for improving the leverage of implementation partners and donors on the health reforms?	

Assess gaps between planned and actual expenditures to understand the gaps (if any) and reasons if they are related to economy (right methodology, human resources), governance or delivery issue?

V. Composition of the Peer Review Team

1. Dr Louis Loutan, HUG;
2. Dr Alexandre Bishoff, HUG (only from 16 Oct);
3. Ms Erica Placella, Health Advisor Eastern Europe and Central Asia, SDC Bern
4. Dr Kaspar Wyss, Swiss TPH, Project manager MEP – Tajikistan (only up to 20 Oct);
5. Mrs Elvira Muratalieva, Senior Program Officer, Embassy of Switzerland in the Kyrgyzstan
6. Ms Nisoramo, Family Medcine coordinator, AKF/AKHS
7. Mrs Mouazamma Djamalova, Senior Program Manager, SCO Dushanbe

Louis Loutan will facilitate and coordinate the peer review and as team leader will be responsible:

- To comment the ToRs of the review in view of establishing a final version
- To develop a detailed methodology and a tool to analyze causal relationships in answering the key review questions. The chosen methodology shall foster the knowledge sharing among the review team. The methodology is to be validated by SDC/SCO.
- To organize the review process among the review team (roles, responsibilities and tasks)
- To review the mission schedule with the assistance of the MEP project
- To collect the review report's contributions of the review team and to write the review report.

VI. Methodology and reporting

It is expected that the Peer Review will be carried out in conformity with requirements to formative assessment and will be then a participatory and learning exercise.

The Peer Review will use qualitative methods and draw both primary (consultations with SDC HQ, SCO TJK, project's core team; key stakeholders, including representatives of the Swiss family medicine association ("Hausärzte Schweiz") and the University of Calgary; key informant interviews, field visits, focus group discussions) and secondary (desk/literature reviews of relevant documents) data collection methods.

The mission in Tajikistan is scheduled for weeks 42-43 (October 12 -22. 2014).

It is anticipated that at the end of the mission, a half a day debriefing workshop will be organized in Dushanbe. The review team will present its preliminary findings, conclusions, and recommendations to SCO Dushanbe, implementing partners and key stakeholders and collect their first general impressions and feedback. The presentation and minutes of the debriefing are to be handed over to SCO before the mission's departure.

The Peer Review Report should be submitted in English and cover all the elements mentioned in chapter IV in a maximum of 20 pages (excluding annexes). The report is to be introduced by an executive summary. Its main body starts with a description of the method used and is structured in accordance with the present ToRs.

Based on the peer review assessment and findings, the review team shall draw conclusions and lessons learnt, as well as make recommendations and present them in order of priority.

The first draft of the Peer Review Report should be submitted no later than 17 working days (November, 13 2014) after the end of the Peer Review Mission. The consultant will receive consolidated comments from SDC and project partners, which will be used to finalize the Peer Review Report final version (end of November 2014).

An exposure trip to the Medical Education Reforms Project in the Kyrgyz Republic may contribute to the process of preparation of the new phase the MEP and further exchanges between the two projects, but the right timing for this has to be suggested by the review team and approved by the Embassy in Bishkek.

VII. Tasks of the Swiss TPH Representation Office in Tajikistan, hereafter MEP Office

The MEP Office is responsible for:

a. Preparing the first draft of the Review Schedule and sharing it with the Team leader and Review Team;
b. Arranging relevant meetings with all stakeholders according to the final review Schedule
c. Providing all relevant documents to the Review Team;
d. Reviewing and providing feedback on the draft review report and, once finalised, distributing the final report to relevant stakeholders.
e. Organise and arrange all logistics for the Review Team
f. Organise a workshop to present findings of the review

VIII. Review Timetable

Working days for the Team Leader and two represenatives from the HUG:

0.5 day: Briefing at SDC HQ

2 days: Preparation / desk study, including interactions by telephone with the representatives of the Swiss association for family medicine ("Hausärzte Schweiz"), the University of Calgary and Prof Dr. Galeazzi.

2 days: Travel Switzerland-Tajikistan-Switzerland

6 days: Field mission in Dushanbe and project sites

5 days: Elaboration of report

0.5 days: debriefing at SDC HQ

TOTAL working days: 16

Note: The mission's working week will count at 6 working days if the mission is more than 10 days in total.

IX. Logistics

SDC HQ shall support the travel arrangements of the team from HUG, if required (visa, tickets, travel advance, information for SDC consultants travelling to CA/TJ, etc.).

SCO and MEP Office shall organize the field mission of the review team and provide logistic support.

Translation into Russian both during the mission and of the report will be arranged by MEP Office.

X. Available Documentaion

The review team members will be provided with all of the documentation on the project implementation necessary for the proper review, including:

– Swiss Cooperation Strategy for Central Asia (2012-2015)
– Results framework for the health care sector in Tajikistan
– Tajik National Health strategy, Action Plan, and other related policy documents

- Relevant Medical Education Reform Project's documents (Credit Proposal, project document, annual progress reports, external review report of November 2011)
- Peer review report on the of Community-Based Family Medicine Project

- National Development Strategy 2006-2015
- Project document Medical Education Project phase II
- Annual progress reports
- Relevant consultant mission reports
- Relevant documents generated by the project such as study reports

Annex 1. Tentative Timetable

Prior to the site visit to Tajikistan, the team leader will consult by telephone/skype:

- Dr Didi Burkhardt Representative of the Swiss Family Medicine Association (Hausärzte Schweiz)
- Prof Heather Baxter and Prof Clarence Günther, consultants of the University of Calgary assisting medical education reform at TSMU
- Prof Renato Galeazzi, Medical Education Expert of the Project

Timing, placement, and duration (to be further developed with the review team leader).

