

Case study Tajikistan

- 1) **Submission** – Swiss Center for International Health (SCIH) of the Swiss Tropical and Public Health Institute (SwissTPH).
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- 2) **Context** – The definition of a fragile state is more complex than it appears at a first glance. The adjective fragile suggests something that is in vulnerable condition, at the verge of threats that may break the assumed unit into small uncoordinated fragments. A hurried classification would easily bestow the label of fragile to States without overarching institutions projecting the power over a defined territory; States that have weak hold on the institution that guarantees the legitimate monopoly of coercion, taxation and law. These judgments are inspired by theoretical perspective started by Max Weber in early 20th century and still echoed today in the World Bank, OECD, DFID and other international organizations' definitions. The problem though is to associate fragility with failing or failed States; the facts suggest that in spite of lacking such uphold of power, some States have shown surprising resilience despite the constant assumed threats. In those terms, Tajikistan is an example of how trick the “fragile” classification is. The regime victorious after the Civil War has dominated the political scene for almost all 20 years of independence and has survived among severe gaps and cracks in the structures of the formal institutional apparatus. Classifying Tajikistan as fragile state as if it is extremely vulnerable and about to collapse, would not correspond to the truth despite all the warning prospects the International Crisis Group has been continuously issuing. However, Tajikistan can still be called a fragile state, if one has in mind the weakness of the public institutions; a fragility related to the scarcity of financial resources and reduced budget leverage, by which the Governments are not capable of defining comprehensive social and health policies and implementing them. With a public budget of 926 million USD (2007) and a population around 7 million people, with a per capita public budget of 132 USD, the country cannot afford to fund the institutions inherited from Soviet times. The structures show visible signs of decay. Many public functions operate thanks to the informal payments made directly by users to the public employees delivering the services. The informal sources of income are absolute essential for increasing the public employees' income to survival levels. The conditions of the public services and generalized bribe offering and taking have been described by several authors. Tajikistan lives with many thousands of daily informal and illegal transactions being openly practiced by public employees. Such disseminated practices contradictorily seems to have the counter-intuitive effect of keeping the institutional apparatus operating and therefore sustaining the State, instead of undermining it. Independent from agreeing or not with such interpretation, the informal public economy cannot be ignored by donors in their daily involvement with capacity building and strengthening of state and civil society institutions in the country.
- 3) **Brief description of the interventions** – The specific focus of this paper is on a health system's intervention that have been carried out involving topping up salaries of civil servants. The particular intervention addressed here is the support provided for intensive 6 months re-training courses for doctors and nurses working at Primary Health Care level. The topping up of salaries of

trainees, trainers and curators at least doubles the actual monthly income of the benefited civil servants. During the last nine years, the Tajik-Swiss Health Reform and Family Medicine Support Project (Project Sino), funded by the Swiss Development Cooperation and managed by the SwissTPH, has been engaged in these activities. In the last three years, 156 doctors and 239 nurses were retrained at an estimated total average cost of 3,500 CHF per retrained professional.

- 4) **Brief description and reflection on challenges encountered** – When the project entered a new district the usually expected context is mostly characterized by very low salaries, poor technical and working conditions, and low motivated health workers adapted to a situation where very little can be offered to the patients; medicines are scarce, laboratories are non existent, and basic equipment are not available, broken or outdated. Besides that, there is little engagement on policy making or any confidence that policy processes would eventually bring about the desired solutions. Health workers surrender to the working conditions, show accommodation to their chosen survival strategies, and no intention of finding out ways of bringing about policy changes. To introduce a new dynamic into these scenarios, Projects funded by development partners and aid agencies are pressured to try incentive schemes that can mobilize the civil servants and promote their engagement in the planned activities. In the specific case in focus, the Project had to consider that the time doctors and nurses are away from their working posts during the six months re-training program seriously impact their livelihoods, severely constraining their chances of raising much needed income. That cannot be ignored, and the Project adopted the salary topping up strategy as a sensible solution.
- 5) **Reflection on the possible contribution to conflict transformation** – Conflict is not in fact the main issue or a likely occurrence in the described context. The main aim of the intervention is not concerned with diminishing conflict possibilities or solving them. The concern is rather on the strengthening of the health institutions and improvement of the operational capacities and skills on the ground for a better delivery of healthcare services.
- 6) **Evidence of impact of intervention on health, health system, and conflict** – The continuous support provided by several external partners have made Primary Health Care the core topic of the National Health Strategy 2010-2020. The prominence given to the improvement of the capacity and quality of PHC services has official endorsement and effective adoption as a priority policy. This was clearly confirmed with full ownership by the health authorities with the National Conference on Family Medicine that took place in July 2012. Additional evidences of the appropriateness of the intervention is the low attrition rate of retrained professionals (less than 9% over a period of three years) observed through a census of all retrained professionals. Other surveys carried out regularly looking from users perspective, detected increasing levels users satisfaction with the services received from retrained doctors and nurses.
- 7) **Conclusion** – Although many donors show reluctance in accepting topping up salaries of civil servants of recipient countries, arguing that this strategy plays against sustainability, the experience has shown that without positive financial incentives civil servants will not be as motivated as necessary to dedicate time

and efforts for improving the quality of the services they provide. The financial incentives in the described intervention in fact replaces informal income and rent opportunities that would be lost when the civil servant have to be taken away from their working posts for training. The topping up in fact compensates forgone income raising opportunities. On the other hand, the acquired knowledge is taken back to the working post by the newly retrained professional; knowledge well acquired has sustainability character by itself. Even if the training programs are heavily reliant of external on going financial support, the acquired knowledge will sustain improved practices and better quality of services independent from the continuity of the external support. Although the retrained professionals will still rely on informal income generation strategies to carry on their professional activities, the health institutions become a little less fragile, as the technical quality of their employees is improved.