

Mid-Term Evaluation of USAID/CAR Project
Quality Public Health and Primary Health Care
in the
Central Asian Republics
“ZdravPlus II”

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List of Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AH	Arterial Hypertension
BBP	Basic Benefit Package
BWAK	Business Women’s Association of Kazakhstan
CAH	Swiss Red Cross Community Action for Health (Kyrgyzstan)
CAR	Central Asian Republics
CBO	Community Based Organization
CDC	U.S. Centers for Disease Control
CGD	USAID Center for Global Development
CHSD	Center for Health System Development (Kyrgyzstan)
CI	Cardiology Institute (Kazakhstan)
CME	Continuing Medical Education
COE	Center of Excellence (Tajikistan)
COM	Council of Ministers (Uzbekistan)
CORE	CORE Initiative Capacity Assessment Tool
CPG	Clinical Practice Guideline
CRH	Center for Reproductive Health
CTO	USAID Cognizant Technical Officer
CQI	Continuous Quality Improvement
DFID	United Kingdom Department for International Development
DIC	Drug Information Center (Kazakhstan)
DOTS	Directly Observed Therapy – Short Course
EBM	Evidence Based Medicine
EBG	Evidence Based [Clinical] Guidelines
EML	Essential Medicine List
EDIN	Eurasia Drug Information Network (Uzbekistan)
FBO	Faith Based Organization
FGP	Family Group Practice (Kyrgyzstan)
FGPA	Family Group Practice Association (Kyrgyzstan)
FM	Family Medicine
FMA	Family Medicine Association (Tajikistan)
FMSA	Family Medicine Specialists Association (Kyrgyzstan)
FSU	Former Soviet Union
GAVI HSS	Global Alliance for Vaccine and Immunisation Health Systems Strengthening
GDP	Gross Domestic Product
GH	USAID Bureau of Global Health
GNI	Gross National Income
GOK	Government of Kazakhstan
GOKR	Government of Kyrgyzstan
GOT	Government of Turkmenistan
GoU	Government of Uzbekistan
GP	General Practitioner (Uzbekistan)
HA	Hospital Association (Kyrgyzstan)
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMN	International Health Metrics Network
HR	Human Resources
IDF	Institutional Development Framework
IIP	Integrated Improvement Programs
IMCI	Integrated Management of Childhood Illnesses
IRTT	World Bank Health Sector Institutional Reform and Technology Transfer Project (Kazakhstan)
ISQUA	International Society of Quality Assurance
ISRR	Institutional Structure, Roles and Relationships
JPIB	Joint Program Implementation Board (Uzbekistan)
KAFP	Kazakhstan Association of Family Practitioners
MAC	Medical Accreditation Committee (Kyrgyzstan)
MCC	Millennium Challenge Corporation
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MHIF	Mandatory Health Insurance Fund (Kyrgyzstan)
MHIG	Mahalla Health Initiative Group (Uzbekistan)
MIC	Medical Information Center
MOF	Ministry of Finance
MOH	Ministry of Health
MOHMIT	Ministry of Health and Medical Industry of Turkmenistan

MOEBP	Ministry of Economy and Budget Planning (Kazakhstan)
NGO	Non-governmental Organization
OCAT	Organizational Capacity Assessment Tool
ODB	Outpatient Drug Benefit
ODBP	Outpatient Drug Benefit Program
OECD	Organisation for Economic Co-Operation and Development
OHD	Oblast Health Department
PAL	Practical Approach to Lung Disease (Finnish, Kyrgyzstan)
PDQ	Partnership Defined Quality
PED	U.S. Program for Economic Development
PGI	Post-Graduate Institute for Physicians (Kazakhstan)
PHC	Primary Health Care
PMP	Performance Monitoring Plan
PP/PM	Per Person/Per Month
PPS	Prospective Payment System
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Project (Uzbekistan)
RHC	Rayon Health Committees
RMIC	Republican Medical Information Center (Kyr)
RRS	Rayons of Republican Subordination (Tajikistan)
RTI	Research Triangle Institute
SES	Sanitary Epidemiological Service
SGBP	State Guaranteed Benefit Package (Kyrgyzstan)
SHCDP	State Health Care Development Program (Kazakhstan)
SM	Safe Motherhood
SOW	Scope of Work
STLI	Scientific Technology and Language Institute
STI	Sexually Transmitted Infection
SVP	Rural primary health care centers (Uzbekistan)
SWAp	Sector- Wide Approaches
TA	Technical Assistance
TB	Tuberculosis
TIAME	Tashkent Institute for Advanced Medical Education (Uzbekistan)
TOT	Training of Trainers
TSMU	Tajikistan State Medical University
UNICEF	United Nations Children's Fund
US	United States of America
USAID	United State Agency for International Development
USG	United States Government
VHC	Village Health Committee
WB	World Bank
WB PIU	World Bank Project Implementation Unit (Tajikistan)
WHO	World Health Organization
WHOI-EURO	World Health Organization International-Europe
WTO	World Trade Organization

Executive Summary

A. Background and Objectives

The Quality Public Health and Primary Health Care in Central Asia (ZdravPlus II) project is the third of a series of projects (“Zdrav”) that began in 1994 with the same prime contractor (Abt Associates, Inc.) to support the reform of the Soviet-era health systems in the Central Asian Republics. The countries of Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan have been part of the project since the beginning. Due to a civil war, assistance to the country of Tajikistan did not begin until 2005. The current contract period is five years (January 7, 2005-December 6, 2009) for a total estimated cost of \$30,551,021.

The USAID/Central Asian Republics (CAR) Mission commissioned a mid-term project evaluation to be conducted by a five-person team (“the Team”) starting in January 2008, with four objectives:

- Assess the contractor’s performance.
- Review the regional approach used in this contract.
- Summarize lessons learned.
- Identify priorities for USAID assistance in health systems strengthening during and beyond the contract period.

B. Context

The objective of USAID assistance was to restructure the health care system to have a strong primary care foundation. The strategy was summed up as “inverting the health care pyramid,” whereby most resources were concentrated at the bottom of the health care system (at the primary care level) rather than at the top (at the hospital level). To achieve this, the quality of primary care had to be improved, resources redirected and patients educated about the benefits of self-care and primary care.

Since the beginning of the Zdrav series an overall framework of four components has been used for organizing country specific reform strategies. The components are

- 1) **Stewardship** – The government’s role in health—policies, laws, and institutions;
- 2) **Resource use** – Financing, organizing, managing and staffing health services;
- 3) **Service delivery** - The combination of services, providers and strategies for delivering quality patient care; and
- 4) **Population and Community Health** - Education and empowerment of individuals and communities to care about their health and health care.