The following schedule **is tentative and will be further developed by the MEP team**:

- October 12, 2014 (Sunday) Departure from Switzerland
- October 13, 2014 (Monday) Arrival in Dushanbe
- October 13, 2014 (Monday):
- Briefing with the SCO Country Director, peer review group; briefing by the MEP project director and the medical education expert of the project on key achievements and challenges of the project
- October 13, 2014 (Monday) Meeting with the Minister/or Deputy Minister of Health;
- October 14, 2014 (Tuesday) meetings with the:
  - The Rector of the Tajik State Medical University
  - The Working Group of TSMU
  - Students of the TSMU
- October 15, 2014 Wednesday meetings with
  - the staff of Post Graduate Medical Institute
  - focus groups with PUST students at PGMI affiliate in Dushanbe
  - Rector of the nurse college in Dushanbe
  - Family nurses in Dushanbe nurse college
- October 16, 2014 Thursday meetings with
- Health Policy Analysis Unit MoHSP,
- Health reform department MoHSP
- the staff of Republican Centre of Family Medicine
- the USAID Health Quality Project
- October 16, 2014 Friday, field visit to Vose and Khamadoni
- October 17, 2014 (Saturday) visit to Vose district;
  - Meeting with PHC manager of Vose,
  - Meeting with FM Peer Review Group participants. Departure to Dushanbe
- October 18, 2014, Sunday – day off.
- October 19, 2014 (Monday) work on the debriefing session and report, meetings with WHO, AKF/AKHS
- October 20, 2014 (Tuesday) preparation of the debriefing session and report
- October 21, 2014 (Wednesday) debriefing at SCO, Dushanbe with Country Director, MEP Project, and Ministry of Health, Republican Family Medicine Center, Post Graduate Medical Institute in Swiss Cooperation Office, Dushanbe
- October 22, 2014 (Thursday) –Departure from Dushanbe and arrival at home destination

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Eidgenössisches Departement für auswärtige Angelegenheiten EDA
Direktion für Entwicklung und Zusammenarbeit DEZA
OZA

Detailed responses to ToRs review questions.

Peer Review of Medical Education reform Project

October 13- 24 2014

I. Achievements, Peer-review findings and recommendations

Outcome 1: Students at TSMU in year 1 and 2 have improved their knowledge and practices through a new curriculum and better teaching approaches

Peer-Review key questions	Achievements as of October 2014	Peer-Review findings and recommendations
Curriculum reform • To what extent is the new curriculum implemented and showing positive results on students' knowledge and practices? • Is there a need to continue assistance to curriculum reform and strengthening pedagogical/teaching approaches at undergraduate level or is the agenda over? • Does the working group in charge of overseeing the revision of the curriculum at TSMU function well, in a participative process, and what are the main challenges faced? • Is there any institutional resistance to the new curriculum? • Are most of the department heads and TSMU supportive to the revisions, including in relation to the necessary adjustments in the teaching hours?	**Curriculum reform** • Detailed curricula for years 3 and 4 developed and implemented. • Work on curriculum for year 5 on track, for implementation in 2015/16. • Testing center set up, written and centralized MCQ exam designed and introduced. • Course evaluation with student feedback introduced. • Quality assessment procedures at TSMU have been evaluated and a workshop on possible approaches for quality assessment procedures of teaching at TSMU has been conducted in 2013 by the Calgary University experts. • In 2014, TSMU clinical teachers have been trained by experts from Calgary in building clinical cases around manikins and using them with a team-based learning approach in order to improve clinical reasoning skills. Teachers from a range of clinical departments participated in this workshop: neonatology, anesthesiology, general surgery,	**Curriculum reform** • **Students** and **teachers satisfaction** seems to be **high**. Additionally, **course evaluation** with **student feedback** has been introduced. This allows to continuously improve both courses and teacher's skills. • **TSMU leadership** continues to be fully **supportive** of the curriculum reform process. The Rector and the coordinator of the working group on new curricula (WG) who is at the same time the Head of Education Department of TSMU and the coordinator of MEP within TSMU, show strong leadership and are real **"champions of change"**. • The **WG** on new curricula seems to **function well** and **no resistance** to FM is reported by its members who have expressed great **enthusiasm** and **motivation** for their assignment. 51 curricula from other countries have been consulted for the development of the new TSMU curricula. • The composition of the working group is the following: 2 paediatricians, 3 surgeons, , 2 internists. Efforts should be made to **diversify the WG composition** and to involve for example public health specialists or resource persons outside TSMU. • The support of the **Calgary consultants** is highly **appreciated**,

	ophthalmology, ENT, internal medicine and obgyn. • In May/June 2014, TSMU clinical skills lab staff trained 26 teachers from other clinical departments in team-based learning and in developing clinical case scenarios and descriptions of clinical skills. This training will continue in year 3, so that these approaches can be introduced in all clinical departments. • A Learning Management System (LMS- open source Moodle) for students and staff has been introduced, aiming at facilitating information sharing and e-learning. **Clinical Skills Training** • Clinical skills center/laboratory established and clinical skills teaching early in the program	particularly the participative team-based training approach introduced and the support to the WG while designing the new curricula. • The preparation of year **6 practical year** is expected to be a real **challenge**. The project should, at this stage, already carry out a **thorough reflection** in this regard, in order to anticipate problems and identify major obstacles. • The **reform** is **very well perceived** and accepted by all interlocutors interviewed by the peer-review team (including TSMU staff). The **resistance to change** among staff at TSMU is slowly **decreasing**. • The setting up of a **testing center** and the introduction of **written and centralized QCM** (every 6 months) highly contributes to more **transparency** and **objectivity** in the assessment of students. • However, there's still **no entry exam** and/or selection criteria at TSMU and around **1200 new students** manage to enter the Faculty of Medicine every year (300 additional students chose pharmacy or public health)[1]. • 45% of Tajik students are paid by the **state budget** and 55% pay by themselves (**contract-based**- USD 800-1100 per year) and thus get benefits. There are still a high number of **foreign students** (mainly from India, Pakistan, Iran, Russia, Afghanistan and Kazakhstan) at TSMU and they all pay by themselves (between USD 3500- 5000 per year). 40% of the **Tajik students** are coming from rural areas. The students who pay by themselves are free to choose the specialty but those who are on the state budget are obliged to follow MoH orders. • According to the interviewed management staff, the number of new students should be **reduced by 50%.** However, the r**esistance from the MoH and the Ministry of Finance** is very strong, as the students fees are highly contributing (**75%)** to the **University budget.** These same authorities declare that they want to turn the TSMU into a **regional center of excellence in medical education**, and thus attract the maximum amount of foreign students. This is a problem that is well **beyond the area of action and influence** of the project.

