

2/3/2008						
Response to Tina's Questions -- Kyrgyzstan						
Most activities done in collaboration with other donors/projects, documented elsewhere, not included due to space constraints						
Same situation at independence for all countries although level of health financing collapse varied						Tina's
See ZdravPlus II Project Regional Conceptual/Technical Overview Paper Distributed to USAID Evaluation Team for General Definition of Project Components						Scale
Just intended to provide a general picture, not fully specified, activities not always fit precisely across projects, generally allocated to time where most accomplished						For Z+II
Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	ZdravPlus II Remainder and Beyond	+R for Roll-out
Stewardship						
Legal and Policy	No comprehensive policies, patchwork of laws/regulations, governing done by decree	WHO top-down policy development of Manas Program Waivers of laws/regs to start bottom-up Issyk-Kul pilot	Solidified policies, established long-term legal framework consisting of 3 main laws	Developed and approved Manas Taalimi Plan, policy dialogue in priority areas, solidified regulatory base	Policy dialogue in priority areas, improve regulatory base, develop Manas Taalimi II	O
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	Established independent FGPs and MHIF as health purchaser	General dialogue about ISRR, developed MHIF, established associations (FGPA, HA, MAC), dialogue national vs. regional role	Some solidification of overall ISRR, more development of MHIF and decided MOH will be purchaser for public health services, development of FMSA, FGPA, HA, MAC, more delegation of MOH functions to NGO/CBO, establish EBM Unit & some development of Specialty Associations, VHC role as CBO solidified, institutional capacity building	More solidification of overall ISRR and institutional capacity building	O
Policy Marketing	Command and control, little dialogue	Raw politics, donor influence	Establish Press Center, initiate policy marketing	Develop Press Center, more policy marketing	More policy marketing	O
Monitoring and Evaluation	Politically driven	Politically driven	WHO HPAP establishes M&E and policy analysis functions, ZdravPlus contributes to some studies	MOH policy analysis improves, start establish NHA, increase in support for partners assessing data to refine reforms and do studies, built into service delivery QI process	Continue progression of M&E, policy analysis, and applied research studies driving evidence-based policy	O
Donor/Project Coordination	None	Strong informal connections	Strong informal connections	Formalized through SWAp	Expect even more formalized and stronger	O
Resource Use						
Health Delivery System Structure	Inverted pyramid	Establish new PHC sector through independent entities called Family Group Practices (FGPs) in Issyk-Kul Oblast	National roll-out of FGP formation through Family Medicine Centers, and largely restructure hospital sector	Continue restructure hospital sector, 2nd generation internal hospital restructuring, start restructure SES, dialogue about restructure vertical infectious disease systems	Continue 2nd generation internal facility restructuring, continue SES restructuring, implement vertical ID system restructuring	O, P for SES, S for ID systems
Human Resources Planning	None	Limited dialogue on PHC workforce	General dialogue on work force planning	Intensify dialogue on workforce planning due to rural HR crisis, collect and analyze personnel data, implement a few specific interventions	Expect workforce planning and specific interventions to continue as Manas Taalimi priority	O, P, S

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Health Financing	See writing on fragmented financing, no separation of purchaser/provider, wrong incentives in provider payment systems (PPS), etc.	MHIF implement new PPS for variable costs using payroll tax funding, health insurance added horizontally on top of budget financing system rather than separated vertically as in KZ allows MHIF time to build capacity and develop as an institution	MHIF single-payer system piloted and rolled-out nationwide with payroll tax and budget financing, oblast level pooling, and unified PPS; add SGBP and formal copayments; definition of Treasury System problem	Solidify MHIF single-payer system for SGBP including adding rural coefficient and design of performance-based payment under GAVI grant, move to national pooling, work on resolving Treasury System problem, define and approve health sector program budgets, start public health financing reform, very early design of changes in TB financing, very early work on program budgets of High-Tech Fund and capital, SWAp mechanism extends into broader governance and transparency including fiduciary risk measures such as external audit, internal audit, internal controls, etc.	Continue solidify MHIF single-payer system including piloting performance-based payment, hopefully solve Treasury System problem, strengthen public health financing, pilot TB financing, continue work on other program budgets including High-Tech, capital, medical education, enhance broader governance and transparency activities	O, P, R, S
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	New automated hospital database, HIS linked to formation of new independent FGPs	Comprehensive HIS system for MHIF single-payer, start improvement of overall HIS system	Continue solidify MHIF single-payer HIS, incorporate specific elements into RMIC integrated national system	Continue solidify MHIF single-payer HIS, incorporate specific elements into RMIC integrated national system, more links curative and public health data	O
Health Management	Command and control, politics equated with management	PPS triggered some better facility level management	PPS triggered better facility level management, started health management courses for facility managers	PPS continues trigger some better facility level management, continue health management courses for facility managers and expand to public health, realized that hard to improve facility level management without more provider autonomy coming from solving Treasury System problem	Hopefully solving Treasury System problem enhances facility level health management; plan, develop, and introduce long-term health management education	O,S
Service Delivery						
General Health System Functions						
Postgraduate Medical Education	Old system collapsed	Train FM trainers, start PHC doctor and nurse retraining process	Establish oblast level FMTCs and FMSA, largely finish national PHC doctor and nurse retraining, start integrating vertical training into PHC training structure including TB DOTS, start converting to long-term CME	Strengthen FMTCs/FMSA and FM facility development, solidify PHC doctor and nurse CME/CNE, link CME to EBM/CPG and service delivery priority program QI, continue incorporate vertical program training into integrated PHC FMTC structure, initiate feldsher training	Largely the same as Z+ II to date -- just a natural progression... Solidify FM residency, decentralize and institutionalize into oblast FMTCs/FGPs for sustainability and to address rural HR crisis, improve all residency training	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	Minimal	Start family medicine residency	Continue family medicine residency but hard to strengthen without reform of undergraduate ME, start linking with rotations at republican institutes especially Cardiology Institute	Continue develop ME accreditation and link to WFME standards, develop ME Reform Concept and initiate real movement to improve undergraduate ME	O, S
Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	None	Link with Regional Council of Rectors	Realign regional Council of Rectors to focus on ME accreditation and move more to country level, undergraduate ME becomes Manas Taalimi priority		O,S