C. ZdravPlus II Performance Assessment

1. Overview:

In the context of each country's opportunities and limitations, Zdrav Plus II has made significant progress with its comprehensive, yet tailored, approach to health system restructuring. They are fully meeting and often exceeding the technical requirements of the USAID contract. The success achieved by this relatively small technical assistance project is due to a number of factors. For one, ZdravPlus II has been unusually diligent about coordinating its work with major donors, such as the World Bank and the Asia Development Bank, effectively leveraging very large resources.

Knowledgeable officials from host countries and donors describe ZdravPlus II as a critical collaborator, highly valuing its in-depth knowledge of the local context, superior expertise in health reform issues, experience in change management and details of implementation as well as excellent working relations with governments. Among the enabling factors behind this performance, the Team would identify the long continuity of the Zdrav series, USAID's flexible management in allowing ZdravPlus II broad latitude to pursue reform, and sustained visionary leadership. These attributes have allowed ZdravPlus II to leverage country health system resources, move expeditiously when opportunities arise and collaborate with a large number of international partners.

ZdravPlus II has recently entered a phase of accelerating value added, with multiple reforms entering large-scale implementation across the region. This expansion suggests that host countries are increasingly open to enacting reforms, based on successes they are seeing in the region, particularly in Kyrgyzstan, and their confidence in ZdravPlus II's advice. ZdravPlus II assistance may also be growing more effective based on their experience testing reform models.

The Zdrav series of projects is remarkable for its ambitious goals, long-term continuity, and potential for large-scale, institutionalized benefits for health. It has pushed well beyond the boundaries of previous USAID health reform initiatives globally. That such a wide range of promising changes was supported with such a modest investment by USAID is a tribute to the dedication and skills of both the Zdrav and USAID/CAR managers.

2. Performance against Performance Monitoring Plan (PMP) Indicators

Analysis of the PMPs for the five CAR countries shows that with few exceptions ZdravPlus II has met or exceeded targets in all countries. In some cases, the targets for 2009 have already been met. The PMPs were found to not always be useful in gauging the progress of reform in the country.

3. The Four Components

ZdravPlus II's approach to project implementation is summed up as a top-down/bottom-up strategy. The four components are useful for teasing apart the layers within the system.

a. Stewardship

Achievements in the stewardship component have been an area of consistent strength. From the outset of its work, Zdrav effectively gained trust from host governments along with a willingness to be open to Zdrav's ideas about how to proceed with reforms. The high level of trust is so pervasive that host country leaders have adopted ZdravPlus II's ideas as their own, greatly facilitating the advancement of reform through the stages of legal and regulatory change to pilot testing. All governments regard ZdravPlus II as an invaluable advisor.

The changes that have resulted from ZdravPlus II's work in this component are quite variable and depend upon the governance and recent history of each country. Kyrgyzstan and Kazakhstan have been most active in reforming policies and institutional roles, achieving changes across a wide spectrum of reform issues. In Kyrgyzstan, the legal framework for reform is now firmly established. Kazakhstan still has significant issues to address.

Uzbekistan was slower to open up to health reform and its progress in stewardship is limited to legislation related to resource use. In Tajikistan, the government has passed a few measures that are consumer-oriented, such as introduction of a basic benefit package and co-payments. Turkmenistan has adopted policy changes related to nine clinical areas, mostly maternal and child health.

b. Resource Use

The acceptance of new financing systems and roles for facility managers has been uneven. Kyrgyzstan, Kazakhstan and Uzbekistan have implemented capitated payment for primary care, pooling of health service delivery funds under one institution at either the national or oblast level, a single payer system and establishment of health care facilities as independent legal entities, giving decision making authority to managers. Of these four indicators of reform progress, only Kyrgyzstan has a fully functional system. Kazakhstan does not yet have information systems in place that enable managers to perform their new functions. Uzbekistan is capitating only rural facilities nationwide, and facility managers have little actual autonomy. In Tajikistan capitated payment has been implemented in eight pilot rayons. In Turkmenistan the project has supported new management systems, in particular health information, health financing and provider payment systems.

c. Service Delivery

In this component, the differences in country priorities are pronounced, and demonstrate why responsiveness to host country conditions has been such an important factor in ZdravPlus II's success. They have been flexible about how reforms should be sequenced, and have concentrated on areas where they could gain the most immediate traction.

Family medicine, EBM and continuous quality improvement (CQI) are at the heart of the reform agenda. The project's efforts to help change physician practice, however, are proving to be quite challenging. Kyrgyzstan and Kazakhstan are promoting family medicine and evidence-based medicine (EBM) as national priorities, but the medical academic establishment continues to resist EBM. This situation is impeding the progress of reform.

In Kyrgyzstan low physician salaries are creating a serious problem of attracting and retaining providers for rural areas. ZdravPlus II is assisting the Kyrgyz government in developing options for mitigating this crisis.

In Kazakhstan, ZdravPlus II designed integrated improvement projects (IIP) to combine the following at one facility: patient training, CME, CPG implementation and quality monitoring. The Team found this approach to be potentially very influential globally.

Current conditions in Tajikistan are such that the ZdravPlus II program has concentrated on improvements in service delivery. Two centers are combining the use of evidence-based medicine CPGs with practical training in clinics and interaction with patients. They are also capitalizing on the unusually strong leadership at the medical academy to make significant in evidence-based medicine.

In Turkmenistan, host country officials and donors find that ZdravPlus II's depth of knowledge about program implementation in the Turkmen health system to be a unique strength. ZdravPlus II has used a very small budget effectively to support maternal-child health, introducing innovations in a highly conservative system.

In Uzbekistan, ZdravPlus II is working on health services improvements through collaboration with other donors.

d. Population and Community Health

Kyrgyzstan is the only country where there has been significant progress in establishing national membership organizations for professionals, associations of groups working in the health sector and community-based organizations for involving the public in the health care system and their health care. The shared vulnerability is the lack of plans for ongoing financial sustainability.

The role of NGOs in Kazakhstan is limited, but it has been accepted. ZdravPlus II funded the Kazakhstan Association of Family Practice (KAFP) to promote the new profession of family medicine and evidence-based approaches to disease treatment. Long term financial viability of KAFP is a source of concern.

In Tajikistan, there are modest, but encouraging signs that the government will be receptive to ZdravPlus II's assistance in educating the public about the reforms and promotion of personal health.