[1] Since this year, the general exam to enter the University (all faculties combined) has been outsourced.

Clinical Skills Training • Is the clinical skills **laboratory** adequately **operating** and being used to improve clinical skills? • To what extent have **clinical skills** of teachers, especially in areas of history taking and physical examination, been strengthened? • Is the idea of making the clinical skills laboratory gradually evolve towards a **clinical skills center**, still relevant?	introduced (2nd year). • Training of clinical skills center teachers (ToT) done and ongoing (by the University of Calgary). • Study tours to other clinical skills labs (Karaganda University) organized. • Step-by-step descriptions of clinical skills developed. • Pocket guide for history taking and physical examination elaborated and introduced. • Director for the laboratory has been newly appointed. **Other**	**Clinical Skills Training** • The clinical skills laboratory is **fully operational** and showing **positive results** on students' knowledge and practices. **47 clinical specialties** are currently taught at the clinical lab, for interns (90%), undergraduates (10%), and for FDs and FNs involved in the 6 months retraining program conducted by RCFM, thus contributing to the **"profitability" of the structure** (opening hours: 8am to 6pm and even 7pm during test periods). • The **progress** in terms of **clinical skills teaching** within the undergraduate training of doctors at TSMU has been underlined by all stakeholders interviewed. However, clinical skills' strengthening **requires continued attention** for both staff and students. • **Teaching clinical reasoning** remains a **challenge** and this will be one of the main aspects of the year 5 detailed curriculum and project activities at TSMU in year 3. • The **input** and the **collaboration** with the **University of Calgary** (training of clinical skills trainers) have been **highly appreciated**. • The **pocket guide** for **history-taking** and **physical examination** is a very **relevant** and useful resource for students and staff. Additionally, it increases the **uniformity** of clinical skills **teaching** across departments. • **More study tours** or **exposure trips** to other similar national and international clinical skills centers **should be organized**, especially for the teachers. • The **low proportion of teachers** compared to the number of students is considered a major problem by the people interviewed. This also seems to be aggravated by the **high staff turnover**. • There was also mention of the necessity of increasing the number of hours allocated to students for the Clinical Skills laboratory (currently, 60% of the time for the ex-cathedra courses and 40% for the laboratory), as well as of increasing the amount of equipment and books to meet the growing number of students. The management of the University and the Rector have declared themselves ready, for their part, to make more space available (new building) in order to increase the potential and capabilities of the laboratory.

Other • Have qualitative and quantitative (**gender-sensitive) studies** and surveys in the area of family medicine on relevant epidemiological and public health topics, been conducted and their results adequately **disseminated by the** department for family medicine?	• In 2013/2014 a study was conducted by TSMU respectively the two chairs in family medicine (substantially assisted by the Swiss TPH) looking at the perception of family medicine among students and teachers. Results were widely disseminated at TSMU and beyond (e.g. Geneva health forum) • In 2014 an implementation research on staff time allocation of family practitioners was initiated by the department of public health at TSMU. Results will become available in early 2015 • In collaboration with project Sino, a workshop for project staff on gender and gender mainstreaming was conducted in May 2014.	• The desire of **increasing** and **diversifying** the **courses** for clinical skills center teachers was also expressed. **Other** • Additionally, the **Chair of Family medicine** #1 of TSMU has been **renovated** and **equipped** with furniture and family medicine literature. This creates a **good environment** for study and may **encourage** students to study family medicine. • **Research cap**acities at TSMU rem**ain a con**cern and have to be further developed so to better relate the university to the international context. One main challenges hereby is the isolation of TSMU and the very low number of academic staff speaking English,

Outcome 2: Family medicine residents/interns have improved their knowledge and practices through the implementation of Post University Specialty Training program (PUST) and a functioning mentoring system

Peer-Review key questions	Achievements as of October 2014	Peer-Review findings and recommendations
PUST • Have advantages and disadvantages of different approaches to Post-university Specialty Training (PUST) been assessed? • What were the main lessons learnt regarding the piloting of the concept? • How can the project build on initial positive experiences with PUST? What can/shall be carried forward and how to make sure the	**PUST** • New two years program for pilot-testing designed and introduced. • A clear program and support for residents has been designed (day-to-day work with patients under supervision of experienced FD-Tutor; one theoretical training day per week at clinical training base).	**PUST** • **Knowledge** and **skills** level of **residents** is particularly **low** when entering PUST (worst students on state budget choosing FM). • Initial **results** show that the newly developed **PUST**, currently in the second year of implementation, is much **appreciated** by residents and that they are learning the skills needed to work independently as a FD. Feedback about the program is positive (according to interviewed stakeholders). Also see the exchange visit report 20142 stating that 93% of residents rated their **learning environment** as either good or **excellent.**

[2] Zukhra Kasymova**,** Erik van Twillert**,** Exchange visits of residents and tutors involved in the post-university family medicine specialty training in Tajikistan**,** May 27-30, 2014, Medical Education Project (MEP) in Tajikistan, Phase 2.