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
EBM/CPGs	Nature of clinical practice not based on evidence	Minimal	Start promoting and build capacity in EBM, begin to separate functions by early work with Speciality Associations to develop new CPGs	EBM Unit established, EBM/CPG dialogue including roles and relationships of all stakeholders, continue promote and build EBM capacity, introduce CPG development methodology, continue work with EBM Unit, Specialty Associations, and FGPA/HA on developing CPGs with relatively good process/result in Asthma CPG which can be used as a model	Continue promote EBM; strengthen roles of EBM Unit, Specialty Associations, and FGPA/HA; continue develop better CPGs; improve link to CPG implementation process using bottom-up QI	O
Quality Assurance	Punishment	Minimal	Initiate facility accreditation through MAC, MHIF develop QA techniques linked to payment	Strengthen MAC facility accreditation and extend to private facilities, strengthen MHIF QA	Continue natural progression...	O
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	Pharmacy privatization, essential drug list, formularies	Start outpatient drug benefit (ODB), limited national drug policy work, rational drug use	Strengthen ODB, donated drugs to support ODB, extend rural pharmacies including collaboration with Swiss, WHO, and USAID/CFAR, strengthen rational drug use and link to EBM/CPG, CME, health promotion	Strengthen ODB, continue link rational drug use EBM/CPGs, medical education, service delivery priority program QI, population health promotion	O
Infrastructure	All owned by state, massive and deteriorating	Support Kyrgyz partners in specification for WB project equipment, contribute architectural plans for FGPs, limited equipment and renovation	Support Kyrgyz partners in specification for WB project equipment, initiate facility inventory databases, limited equipment and renovation	Strengthen facility inventory databases, limited equipment and renovation, move to extend PHC strengthening to include FAPs and equip them through Manas Taalimi	Likely minimal...	O
Service Delivery Priority Programs						
General Practice/Hypertension	Problems inherent in system including weak PHC	Included in FM	Included in FM	Became service delivery priority program, linked CME, EBM/CPG, ODB and rational drug use, facility level QI, and health promotion to improve service delivery	Continue QI expansion and solidification at PHC level, link to hospital level including new CPGs	P, R, O
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based	Some inclusion in FM and some specific family planning activities	Some inclusion in FM, increase access to FP through rural midwife/IUD program	SM became service delivery priority program, linked intensive training/CME, EBM/CPG, rational drug use, facility level QI, and health promotion to improve service delivery across levels of care, first pilot then roll-out. FP linked to SM, post-partum and post-abortion, received and integrated contraceptives into program, and continued rural midwife/IUD program	Continue roll-out	P, R, O
Child Health	Problems inherent in system including weak PHC and not evidence-based	Started integrating into FM	Solidified integration into FM, IMCI included in FM retraining, IMCI facility level supervision and QI in Issyk-Kul Oblast	Solidify integration into FM, Asthma CPG development and implementation serves as model	Continue solidify in FM, continue develop and implement new CPGs	O
TB	Excess capacity in vertical system, not evidence-based treatment, reach of vertical system no longer able to control all TB-related issues	Minimal	Integrated TB DOTS into PHC retraining and some linkages on health promotion	See Askar's program summary and other writing -- generally, policy dialogue including stewardship and restructuring, start design of change in TB financing, integrate TB DOTS into ME, integrate TB DOTS into PHC, link civilian and prison TB systems, health promotion. All activities in collaboration with Project HOPE.	Much work required to strengthen integration between general health system and vertical TB system and restructure and change financing of vertical TB system	O, S
HIV/AIDS	Not yet emerge	None	Some linkages in FM and health promotion	Incorporate into Safe Motherhood, PHC training, health promotion including in VHCs, dialogue on linkages HIV/AIDS and broader health system and financing	Decision on nature of vertical HIV/AIDS system, restructuring and financing, and continue link service delivery and health promotion	O,S
Population and Community Health						

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Marketing the Reforms	Population role not seen as important	Free choice of FGP and enrollment	Continue free choice of FGP and enrollment, promote benefits and rights, MHIF complaint line, promote FM/PHC	Incorporate enrollment in FGP into health financing linked to capitated rate, intensify promotion of benefits and rights	Expand activities and link with more open society	O
Health Promotion -- Government	Not yet emerge	None although did independent mass media campaigns on selected health topics	Limited support for Republican Center for Health Promotion	Limited support for Republican Center for Health Promotion	Limited support for Republican Center for Health Promotion	O
Health Promotion -- Providers Linked to Service Delivery	Not yet emerge	Minimal	Started facility level health promotion to empower population with information and change nature of relationship between FGPs and population, start improving inter-personal communication skills of providers	More intense and focused health promotion at health provider level directly linked to service delivery priority programs, continue improving inter-personal communication skills of providers	More intense and focused health promotion at health provider level for service delivery priority programs	P, R, O
Health Promotion -- Community-Based Entities	Not yet emerge	None	Minimal, connected to various consumer organizations	Collaborate with Swiss to roll-out Village Health Committee model including contribution to building civil society	Continue roll-out VHC model and broader linkages to civil society and democratization	P, R, O