Turkmenistan has one program for health promotion which operates in only part of the country.

Due to the climate in Uzbekistan regarding community action, ZdravPlus II's work has been scaled back and refocused through different channels.

4. Performance by Country

Kazakhstan: As it moves to modernize its system, the GOK has expressed a sense of urgency about the need for the resources of ZdravPlus II to be available to it, as they are still greatly dependent on the project for analysis and guidance.

ZdravPlus II achievements in Kazakhstan are most significant in the areas of stewardship and improved resource use. The greatest challenges for ZdravPlus II lie in the complexity of transitioning to a new service delivery system and the resistance to an active NGO role in gaining public awareness and enthusiasm for the reforms. They are testing models that integrate all the components of their multi-faceted program, including financing and payment, family medicine, evidence-based medicine, health information systems and outpatient drug benefits. But the new system is not yet fully operational across any oblast. To protect the USAID investment in the Kazakh health reform program, the project's continued presence is essential for at least the next two years. The Team suggests that the GOK be approached about assuming responsibility for future funding of activities in Kazakhstan under the direction of USAID.

Kyrgyzstan: ZdravPlusII has made impressive contributions to the health system in the Kyrgyz Republic through all four components in fundamental and significant ways. By the end of this project, the Kyrgyz Republic health system will operate in fundamentally different and better ways because of ZdravPlusII's engagement. The remaining challenges are to reform the public health system and ensure the sustainability of local institutions that will bear the responsibility of continuing to operate and strengthen the health system. The long-term viability of the health system will depend on continued political support, engagement of strong civil society entities, increased public spending on health, solving the problem of workforce migration, and solutions that engage the private sector and respond to the needs and interests of urban as well as rural residents. USAID support to address these issues continues to be needed.

Tajikistan: The Tajik government is just beginning to restructure and strengthen primary care. There is little human or institutional capacity in the country to achieve this; but where pockets of capacity exist, ZdravPlus II is leveraging them to make exceptional gains. ZdravPlus II has established itself as the primary policy and legislative adviser to both the Tajik government and other donors.

In the stewardship area, legislation has been passed on family medicine, physician capitation, a basic benefit package and co-payments. The service delivery component is the heart of the project in Tajikistan. There are two important demonstrations showing how vertical programs can be integrated into a family medicine practice. There are good prospects for continued progress in the service delivery component because several prominent academic leaders are working with ZdravPlus II to modernize clinical practice.

Turkmenistan: From the beginning of the Zdrav series, the project has maintained an effective working relationship with the government, even as many other assistance programs made little progress or were ended. To a large degree, Zdrav's continued presence in Turkmenistan since 1994 reflects its responsiveness to the government and appreciation for the benefits they received from learning about the experiences of other ZdravPlus II countries, and the adaptation of tools from these countries. Zdrav's work on IMCI and SM provided the clinical subject matter for successfully introducing EBM, eliciting a request to expand the EBM training program. Senior officials expressed a high degree of trust in the project staff. Recent political changes seem likely to accelerate the reform process.

Uzbekistan: With the assistance of ZdravPlus II and other donors, Uzbekistan has almost completed the roll-out of a rural primary health care program. Important reforms have been achieved in resource use and service delivery. These initiatives, coupled with clinical training and introduction of quality improvement systems, are expected to significantly improve services and efficiencies. The changes have led to increased capacity to make budget decisions at the oblast level and have also given facilities more (though still quite limited) control of their finances and management. An urban version of this approach is currently being piloted.

C. The Regional Approach

The Team found that the regional approach taken under the Zdrav initiative had many benefits –technical, economic and strategic. However, under ZdravPlus II funding of the regional activities has been greatly reduced. As health systems reform moves from policy debates to the details of implementing complex changes, the Team finds the technical relevance of work across countries to be of growing, not diminishing, importance.

D. Lessons Learned

The team defined a lesson learned as a feature of the project that has been particularly effective in the achievement of USAID's objectives, both in the health sector and beyond.

- Reform takes time.

- Well managed projects attract capital to the health sector from the host country and other donors.
- The strongly supportive relationship between ZdravPlus II and host country counterparts is a proxy for US relations, creating an immense amount of goodwill for the United States and USAID in the region.
- Models of good governance, Treasury system reform and civil society in the health sector are transferable to other sectors within the government.
- Donor harmonization, project coordination and integration will maximize the impact of each donor's efforts and reduce the host country costs of servicing the donors.
- Host countries and the World Bank view the continuity of USAID's role in successful reform efforts as a form of insurance for their investments due to the technical expertise of ZdravPlus II.
- Self-contained, vertical disease-specific programs, such as those for HIV/AIDS and TB, are not making use of all the available resources for treatment. ZdravPlus II's success at grounding these programs in the primary care system has given providers access to expanded resources, improving patient care and outcomes.
- A bottom up and top down approach brings together the community and service delivery levels and the political and legal levels of reform to creating lasting change and ownership of reform efforts.
- Key stakeholders are the engine of change. Well-placed advocates accelerate change once institutions are in place.
- Creating regular forums (i.e., seminars, conferences, workshops) for sharing ideas and solving problems across countries and within countries facilitates understanding of the reforms and creates linkages.
- Complex reform initiatives can be tailored to the abilities of each country.
- Maintaining the role of a technical resource, not aligned with a political agenda, enables the contractor to be flexible and agile as governments undergo change.
- Engagement of civil society organizations and professional associations contributes to country ownership and sustainability.

E. Priorities for USAID Assistance in Health Systems Strengthening During and Beyond the Contract Period

This project has helped Central Asian countries make tremendous advances in structuring their health systems to operate efficiently and to respond to the health care needs of their population. Selected strategic recommendations relating to areas that need a boost are listed below. The report includes additional individual country recommendations for the next two years and beyond which are not included here.

1. The Last Two Years of the Contract Period (Unless a specific country is identified, the recommendation applies to all countries.)

- Determine the prospects for success in reforming the SES system before proceeding further. (Kazakhstan, Kyrgyzstan)
- New strategies are needed to improve the prospects for adoption of EBM FM.