model is institutionalized and scale-up? • Are the PUST and the tutoring system showing positive results for interns? • Does the PUST working group function well and in a participative process? What are the main challenges faced? • Does the tutoring/teaching system focus on both professional and personal development of interns? • Do enough clinical training bases (CTBs) collaborate at the PUST level (only in districts covered by Sino project?) and do they perform well in their new responsibilities?	• Support to tutors and quality assurance through PGMI trainers have been provided. • 20 residents from both districts and Dushanbe participated in first year of PUST (5 locations). Their training is mainly clinical and takes place in 4 policlinics of project districts, as well as at the FM department of PGMI. • In the first year, 12 tutors, 6 trainers and 1 curator have been involved. • In 2014, 32 new residents participate in the PUST (all from rural districts in 7 locations). Around 6% of medical graduates continuing their specialty in family medicine. • District level FDs have been prepared to work as tutors. Tutors were selected at the beginning of the internship according to criteria developed by the PUST WG. 1 tutor supervises 2 interns. • All interns have been provided with a medical bag, the book "A practical guide to common medical problems" by Blumröder, and several clinical protocols (IMCI, protocols for management of the major respiratory diseases in primary care, antenatal care standards). • In May 2014, exchange visits for residents and tutors took place. Residents from Dushanbe visited District Health Centres in Hisor, Rudaki and Tursunzoda, while residents from the districts visited the PGMI training base in Dushanbe. • The overall opinion of both residents	• The biggest problem remains the parallel existence of curricula for 1-year specialization (internatura) in pediatrics, gynecology, cardiology, etc. that students continue to prefer to the two years proposed by the PUST to become a FD. In short, there are currently 3 ways to become a FD in Tajikistan: 1. PUST 2. Internatura FD (before PUST) 3. Retraining in FM. The **need** for **harmonization** is evident here. • **Access** to **clinical sites** remains another crucial **problem**. **However**, residents are **increasingly** able to **see patients** on their own and some have been assigned their own patient population, especially in urban settings where it still remains a challenge. • **Training residents in rural clinics contribute to reinforcing the capacity of these clinics to see more patients and improve quality of care. It also encourage graduates to return to rural districts, thus participating to the decentralization process.** • PUST should be **consolidated** and **experiences disseminated**. The project should continue to make changes to the PUST based on feedback from trainers, tutors and residents. • The **training** of **tutors** is very **comprehensive**: main responsibilities of tutors, specifics of adult learning, effective communication (interpersonal communication included) in the learning process and encouraging interns to learn and further practice as a family physician. They also received training in clinical skills where needed. • The **tutors** are selected among the best FDs and don't receive credits to become tutors. To date, they receive **incentives from MEP**. What measures/solutions could be introduced in order to ensure the **sustainability** of the approach? • Representatives of the main stakeholders participate to the **working group** (PGMI, TSMU, RCFM) which seems to be **well functioning**.

Interest in family medicine • Has the interest of students in the specialty of family medicine increased since the launching of the project? • How many graduates are currently followed up by the project (benchmark: 5% of graduated targeted in the first year)? • What kind of approaches and collaboration to increase the interest of the students in family medicine, have been identified and tested? What are the main findings?	and tutors about the PUST is positive. They appreciated the combination of clinical work with theoretical teaching and the tutor-resident relationship. **Interest in family medicine** • A lower number of residents than expected participated in the first year of PUST. However in year 2 the percentage has increased (32 out of around 600 corresponding to around 5%) • Finding experienced well-trained family doctors to function as tutors remains a challenge, especially in the new project districts (Rudaki and Faizabad). Identified FDs need more training than initially anticipated. • In order to inform and involve high-level decision makers, a study tour to Switzerland was organized in May 2014, with participation of a representative from the executive office of the President of the Republic of Tajikistan, the Head of the Health budget department of the Ministry of Finance and representatives of MoH. Study tour participants were exposed to the political commitment in Switzerland to strengthen the role of family medicine within the overall health systems. • A study on TSMU students and staff perception of family medicine has been carried out in September 2013, involving both Chairs of Family Medicine of TSMU. The results were	**Interest in family medicine** • The **re-introduction** of a **Department of pediatrics** at TSMU in January 2014 at the request of the MoH (decision made against the will of the TSMU leadership as well as the project's vision and approach) and the planned **opening** of a **new medical faculty** at the **National University in Dushanbe**, are serious **challenges** for further education reform in TSMU. • **TSMU leadership** towards the newly reopened paediatric faculty consists in **limiting** the **number** of admitted **students** to 100 to 200 per year. • The **project** should **intensify** the **policy dialogue/advocacy activities** and lobby to **minimize** the **risks** of this decision, the biggest one being that the students may prefer the shorter narrower path to becoming a paediatrician to the longer broader way which is the international standard for family medicine. The project has already organized a study tour in May 2014 to Switzerland including high level government officials to expose them to the political commitment in Switzerland to strengthen family medicine. Currently, the position of the project is to avoid investing too much in the newly opened faculty. The **collaboration** with the **Department of pediatrics** should on the contrary be **intensified** in order to **harmonize** and **coordinate** the **approaches**. This would be also a very good opportunity to show how curricula could be developed according to international standards. Another option could be to **advocate** for the **further limiting** of the **number** of admitted **students** at the new faculty per year. • This **policy dialogue** should be conducted in close **collaboration** with the **SCO** who has a very good **leverage,** considering the **volume** of the health portfolio, the successful achievements and the **very good contacts** established with the health authorities. • The **number** of **graduates** choosing a FM internship still remains a **challenge**, although the increase in the number of new interns for the coming year is encouraging.The **lack o**f in**terest fo**r family medicine mainly lies in the **low** e**ffective salaries** and **lack** of **incentives** for those who choose this path (family doctors get a higher salary than other specialists and the salary levels ha**ve** been raised **over th**e las**t ye**ars, **but their** effective salaries are however lower given that informal payments (making up at least 70% of an income of doctor) are lower than for other specialists). • Currently, a FD trained by PUST receives the same salary as a FD having

	presented at the Geneva Health Forum (April 2014).	taken the 6- months retraining in FM. His salary is also lower than that, for example, of an intern who has completed 1 year of internatura in pediatrics, or than that of a FD who has chosen one year of internatura in FM! In Tajikistan, the **salary scale** is based on an **augmentation every 5 years** (3 years for rare exceptions) no matter the profession and the training followed during this period. This is done through a test, which, if passed, allows the trainee to move to a higher category. The **compensation system** is thus **totally separate from** the **training system** and does not take it into account in any way. This is again a problem that is well **beyond** the scope of **influence** of the **project**. • **Lobbying activities** in order to increase the number of interns in family medicine similar to those carried out during **Prof. R. Galeazzi mission**, should be **intensified**. • In order to attract the **interest** of the students to the **FM**, **meetings** with **graduates** in FM in **a peer-review** form should be organized on a regular • **Meetings** with the **Swiss FD** have also been considered as a good **lobbying opportunity** to increase the **students' interest** in family medicine. • This **peer-review** was a good **opportunity** to expose the problems surrounding the choice of family medicine in Kyrgyzstan, and even in Switzerland. • Considering the development of a **concept** of "**General internal Medicine**" was also suggested.

Outcome 3: Family doctors and nurses have improved their knowledge and practices through a functioning Continuing Medical Education and Learning (CME&L) system that is steered and managed by Tajik institutions

Peer-Review key questions	Achievements as of October 2014	Peer-Review findings and recommendations
Retraining (FDs and FNs) • Is the concept for CME&L curriculum for family doctors and nurses finalized and to what extent is it implemented? • To which extend is the developed concept cost-effective and economically viable in the context of Tajikistan? • Is the CME&L system contributing to make family medicine more attractive? • Is the CME&L system producing positive results for family doctors and nurses?	**Retraining (FDs and FNs)** • Revision of 6-month training programs for FDs and FNs finalized, approved by MoH and implemented. • The 6-months retraining program for FDs has been revised taking into account learning objectives and assessment tools. This is meant to lead to a more unified approach to the re-training between the two main training institutes (PGMI and RCFM).	**Retraining (FDs and FNs)** • The peer-review insisted on the **role** of **medical associations** which has **to be strengthened** and/or **revitalized**. • The **costs** of the new retraining program have been calculated **according** to **MoH/MoF annual budget**. • Currently, there are **no common courses** between **FDs and FNs**, but some subjects are together (approx. 5%-8% of subjects). Here, increasing the number of common segments would be appropriate.

• Is the teaching within the retraining courses based on adult learning theory and cognitive knowledge acquisition and up-to-date approaches and techniques for medical education? • Is communication skills development included in the training modules? Are they resistances to this regards? **Nurses** • What are the challenges in improving the quality of nurses training when cooperating with medical colleges? • Should the assistance to nurse training and retraining be continued in this form?	• Expansion to new pilot districts (Rudaki and Faizabad). • 49 FDs and 60 FNs (12 from Vose, 12 from Hamadoni, 15 from Rudaki and 9 from Faizabad) retrained and supplied with medical bags (containing sets of medical equipment for daily practical work) and literature. **Nurses (**4th year of medical college) • The WG for the revision of the 4th year nursing curriculum (based on 12 topics among which healthy lifestyles, communication, prevention campaigns, management, etc.) started to work in summer 2014 and should finish the revision in the first half of year 2. • Support to colleges in Dushanbe and Kulob (renovation of FM building in Kulob, equipment and literature for students from MEP pilot districts) provided to improve education environment and conditions. • ToT for nurse trainers has started in October 2014. •	• During the 6-months retraining, 60% of FDs and FNs **work with patients**. There a need to increase this percentage or improve its impact by more one to one work with patients. • Some **competition** between the **PGMI** and the **RCFM** with regards to the lead in the **CME&L** is still perceptible, with the RCFM reporting that it has the best clinical bases and the best professors. Could an **evaluation** of the training undertaken by the two institutions be envisaged by the project (conducting an initial baseline and evaluate in a few years)? **Nurses** • The **status** of nurses has **not** yet been **reformed** by MoH. They is currently **no regulation** of **family nurses activities** approved by MoH. The current job description for FN has been introduced 10 years ago. • Additionally, there is **no unified** and **coordinated strategy** and **system** to **train nurses**. There is a need to strengthen the policy dialogue on this issue. • There are currently a **high number** of **students** in nursing trained in 15 medical colleges and schools. 6000 nurses graduate every year, around 45% of them never enter the health workforce. • **Low motivation** (low salary and bad equipment). • The majority of **teachers** are **doctors** and not nurses. • Some retrained nurses have left the country to **work abroad** (mainly Russia). • There is a real need to **strengthen** the **capacities** of nurse **trainers** involved in delivering the 4th year specialty training, as well as trainers involved in retraining courses in newly to be established CTB of Rudaki (they need to get more acquainted to international exchanges, management, communication, preventive measures, etc.). • **Joint PRGs** with **FD** should be run on specific topics such as joint management of NCDs, but separate PRGs should be maintained as indicated by nurses. • Very **few clinical bases** are accessible for nurses. • There's **no clear task shifting concept** for nurses.

	Peer Review Groups • 34 peer-review groups (PRGs) for FDs (19) and FNs (15) have been set up and regular meetings are held. • Facilitators (based at rayon level) trainings conducted. • Evaluation sheet introduced, discussion guides under development. • RCFM trainers carried out trainings for FDs PRGs of Tursunzoda and Shahrinav on "Management of the main respiratory diseases" and clinical guidelines were distributed to all participants. • Despite the issuing of MoH degree #549, the piloting of a credits-based CME&L system based around PRGs does not seem to have a high priority among decision-makers.	• The peer-review has encouraged the interviewed nurses and the Head of FN Department at PMGI to **strengthen nurses associations** (better organization, more lobbying). **Peer Review Groups** • PRGs are **relevant** and show good **potentialities** to become **sustainable** (efforts to decrease travel costs for members have been made, no salary for the facilitator). • The meetings address **different topics**, such as problems associated with the use of clinical protocols, diagnosis and treatment of various diseases encountered in the practice of the FDs. **Management** and **organizational** issues are also discussed, which is very **relevant**. • One of the reasons of the **success** of the **PRGs** is that they are very **flexible**. Members can choose the topics and can organize themselves whenever they want (every two weeks- once a month). • However, the **depth** and **content** of PRGs **should be strengthened** through the training of facilitators and promoting problem-based presentations. • A better **definition** of **roles** and **responsibilities** as well as a revised **accreditation**/licensing **system** for the PRGs should be defined. • **PRGs** composed by **FDs and FNs** should be organized. This could help to decrease the resistance showed by both groups. • **PGMI and RCFM management** should be better informed and **more involved** in the PRGs process.
Clinical Mentoring by Swiss FD • Is the involvement of the Swiss Association for PHC relevant and the collaboration successful? • Have complementary resources (non SDC funds) for extending the collaboration and mentoring functions, been identified so far?	**Clinical Mentoring by Swiss FD** • Twice a year, 4 Swiss FDs conduct a 3 weeks mission to train local mentors, both from districts and RCFM. A MoU between Swiss FM Association and RCFM has been signed. • Mini-CEX (clinical audits) have been introduced. • 35 FDs from Vose and Hamadoni received clinical mentoring during two mentoring missions by the Swiss FM Association. • A study tour to Switzerland has been organized in 2014, with participation of key decision-makers from different high level	**Clinical Mentoring by Swiss FD** • The mentoring activities through the Swiss Association for Family Medicine ("**HausärzteSchweiz**") are **highly appreciated** by all stakeholders. • The participants of a visited PRGs meeting suggested to **increase** the number of **female Swiss FDs** sent for mentoring, in order to increase the number of women visiting the FDs in the rural areas. • **More local FDs** should be **trained as mentors** (6 to date) in order to ensure the **sustainability** of the approach.