- Address areas of vulnerability before withdrawing USAID support: 1) measures to sustain the non-governmental organizations that have been spawned by this project, and 2) ways to link retention incentives with human capacity development. (Kyrgyzstan)
- Develop a fully integrated model of health reform in at least one entire oblast in Kazakhstan. Expand this model to at least one other entire oblast (Kazakhstan)
- Begin developing a PED-type arrangement with the GOK so that it can have on-going access to ZdravPlus II technical assistance and USAID can maintain high visibility in the improvement of health care in Kazakhstan.
- The service delivery component should continue to be given highest priority in project activities. (Tajikistan, Turkmenistan, Uzbekistan)
- Expand the number of CPGs to be piloted at primary care centers. (All)
- Incorporate the “improvement collaborative approach” into quality improvement
- Use assessment based approaches to strengthen health promotion activities.
- Begin using the Health Metrics Network assessment tool and guidelines.
- Build capacity to manage complex issues that financing reforms will bring,
- Organize management improvement collaborative among polyclinic managers.
- Apply CQI and EBM to TB and HIV/AIDS in new pilots.
- Establish tutorials for health managers based on financing and service delivery implementation experiences.
- Establish a regional fund for conferences and information exchanges among peer stakeholders in the region.
- Invest in analysis of project experience (successes and failures) and globally disseminate lessons learned.
- Continue to support ZdravPlus II’s role as a collaborator and technical adviser to other donors.
- Align project structure with consensus framework on health system components.

2. 2010 and Beyond

- Expand stewardship and population/community health initiatives in Tajikistan, Turkmenistan and Uzbekistan.
- Establish support and capacity for an institutional structure for pooling of funds for health services delivery and financial management autonomy for health facility managers. (Tajikistan)
- Expand clinical practice improvements using EBM CPGs. (All countries)

I. Background and Context

When the Soviet Union broke up in 1991, each country in the USSR gained independence and assumed responsibility for its economic and political future. However, health reform had actually begun earlier in the USSR; when in 1987, management of the health care system was decentralized to the republic level. While health care management had devolved from Moscow, the structure of the Soviet system was entrenched as was the notion that the state was responsible for the social safety net, giving citizens entitlement to health care services “free of charge.”

The Soviet system was based on the Semashko model of health care, a centralized system where the state owned and operated the health care facilities and all health care personnel were employees of the state. The concept of the Semashko system was that primary care was the foundation for a strong health care system. But over the years, the system had become greatly distorted and financing had concentrated at the hospital level with more than 70% of funding going to the highest level of care. Also, the supply of physicians per population was above international norms; treatment plans were heavily medicalized; and there was a predominant reliance on specialist care. Further weakening the system, the running cost of the health sector had always been under-funded since it was viewed as a “consuming” sector, rather than a “producing” sector. In order to get service and medications, patients often had to offer gratuities or “under-the-table” payments to providers. The combined result of under-funding along with distortions favoring specialty and hospital care, was that primary care was starved of both funds and talent. Reflecting the lack of capacity for early diagnosis and treatment and failure of the population to take responsibility for its own health, the health status of the population was in steady decline. Despite the fact that the sector was under-funded, the state was wasting its scarce resources and the population was absorbing the brunt of the system failures.

In 1994, USAID funded *ZdravReform*, the first in a series of three projects to help the Central Asian Republics to reform their health care systems. The first project offered assistance to Kyrgyzstan, Kazakhstan, Turkmenistan and Uzbekistan. Now in its third contract period, the Quality Public Health and Primary Health Care in Central Asia (*ZdravPlus II*) project is funded through 2009 and includes Tajikistan in the scope of work. The current contract period is five years (January 7, 2005-December 6, 2009) for a total estimated cost of \$30,551,021. In this report, the group of projects implemented by the prime contractor, Abt Associates, will be referred to generically as “Zdrav.”

The objective of the assistance has been the same since 1994 and is summed up nicely in a project concept paper as follows:

“The restructuring of the primary care delivery system is considered to be a central component of any health reform effort aimed at improving population health status through a strengthened system of primary care. Restructuring the primary care delivery system also provides the conditions necessary for other aspects of health reform, such as the introduction of many modern clinical protocols, the implementation of new provider

payment methods, and increasing population involvement and choice.” [Conceptual Foundations for Central Asian Republics Health Reform Model, September 1999]

II. Problem Statement and Theory of the Intervention and Design of Project

In preparation for this evaluation, the team requested ZdravPlus II to submit background information on selected topics. To establish the development theory for Zdrav’s health system reform intervention, the team asked this question: “Provide a statement of the problem when Zdrav was first funded. What was it that USAID set out to fix or change in CAR?” The response follows:

“ZdravReform was first funded in 1994. Early in ZdravReform, three major problems were identified:

- a. The very large, overly specialized, and fragmented health system with enormous amounts of excess capacity was no longer sustainable given the general economic and health budget collapse that occurred after the fall of the Former Soviet Union (FSU). Specifically, the hospital sector was very overdeveloped and fragmented and more cost-effective primary health care (PHC) was very weak or even non-existent.
- b. In addition to the problems caused by health delivery system structure and financing, PHC was weak or non-existent due to the lack of family or general practice (all doctors were specialists) and the low capacity of PHC practitioners (catchment area physicians largely serving as dispatchers referring the high majority of their patients).
- c. The system was not responsive to the needs of the population and the population was not involved in their health.

It was decided the solution to these problems was the overarching project strategy of inverting the health delivery system pyramid. The early specific interventions were forming a new PHC sector; introducing health financing reform including new provider payment systems; introducing family or general practice and upgrading the skills of PHC practitioners; and involving the population through free choice of PHC practice and health promotion. The scope of the health reforms expanded significantly over time and specific interventions evolved with them, however, they generally continued to be built on this basic foundation.

Towards the end of ZdravPlus I, another underlying or core problem was added:

- While producing results, significant efforts to retrain PHC practitioners and implement PHC-level service delivery improvements (largely through WHO programs such as IMCI) were not creating a critical mass for change in the overall nature of clinical practice.
- The problem was defined as medical leadership and specialists not accepting

the changes in clinical practice or allowing PHC practitioners to use their new knowledge or to expand the scope of services in PHC.

The solution decided upon was to work to change the overall nature of clinical practice by broadly promoting evidence-based medicine (EBM) to medical leadership and the development and implementation of new clinical practice guidelines (CPGs) in addition to continuing to introduce family or general practice and specific service delivery improvements in priority program areas.

The overall intended results were to use implementation strategies to introduce conceptual/technical interventions solving or improving the major problems identified in the health sector.