Other • Is CME&L done in gender-sensitive way (gender balance participation and training contents taking into account the differentiated health needs and care approach)?	institutes. **Other** • In collaboration with project Sino, a workshop for project staff on gender and gender mainstreaming was conducted in May 2014. • The results of the gender-sensitive study on perception of FM among students and TSMU staff were presented at the Geneva Health Forum 2014. Results were also discussed during a round table in August 2014 at TSMU and specific plans were made to influence the perception of students and staff.	• **No complementary resources** for extending the collaboration and mentoring functions have been **identified** so far. • **Alternatives to the present model** need to be found through joint partnership between the Swiss society and the Tajik society of FM and more ToT of local mentors to ensure some sustainability **Other** • Due to time constraints, it has not been possible to assess if and to which extent CME&L is done in a gender-sensitive way. • Only **1 female FD** was attending the PRGs visited in the frame of the peer-review.

Outcome 4: Roles and responsibilities of different institutions as well as the financing of medical education are clarified through policy dialogue

Peer-Review key questions	Achievements as of October 2014	Peer-Review findings and recommendations
• Has a mechanism for a regular dialogue across key actors and institutions involved in medical education and human resource development, been set-up by the project and how is it functioning?	• Participation and high visibility of MEP in the Joint Annual Review.	• **Good cooperation with MoH** and **other stakeholders** in the revision of PUST, 6 months retraining FDs and FNs. • **MoH** highly appreciates the program and **considers** it as one of

• Have the roles, tasks and responsibilities between TSMU, MoH, PGMI and RCFM been clarified? What are the main difficulties/resistances/oppositions encountered and is the project able to address these challenges? • Does TSMU still demonstrate a strong leadership and a strategic vision (commitment of the rector and other key persons)? • Is there an agreement on which one is overseeing PUST? • Is there an agreement on training sites overseen by TSMU, RCFM and PGMI, including polyclinic 8 in Dushanbe? • Has the leadership role of RCFM as the responsible institution for CME&L been strengthened? • In which way strategic communication and capitalization feed the policy dialogue? • Is there sufficient political willingness to address structurally the issue of available and qualified health staff at the PHC level? • Is the strong focus on medical education for medical doctors (vs. improving nurses' qualifications and tasks shifting in family medicine centers) still appropriate in the context of Tajikistan? • What is the influence of the project, the SDC health program, the Swiss Cooperation Office and the other donors, in their respective roles in advocacy and policy dialogue, on the implementation of the medical education reform? • Is there potential for improving the leverage of implementation partners and donors on the health reforms?	• Round table on low number of FM interns organized. • Study tour to Switzerland with participants from presidential office, MoH, RCFM, MoF, TSMU, organized.	the most **successful** projects on medical education ever launched in Tajikistan. • **MoH** has **no clear strategic vision** on medical education and demonstrates **weak** stewardship and **leadership**, although it is declared that the reform of medical education is a national priority. On the contrary, **TSMU Rector and high level management** staff have a **very good strategic vision** in medical education. • **PGMI** has demonstrated a **strong leadership** in the design of PUST. • The **policy dialogue** with **MoH** and development partners remains **essential** for the success of planned activities, especially in relation to the introduction of PUST and a national consensus on CME&L concepts and practices. A **strategic communication concept** has to be developed and the **joint policy dialogue SDC/SCO-Project/Swiss TPH** has **to be strengthened**. Shift from a "technical" policy dialogue to a more strategic policy dialogue at higher level, aiming at systemic changes. **Experiences** and best practices compiled in **Kyrgyzstan** in this regard should be **shared** with MEP, MoH and other stakeholders. It should be however kept in mind that some **structural problems** are totally **out** of the **sphere of influence** of both project and SCO. • **Best practices** and **case studies** should be further **documented**, **capitalized**, **shared** and disseminated to MoH, MoE, and other stakeholders. • The **peer-review**, where it was relevant and could advance the strategic thinking and involvement of Tajik authorities, **shared** the **experience** gathered in the **collaboration with the MoH** in **Kyrgyzstan** where SDC is also supporting the medical education reform.

Some differences between MEP Tajikistan and MER Kyrgyzstan

Tajikistan	Kyrgyzstan
Low strategic vision and leadership of MoH.	High stewardship and leadership of MoH.
TSMU high level management has a real strategic vision on this which is not the case at MoH level	University management shows lower commitment

Clinical skills training is well developed	Clinical skills training needs to be improved.
Too many undergrad students, but only one university	Too many students but several competing universities
Public universities by majority of students pay tuitions; little selection	Public universities but students pay tuition; very little selection
No strategy developed for post-graduate medical education	Strategy developed, in circulation for approval
PGMI and RCFM in charge of postgraduate training	Universities in charge of postgraduate training
Interns don't have to pay the fees (a salary, a plot of land or an apartment are allocated by local budget).	Interns and residents still have to pay the fees.
A strategy for CME exists	A strategy for CME is developed, to be approved.
Two main competing institutions in charge of CME	One single institution of CME
Role of medical associations in PGME and CME not defined	Role of medical associations in PGME and CME: definition in process
Introduction of Peer-review groups	Peer-review groups not yet introduced
Pilot interventions in PGME and CME well developed.	Pilot intervention to start soon
FM nursing with a 4th year training already in place	FM nursing pilot tested in Naryn.