[In the] Performance Monitoring Plan (PMP) tables (Annex P), ZdravPlus II Project Regional/Technical Overview paper (Annex Q), Implementation Strategies paper (Annex R), and matrix tables (Annex S) there is more detail; but in general, intended results were/are as follows:

- A. Form new PHC sector, restructure and rationalize hospital sector and shift savings to PHC, and introduce new health financing system increasing both equity and efficiency in individual health services
- B. Service delivery:
 - Introduce family or general practice to increase capacity and improve service delivery in PHC and gradually expand scope of services in PHC by integrating priority programs
 - Specific service delivery improvements in priority program areas by implementing new CPGs or standards or implementing WHO programs using facility level quality improvement techniques
 - Broadly promote EBM, develop new CPGs, and rational drug use
- C. Greater population and community involvement in their health
- D. Improve overall stewardship in the health sector
- E. Expand the scope of the health reforms to include next generation areas of improving financing system and service delivery for public health, infectious diseases, and undergraduate medical education.

The indicators that the reforms are sustainable and that countries are self-directing their health care systems are as follows:

A. The intended results outlined above

B. Institutional structure, roles, and relationships appropriately separating functions and allowing the right institution to do the right thing, a well established health purchaser and provider autonomy, delegating functions to NGOs and CBOs, clear roles and relationships at national and regional levels, and capacity in the MOH and other entities for health sector stewardship.

C. [As shown in the] health sector pendulum [included in the Implementation Strategies paper (Annex R)], the health system begins to show its capability to continuously refine and self-adjust the system to adapt to changes in the environment and increase the responsiveness of the system.”

III. Purpose of Evaluation

The project to be evaluated is the Quality Public Health and Primary Health Care in Central Asia (ZdravPlus II) Contract #176-C-00-05-00002-00 implemented by Abt Associates, Inc. and various sub-grantees. This contract is currently in its third year of implementation. The project will end on December 6, 2009.

The purpose of this evaluation is to: (1) assess the contractor’s performance; (2) review the regional approach used in this contract; (3) summarize lessons learned; and (4) identify priorities for USAID assistance in health systems strengthening during and beyond the contract period.

IV. Country and Regional Findings

A. Summary: The team found that since 2005 ZdravPlus II has achieved significant successes in all five Central Asian Republics. They have vigorously continued pursuing the Zdrav strategy launched in 1994 to be a partner to countries as they restructure and strengthen their health care system by building a strong foundation of primary care. Since quality primary care is the end result of a well functioning system which includes a multitude of sub-systems, the breadth and depth of program has been audacious and ambitious. The sub-systems involved are financing, organization, management, health information, clinical training, quality assurance and improvement, monitoring and evaluation and health promotion. The regional system of management with country level teams has been effective in utilizing the intra-regional experience of neighboring countries as models for change while at the same time tailoring the project’s concept and strategy to each country’s priorities and stage of development. They have achieved significant economies of scale and the team found that USAID has earned a high return on its relatively modest investment in health reform in five countries.

B. Organization of the Project. Under the ZdravPlus II contract, the scope of work includes country strategies for the five Central Asian Republics and a three part overall regional strategy that is a continuation of the strategy pursued since the original contract award in 1994. Work plans have incorporated 4 broad areas of activity: 1) the regional strategy, 2) country specific reform strategies, 3) cross cutting issues, and 4) donor/project collaboration and coordination.

The overarching regional strategy is to 1) Continue to Strengthen the Core Health System Functions, 2) Deepen and Expand the Integrated PHC Model, and 3) Expand Strengthening Core Health System Functions and Corresponding Integrated Improvement Programs (IIP) to New Areas. IIPs are sites where linkages and synergies have been developed between core health system functions and improvements in clinical care at the point of service or facility level.

Country specific strategies are organized around four components of health system reform: stewardship, resource use, services delivery, and population/community health. The regional management structure supports each country program through cross-fertilization of ideas, methods, technical expertise and models of reforms. All project activities are identified under one or more of these components. Definitions of the components are as follows:

- **Stewardship:** (1) Policy dialogue mechanisms and processes, health policy content, and the legal and regulatory framework; (2) Solidify institutional structure, roles and relationships with the health sector and across sectors where necessary, and (3) Contribute to monitoring and evaluation systems for health reform and health service delivery, (4) Policy marketing and public relations and (5) Donor/project collaboration and coordination.
- **Resource Use:** (1) Health delivery system structure and human resources planning; (2) Health financing – collection, pooling, purchasing/provider payment; (3) Health information systems; and (4) Health management. This component is very broad. It collapses three major health system functions-- health finance, human resources, and health information systems. It also encompasses some elements of the service delivery and governance functions from the health system framework which WHO and USAID now use.
- **Service Delivery:** This component addresses the provision of quality patient care. There are five main activity areas 1) Medical education and human resource capacity development in family medicine (FM) and maternal and child health (MCH), 2) Evidence based medicine and clinical practice guidelines, 3) Peer review through continuous quality improvement, 4) Health purchaser quality assurance systems, licensing and accreditation, 5) Upgrading buildings and equipment and 6) Pharmaceuticals. In Kyrgyzstan, this component also includes SES reform.
- **Population and Community Health:** This component is devoted to involving

the population in caring for their own health and caring about their health care. The strategy includes two areas of activity 1) Educate the population/communities about health reform and their rights, and 2) Educate and empower the population/communities to be responsible for their health.

During this contract period, the contractor was asked to report by country on progress related to the four components of health systems reform, as well as the Integrated Improvement Programs (IIPs), and the new areas of interest under this contract – public health or SES reform, infectious diseases and medical education.

ZdravPlus II's country specific work plans are organized around the 4 components of a health care system described above. The work plan generally reads as a statement of the problem and its relevance to achieving the goals of the health reform program, along with a statement of intent to engage in activities that will address the problem. It is not specific as to the steps or timeline for how this will be accomplished. The semi-annual reports illuminate the strategy that was followed or is being followed in accomplishing the objective described in the work plan. In this way, Zdrav has used the work plan as a snapshot of the challenges to be tackled, but has not tied its hands by saying how it will proceed. The semi-annual reports include detailed descriptions of the steps taken to move the reforms along as well as the status of the effort, creating a valuable chronology of the sequencing and step-by-step process that are important for understanding the success behind ZdravPlusII's strategy.

C. Description of Country Specific Analysis This report focuses on the strengths and weaknesses of the ZdravPlus II project. First, there is a review of project performance in each country, looking at the status of each of the four project components as described above. A summary of performance findings is included in the main body of the report and the full analysis for each country is found in Annexes A-E. The primary focus of the country findings responds to the Mission's special interest in three areas:

- 1) The recommended priorities for health system strengthening over the remaining project period through December 2009, and
- 2) The recommended priorities for country programs beginning in 2010 when the ZdravPlus II project ends,
- 3) The potential for countries to move along the development continuum from "Developing" to "Transition" to "Sustaining Partner" over the next two years. (An analysis for each country is included in Annexes A1-E1).

The first two issues are self-explanatory, but the last question regarding movement along the development continuum needs some explanation. In health, the US Foreign Assistance framework for developing countries calls for helping countries to strengthen health systems and health service delivery. It focuses on encouraging good health governance, including policies that strengthen the state's capacity to establish appropriate

roles for the public and private sectors. Transforming countries have basic services and insurance mechanisms in place and functioning. They may face specific weaknesses in financing, accountability, targeting or legislation. They may need help sustaining and accelerating gains in health status through the complementary efforts of the public and private sectors, NGOs, and civil society. Progress from the developing country category to the transforming country category requires expanding and deepening democracy, strengthening public and private institutions, and supporting policies that promote economic growth and poverty reduction. A full analysis of each country's position on the continuum of development is found in Annexes A1-E1 following the analysis of country performance in Annexes A-E.

D. 1. Kazakhstan Country Findings

D.1.1 Summary of Performance Findings: The project has had important impact in improving the health sector as well as in improving national governance. Many of the obstacles that arose in project implementation were linked to the operations of systems that still concentrate too much control in the central government and are not sufficiently flexible to support decentralized and autonomous operations at the Oblast level. Zdrav has used its pilots to demonstrate how the national systems are impeding progress in achieving the government's objectives. At the highest levels of government, their analytical and communication skills are viewed as critical to the success of the reforms, both in achievements to date and for the future.

There has been steady movement in establishing a legal and regulatory basis for health reform and testing models that integrate all the components of the multi-faceted program. National roll-out is beginning. Given the commitment of government to increase the health budget significantly, the two greatest impediments to rapid modernization of the system are 1) the reluctance of the medical profession to embrace evidence-based medicine, and 2) the lack of technical and management expertise to implement reforms nationwide (including the provisions of the World Bank loan). The government is still greatly dependent on ZdravPlus II for analysis and guidance. To protect the USAID investment in the Kazakh health reform program, the project's continued presence is essential for at least the next two years.

A complete discussion of Kazakhstan's performance is found in Annex A.

D.1.2. Kazakhstan: Recommended Priorities for Health System Strengthening over Next Two Years

The Team recommends the following health systems strengthening priorities for the next two years. We base these on key informant interviews with senior MOH officials, other GOK counterparts in other agencies at the national and oblast levels, and medical professionals in the facilities we visited. We present recommendations in the context of continuing, starting, or stopping activities depending upon where FY 08-09 funding remains the same, increases, or decreases.

Assuming USAID maintains the current funding level for the project, we recommend that ZdravPlus II continue ongoing activities, giving priority to the following:

- Assist the MOH in analyzing performance under Phase I of the State Health Care Development Program and assist with the design and implementation of Phase II to deepen and expand reforms. As has been done so well to date, the project must collaborate closely with the World Bank in these efforts. The new \$296.1m World Bank sector loan (which will be co-financed by the GOK with a \$178.4m contribution) and increasing GOK budgetary allocations to health will provide the resources necessary to implement Phase II, and the priorities that follow.
- Protect pooling at the oblast level; maintain the single payer system; and roll out further the information systems (developed in Karaganda) required to support pooling. The MOH is facing pressure from some oblast governors to restore pooling to the rayon level. It must resist these pressures as rayon level pooling seriously undermines the efficiency and equity of the financing system.
- Develop model budgets for PHCs which can represent targets for budget allocations to manpower, pharmaceuticals, supplies, utilities, and capital expenditures.
- Implement fully the new provider payment systems, make changes in Treasury operations to permit reimbursements on a monthly as opposed to annual basis, and remove chapter budgeting that restricts facility management autonomy.
- Establish a government outcome-based budget system (pay for performance) and introduce it in all oblasts.
- Strengthen the Continuous Quality Improvement functions for Safe Motherhood and Arterial Hypertension programs at the clinical practice level. Focus especially on the mentoring function whereby experts observe practice, provide feedback, and demonstrate improved techniques. The team heard frequently that health workers receive training but some health professionals find it difficult or are unwilling to put it into practice.
- Involve the Sanitation and Epidemiological Services (SES) on CPG working groups and enlist their support in issuing and implementing new guidelines.
- Work with the GOK and ZdravPlusII to identify incentives that will increase involvement of the medical academies in the development of CPGs and in revising their curricula for EBM and bringing their curriculum up to international practice standards. Possibly reactivate ZdravPlus II funding of the Morehouse School of Medicine in order to introduce models for incorporating EBM and CPGs into the medical curriculum.
- In partnership with WHO, strengthen the national framework for PHC monitoring

and evaluation system.

- Collaborate with Project Hope in integrating TB services into the PHC system.
- Coordinate with UNFPA in securing GOK budget funding for contraceptives; establishing a better FP/RH monitoring and evaluation system; and improving health management education at the KSPH, notably the module on commodity logistics management. The UNFPA program ends in 2009.
- Assist NGOs such as the Kazakhstan Association of Family Practitioners and the Business Women Association of Kazakhstan to produce business plans and fundraising initiatives that ensure their sustainability. Advise the MOH on areas where they should contract out services that NGOs can perform.
- Inform the public about family medicine and the “patient friendly” benefits of the health reforms.

With more funding over the next two years, not distorted by disproportionate changes in the earmarked accounts, USAID should provide the following assistance to Kazakhstan in addition to those above:

- Advise the MOH and WB on restructuring the hospital system; improving the cost-efficiency of new and existing hospitals; and rationalizing the continuum of care between primary care and hospital care facilities. Kazakhstan plans to build 200 new hospitals with its newfound wealth. For years, the issue was how to spend scarce funding most efficiently; now the issue shifts to spending more plentiful funding most efficiently.
- Explore and, if feasible for some locations, expand the family group practice model to include the social services and patient clubs pioneered in the “Demeu” family medicine center in Astana.
- Produce additional periodic studies of the impact of co-payments on under-the-table payments and the reduction in out-of-pocket costs to lower income families.
- Pilot the Village Health Committee program implemented in Kyrgyzstan.
- Mount a program to inform the Global Fund about the CAR approach to integrating DOTS into the primary care system, and seek support for a pilot to address the new roles for hospitals and primary care facilities in the treatment of TB.