Annex 7.3
MISSION PROGRAM
13-22.10.2014

PEER REVIEW EVALUATION: Medical Education reform Project
DONOR: Swiss Development and Cooperation
IMPLEMENTING AGENCY:Representative office of Swiss TPHI in RT, Dushanbe, October 13-22

When	Time	What	Where/Contacts	Who	Responsible	Remarks
October 13, Monday	03:45	**Pick up from airport:** Flight TK 0254: Louis Loutan, Kaspar Wyss, Enrichetta Placella	Mercury Hotel, Tolstoy 09, tel +992 37 2244491, Room 107 Cash (local or USD currency) or Credit card (Visa, MasterCard) ATM/cash machine	SCO	STAIG, DJM	SCO
	12:00-13:30	Business lunch/briefing with the SCO Country Director	Delhi Darbar	MKP, LLO, DJM,PLK, KW,	DJM, SCO	
	14:00-15:00	Meeting with the Minister/Deputy Minister of Health	MoHSP	LLO, DJM, PLK, KW, ET, SH, AE	MEP	To be approved
	15:00-16:00	Meeting with the head of HR & education unit MoHSP, Isupov	MoHSP	LLO, DJM, PLK, KW, ET, SH, AE	MEP	To be approved
	16:15-17:00	Presentation by MEP Project Director KW and Medical education expert ET on progress and achievements of MEP	SCO office	LLO, DJM, PLK, KW, NS, ET, SH	KW, ET	
	18:30	Dinner	Place to be defined			
October 14, Tuesday	08:30-09:30	Meeting with students of TSMU and tour in the Clinical Skills Centre	TSMU new corpus	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	QN, RSTPH, MEP	
	09:30-10:30	Meeting with staff of TSMU Clinical Skills Centre	TSMU new corpus	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	QN, RSTPH, MEP	
	10:30-11:00	Transfer to the TSMU main buiding	TSMU main building	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	MG, RSTPH	
	11:00-12:00	Meeting with the Rector of TSMU	TSMU	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	DJM, SCO	
	12:15-13:15	Lunch	Swiss TPH office		MG, RSTPH	
	13:30-14:30	Meeting with director RFMTC and staff	RFMTC	LLO, DJM, PLK, KW, ET, SH,NR, ZH, AE	SH, RSTPH,MEP	To be approved
	14:45-15:00	Tour in TSMU: Library, LMS office etc.	TSMU main building	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	QN, RSTPH, MEP	
	15:00-16:30	Meeting with the members of working group of TSMU	TSMU main building	LLO, DJM, PLK, KW, ET, SH, QN, ZH, AE	QN, RSTPH, MEP	
	17:00	Transfer to Mercury hotel			MG, RSTPH	

When	Time	What	Where/Contacts	Who	Responsible	Remarks
October 15, Wednesday	08:30-09:30	Conference PGMI, presentation by Interns	PGMI, CHC # 1, 65 microrayon	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	To be approved
	9:30-9:45	Tour CHC # 1	CHC # 1	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH		To be approved
	10:00-10:30	Drive to Rudaki district			MG, RSTPH	To be approved
	10:30-10:45	See the rooms and work of family doctors	Rudaki rayon policlinic	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	
	10:45-11:30	Meeting with interns and tutors in Rudaki	Rudaki rayon policlinic	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	
	11:30-12:00	Meeting with PHC Managers of Rudaki	Rudaki rayon policlinic	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	
	12:30-13.40	Lunch	restaurant in Kolkhoz Rossia		MG, RSTPH	
	13:40-14:10	Drive back to Dushanbe			MG, RSTPH	
	14:15-15:15	Meeting with the head of FM department of PGMI, Professor Mirzoeva	CHC # 1, 65 microrayon	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	To be approved
	15:15-16:30	Meeting with the staff of Post Graduate Medical Institute, FM department (trainers, tutors) and interns	CHC # 1, 65 microrayon	LLO, DJM, PLK, KW, NS, ET, SH, ZK, AE, ZH	ZK, RSTPH, MEP	
	17:00	Transfer to Mercury hotel				
October 16, Thursday	03:45	**Pick from airport:** flight # TK0254 Alexander Bischoff	Mercury Hotel, Tolstoy 09, tel +992 37 2244491,	SCO	STAIG, DJM	
	09:00-10:00	Meeting with the head of Health Policy Analysis Unit MoHSP	MoHSP	LLO, DJM, ABF, PLK, KW, NS, ET, SH, MH, ZH, AE	SH, RSTPH,MEP	To be approved
	10:00-10:15	Drive to PGMI				
	10:15-11:15	Meeting with the head of FM nursing department of PGMI, Samadova & trainer Sharipova	PGMI, FM nursing department	LLO, DJM, ABF, PLK, KW, NS, ET, SH, MH, ZH, AE	MH, RSTPH, MEP	
	11:15-12:00	Meeting with the students of ToT and re-training course for nurses	PGMI, FM nursing department	LLO, DJM, ABF, PLK, KW, NS, ET, SH, MH, ZH, AE	MH, RSTPH, MEP	To be approved
	12:00-13:00	Lunch	restaurant "Kebab house"		MG, RSTPH	
	13:10-13:50	Transfer to Medical college	3 Kamongaron street, orientir Mardon mall, restaurant "Dusti"- car market		MG, RSTPH	
	13:50-14:50	Meeting with the 4 year students of medical college	Republican medical college in Dushanbe	LLO, DJM, ABF, PLK, KW, NS, ET, SH, MH, ZH, AE	MH, RSTPH, MEP	To be approved
	14:50-16:30	Meeting with the head of FM department of the Republican Medical College in Dushanbe, Azizov and the members of WG	Republican medical college in Dushanbe	LLO, DJM, ABF, PLK, KW, NS, ET, SH, MH, ZH, AE	MH, RSTPH, MEP	To be approved
	16:30	Transfer to Merkury hotel				