With less funding, possibly characterized by increased funding for TB and HIV/AIDS programs and less for MCH and OPHT, USAID should maintain support for the Stewardship, Resource Use, and Population and Community Health components to the extent possible. The service delivery component will need to direct more effort to

integrating TB and HIV/AIDS into PHC as the project is already aiming to do. A high priority is to incorporate EBM and CPGs into the medical curriculum. Using TB and HIV/AIDS as the models would be a way to meet both objectives. The project should continue supporting the Safe Motherhood and Arterial Hypertension programs at a minimum level until the GOK and Mission can negotiate a Program for Economic Development (PED) type of arrangement unencumbered by earmarks. The project should collaborate with the World Bank in expanding the use of these protocols in other oblasts. [A PED type arrangement is a new instrument specially developed for a collaboration between the USAID CAR Office of Economic Growth and the Government of Kazakhstan to jointly fund economic growth programs conducted by USAID. According to the four year agreement, now in its second year of implementation, the US and Kazakhstan share financing of priority projects. USAID and the Ministry of Economy and Budget Planning jointly developed the scope of work to address priority issues of mutual interest. Kazakhstan transfers funds to a USAID account that USAID disburses to its contractors to implement the scope of work.]

If a PED type project is not feasible and USAID funding ends in FY 2009, local technical experts trained through the ZdravPlus II project may be available to continue providing TA through the WB and other donor programs. A key factor will be changes in the Bank's policy to pay salaries commensurate with those paid by the ZdravPlus II project. Now, the Bank must pay locally-indexed salaries but this policy is being reviewed and could change to permit paying internationally-competitive salaries. This would be a second-best arrangement, as the consultants would not have the independence to analyze issues and recommend changes with the independence they enjoy under ZdravPlus II. USAID would also not be able to identify with ongoing successes, assuming these occur and there is no serious backsliding on achievements to date.

D.1.3. Kazakhstan Recommendations for 2010 and Beyond

For many years, Kyrgyzstan and Uzbekistan outpaced Kazakhstan in reforming their health systems. The GOK commitment has wavered over the years, requiring ZdravPlus II to ebb and flow in its efforts to promote reforms at the national level, while persevering at local levels to put the building blocks in place. The GOK began in earnest in 2004 to reform its health system. The government and its donor partners rely heavily on ZdravPlus II to guide these efforts. The MOH portrayed the status of health reform in Kazakhstan to the team as follows: "We are at a new level of reform with new challenges, new thinking, and new approaches to implementing international standards." "It is a mistake to think much has been done and there is not much left to do."

Given Kazakhstan's increased wealth, the USG may not be able to approve a follow-on project to build on the health reform progress to date. However, while Kazakhstan may meet some development criteria to transition to "Transforming" status, it will remain a "Developing" country as measured by health criteria. See discussion above in section IV.D.1.2. The evaluation team, therefore, recommends that USAID explore the feasibility of a new support mechanism patterned on the PED arrangement. For the health sector,

this would entail 100% GOK funding of the program in contrast to the graduated approach used under the PED in place for USAID’s assistance with economic growth programs.

Assuming USAID negotiates a PED-type arrangement, the team recommends that USAID continue building on and expanding implementation of the health reforms, in collaboration with the World Bank and other partners, as follows:

- Collaborate with the GOK, World Bank, and other development partners to review, update, and implement Phase II of the State Health Care Reform Program. The program will likely include many of the activities we highlight below.
- Roll out the primary health care reform model to other oblasts. Kazakhstan needs to “catch up” with Kyrgyzstan and Uzbekistan with the rollout of these reforms.
- Develop service delivery programs to address other major diseases such as bronchial asthma, trauma, and diabetes.
- Modernize the curriculum of medical academies by incorporating EBM in all clinical disciplines. Support the organization responsible for EBM to institutionalize a systematic approach for promoting Evidence Based Medicine and developing Clinical Practice Guidelines.
- Strengthen the health management curriculum at the Kazakhstan School of Public Health and medical academies and establish a mentoring program to ensure graduates practice new management skills.
- Improve the efficiency and effectiveness of specialty outpatient care and inpatient care. This entails examining the continuity of care and the delineation of appropriate levels of care. These issues underpin determinations of excess capacity in the system as well as the quality of care. Resolving them in a rational way will increase the cost effectiveness of the health care, and better serve the patient.
- Support the rationalization and reform of the Sanitation and Epidemiological Service, which often contradicts and impedes progress in institutionalizing new clinical practice guidelines based on EBM.

D.2. Kyrgyz Republic Country Findings

D.2.1. Summary of Performance Findings: Over the life of *ZdravReform*, *ZdravPlus* and *ZdravPlus II*, these projects have helped the Kyrgyz Republic make impressive gains in all four components in fundamental and significant ways. The exact contributions of the project are sometimes difficult to tease out. This is in part because of the collaborative partnership approach the project has taken, and also in part due to

weaknesses in the quantification of targets and achievements in the project's monitoring and reporting system.

The creation of the Mandatory Health Insurance Fund (MHIF) as a single payer is at the core of the reform of the health system in the Kyrgyz Republic. Under this system, the Kyrgyz Republic has achieved the remarkable goal of insuring 80% of its population and subsidizing an additional 8-11%. ZdravPlusII has contributed to the current understanding in the Kyrgyz Republic about issues and options for the health workforce. In service delivery, ZdravPlusII has had notable achievements in strengthening primary health care and prevention services and promoting EBM and quality improvement. By the end of this project, the Kyrgyz Republic health system will operate in fundamentally different and better ways because of ZdravPlusII's engagement. The remaining challenges are to ensure the sustainability of local institutions that will bear the responsibility of continuing to operate and strengthen the health system. The long-term viability of the health system will depend on continued political support, engagement of strong civil society entities, increased public spending on health, and solutions that engage the private sector and respond to the needs and interests of urban as well as rural residents. Special attention is warranted to tackle the threat of human resource migration.

A complete discussion of Kyrgyzstan's performance is found in Annex B.

D.2. 2. Kyrgyzstan: Recommended Priorities for Health System Strengthening over Next Two Years

To assure that the remarkable comprehensive reforms now in place in Kyrgyzstan are durable and that the country realizes their full potential to benefit the society, there are some niche issues that have to be addressed. Having achieved international acclaim for its work thus far in health reform in Kyrgyzstan, USAID has a large stake in upholding its leadership position. To do this, it should remain involved to address the gaps remaining. The project is on track. The following recommendations do not suggest radical changes in planned work, but rather propose areas of emphasis based on the team's assessment of relative priorities in the Kyrgyz Republic context.