When	Time	What	Where/Contacts	Who	Responsible	Remarks
October 17, Friday	8:00 - 12:00	Dirve to Khatlon	to Vose district	LLO, DJM, ABF, PLK, KW, NS, ET, SH, ZH, AE	MG, RSTPH	
	12:00-13:00	Lunch	Vose	LLO, DJM, ABF, PLK, KW, NS, ET, SH, ZH, AE	MG, RSTPH	
	13:15 - 14:00	Meeting with PHC Manager of Vose family doctors PRG;	Vose district policlinic	LLO, DJM, ABF, PLK, KW, NS, ET, SH, ZH, AE	SH, RSTPH,MEP	To be approved
	14:00-15:00	Meeting with family nurses PRG	Vose district policlinic	KW, ABF, NS, SH, MH, AE	MH, RSTPH, MEP	
	14:00-15:30	Meeting with family doctors PRG and who covered by mentoring activity	Vose district policlinic	LLO, DJM, PLK, ET, NR, ZH	NR, RSTPH, MEP	
	15:30-16:30	Meeting with facilitators of doctors	Vose district policlinic	LLO, DJM, ET, NR, ZH	NR, RSTPH, MEP	
	15:00-15:30	Meeting with facilitators of nurses PRGs	Vose district policlinic	KW, ABF, NS, SH, MH, AE	MH, RSTPH, MEP	
	15:30-18:30	**Drive back to Dushanbe with Enrichetta Placella**			MG, RSTPH	
	16:30-17:10	Drive back to Kulob			MG, RSTPH	
	17:00-18:00	Homestay in STPHI guesthouse	Kulob guesthouse	LLO, DJM, ABF, KW, NS	DJ, RSTPH	
	18:00-19:00	Dinner	Kulyab restaurant	LLO, DJM, ABF, KW, NS, ET, SH, MH, ZH, AE, NR	MG, RSTPH	
	00:00	Pick from Mercury Hotel and transfer to airport Enrichetta Placella	Mercury Hotel		SCO	
	02:15	Departure SZ101 to Frankfurt	Airport		SCO	
October 18, Saturday	08:00 - 09:00	Meeting with medical college admininstration, FM department	Kulob nurse college	LLO, DJM, ABF, KW, NS, ET, SH, MH, AE	MH, RSTPH, MEP	
	09:15-10:15	Drive to Hamadoni district			MG, RSTPH	
	10:15-11:15	Meeting with Hamadoni PHC manager	Hamadoni district policlinic	LLO, DJM, ABF, KW, NS, SH, ET, NR, AE	SH, RSTPH,MEP	
	11:15-12:00	Meeting with family doctors PRG and who covered by mentoring activity	Hamadoni district policlinic	LLO, DJM, ABF, KW,NS, ET, SH, NR, ZH	NR, RSTPH, MEP	
	12:00-12:45	Meeting with family nurses PRG	Hamadoni district policlinic	LLO, DJM, ABF, KW, NS, ET, SH, MH, AE	MH, RSTPH, MEP	
	12:45-13:30	Drive to Vose district		LLO, DJM, ABF, KW, NS, ET, SH, MH, NR, ZH, AE	MG, RSTPH	
	13:30-14:30	Lunch	restaurant in Vose	LLO, DJM, ABF, KW, NS, ET, SH, MH, NR, ZH, AE	MG, RSTPH	
	14:30-18:00	Drive back to Dushanbe		LLO, DJM, ABF, KW, NS, ET, SH, MH, NR, ZH, AE	MG, RSTPH	
	18:00	Stay in Merkury hotel			MG, RSTPH	
October 19, Sunday		Day off				

When	Time	What	Where/Contacts	Who	Responsible	Remarks
October 20, Monday	03:40	Pick up Kaspar Wyss from Merkury hotel and transfer to airport Dushanbe	Merkury hotel		SCO, STAIG	
	05:40	Departure TK0255	Airport		SCO	
	09:00 - 10:01	Meeting with WHO	WHO office	LLO, DJM, ABF, ET, NS, KH, SH	DJM, SCO	
	11:30- 12:30	Meeting with USAID QHCP	USAID office	LLO, DJM, ABF, ET, NS, KH, SH	DJM, SCO	
	12:30-13:30	Lunch	Place to be defined	LLO, DJM, ABF, ET, NS, KH, SH	STAIG, DJM	
	14:00-15:00	Meeting with AKF/AKHS	AKF/AKHS office	LLO, DJM, ABF, ET, NS, KH, SH	DJM, SCO	
	15:30-17:30	Work on the debriefing session and report			DJM, SCO	
	17:30	Transfer to Merkury hotel				Mercury Hotel, Dushanbe
October 21, Tuesday	9:00-11:30	Meeting with partners - conclusions debriefing with Country Director, MEP project, MoHSP, RCFM, PGMI, Medical nurse college, TSMU	SCO	LLO, DJM, ABF, ET, NS, KH, SH, MH, NR, ZK	DJM, SCO	
	12:00 - 13:00	Lunch	restaurant		MG, RSTPH	
	13:30-17:00	Preparation review report			SCO	
October 22, Wednesday	08:20	Pick up Louis Loutan from Mercury and transfer to airport Dushanbe		LLO	SCO, STAIG	
	10:20	Departure from Dushanbe to Bishkek				
	08:00-12:00	Preparation the review report		ABF, ET	MEP project	
	12:00-13:00	Lunch				
	13:00-16:30	Preparation the review report		ABF, ET	MEP project	
	16:30	Transfer to Merkury hotel				
October 23, Thursday	03:45	Pick up Alexandre Bischoff from Mercury and transfer to airport Dushanbe			SCO, STAIG	
	05:40	Departure to Istanbul TKO255				

ABBREVIATIONS USED

(DJM) - Dr. Mouazamma Djamalova, National Health Programme Officer, SDC; Mob.: + 992 918 612 309;
(LLO) - Dr. Louis Loutan, HUG;
(ABF) - Dr. Alexandre Bischoff, HUG;
(PLK) - Ms. Placella Enrichetta, Health Advisor Eastern Europe and Central Asia, SDC Bern
(KW) - Dr. Kaspar Wyss, Swiss TPH, Project Manager MEP
(NS) Ms.Nisoramo, Family Medicine coordinator, AKF/AKHS
(ET) Dr. Erik van Twillert, Medical Education Expert of MEP, Representative office STPH in Tajikistan mob: +992 918 61 94 16
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SCO- Swiss Cooperation Office
RSTPH- Representative office Swiss TPH Institute in RT
MEP- Medical education reform project
RFMTC- Republican Family Medicine Training Center
PGMI- Postgraduate Medical Institute
FMC- Family Medicine Center
RHC- Rural health center
FD- Family Medicine Doctor
FN- Family Medicine Nurse
PRG-Peer review group

SDC Changes

Emergency numbers in Dushanbe, Tajikistan	
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