Stewardship:

- Assist the MHIF to develop a practice of routinely analyzing the information now at its disposal to detect and address any evidence of fraud or misuse of the health insurance fund.
- Work with the MHIF to develop a plan to narrow down the extensive list of exempt population groups in the payment system over time.
- Work with the MHIF to incorporate the cost of post graduate health human resource training into reimbursement rates as a way to sustain continuing education.
- Help to develop the legal and operational bases to engage the private sector, by equalizing the terms for licensing, accreditation and tax payment.
- Help the GOKR develop experience applying its legal framework to resolve problems that emerge in implementation, such as possible financial misuse of

- MHIF funds, violation of patient rights, or corruption.
- Help Kyrgyz institutions develop plans for ongoing financial viability. This applies to the Kyrgyz Republic Medical Institute for Continuing Medical Education, the Medical Accreditation Commission (MAC), the Hospital Association (HA), the Family Medicine Association (FMA) and potentially to Socium.
 - Strengthen patient associations such as Diabetes Association, Alliance for Patients Rights, Association for Women with Breast Cancer.
 - Help the MAC to complete the accreditation of urban clinics, private facilities, and dental, rehabilitation and laboratory services.
 - Help the MOH Press Unit educate the media and help print and television reporters to gain access to appropriate health facilities, workers, patients and the public to do their own coverage of these topics. Help the Press Unit ensure that patients are fully informed about the State Guaranteed Benefits Package and about patient rights. Help the Press Unit carry out greater outreach efforts to the urban population who do not see reform as benefiting them.

Resource Use:

- Help the MOH to develop human resource policies and plans based on realistic assessments of the serious risk of out migration of physicians including effective measures for physician retention. Consider the merits of training other types of health care professionals less likely to migrate, such as nurses and midwives.
- Build measures that mitigate the natural tendency for capitated payment at the PHC level to provide less care or over-refer to the hospital level in order to save resources for improving facilities and staff salaries.
- Help the MHIF to mine the rich information now at its disposal to establish expected financing patterns, identify outliers, and address any issues of misuse or corruption underlying these exceptions.
- Help health institutions exploit the information at their disposal more fully for decision making and to disseminate more information to the public. For example, introduce more agile interfaces that allow users to combine and analyze various databases with greater flexibility (for example, to analyze population and service information together).
- Help the MOH to work with the Health Metrics Network to strengthen its information system.
- Help develop improved incentives for family medicine.
- Help the GOKR to carry out and use NHA for policy decisions, such as increasing government investment in health.

Service Delivery:

- Help the Press Unit, the MHIF and facility managers to increase the public's awareness about what accreditation means and what level of accreditation each facility has earned, for example, by posting accreditation certificates at facility entrances and educating the public about the meaning of gold, silver and bronze accreditation status.
- Develop accreditation standards for SES functions.

- Help the SES to undertake reforms and to strengthen health promotion to shift the paradigm in the approach to health care in the Kyrgyz Republic. Help to better integrate SES and service delivery.
- Develop stronger patient ownership of health care through health promotion and disease prevention.
- Based on the pilot in Ton Rayon of Issyk Kul Oblast of Public Health Coordination Council that meets quarterly with SES, formalize the role of the Council within the MOH and SES, and establish pilots in one rayon of each oblast. Continue the policy dialogues with the MOH and SES to institutionalize best practices learned at the pilot sites.
- Help the government develop new models for urban care that take population preferences into account in their design and operation.
- Help the government develop effective approaches for public-private partnerships.

Community and Population Health:

- Work with the MOH and other donors in the context of Manas TaaLimi to ensure that funds continue to be available for the CAH approach after external support ends.
- Continue to support the nascent capacity of VHCs to become sustainable community entities.

The work ZdravPlus II does in stewardship and resource use will likely be of greatest importance for helping the Kyrgyz Republic in its movement along the development continuum. To this end, ZdravPlusII should focus on helping the Kyrgyz Republic achieve the following seven objectives:

1. Comparative up-to-date national health accounts information discussed widely among policymakers and civil society.
2. Health policymakers effectively advocate protecting the share of the government budget for health.
3. Local partners implement financial and operational sustainability plans
4. Federations of Village Health Committees have means of networking, access to funding, and capacity to obtain financial support for their activities.
5. Patient advocacy is linked to international partners for technical and financial support.
6. MOH MIC and MHIF develop and implement data analysis approaches to detect and address fraud and abuse.
7. National human resource for health strategy and plan developed with professional associations, education sector, civil society, private commercial sector and external partner inputs comprehensively address needs for producing new health human resources, continuous education of existing health human resources, incentives for retention, and measures to deal with migration.

D.2. 4. Kyrgyz Republic Recommendations for 2010 and beyond

With the common efforts and resources of the Government of the Kyrgyz Republic, ZdravPlusII, other donors and civil society, the health system in the Kyrgyz Republic should be substantially strengthened by 2010. In addition to supporting continued expansion of successful experiences such as the Public Health Coordination Council that continue to be developed between 2008 and 2010, the areas which are likely to require ongoing effort after 2010 are the following:

1. Increasing and improving the public investment in health.
2. Refining the operation of the MHIF.
3. Improving linkages between health human resource training, placement and retention and the MHIF reimbursement system.
4. Building a positive working relationship between the public and private sectors in health.
5. Building health service delivery models that respond to the needs and preferences of the urban population, and
6. Transitioning from the current generation of health sector leadership to a new generation of health sector leaders.

D.3. Tajikistan Country Findings

D.3.1. Summary of Performance Findings: The Government of Tajikistan is still in the very early stages of its health system restructuring program. The country is behind its CAR neighbors due to time lost during the Civil War. ZdravPlus II, as elsewhere in CAR, is playing a critical role as adviser to both the government and to other donors, providing much of the technical analysis and implementation know-how underpinning the reforms undertaken to date. They have helped the government achieve passage of legislation on family medicine, physician capitation, a basic benefit package and co-payments.

Pilots of primary health care reform are operating in 8 rayons (located in 3 oblasts). There are two Centers of Excellence (COE) that are providing demonstrations of a ground-breaking CME program which combines lectures with practice training. The COEs are performing well, both in terms of patient care and as sites for retraining of physicians to become family medicine doctors. Other donors are using different models of physician training and better coordination in this area is greatly needed.

The Rector of TSMU, the only medical school in the country, is a strong advocate for family medicine and evidence-based medicine. He plans to revise the school curriculum to be a science-based institution. Through the TSMU, he is also supporting the Drug Information Center, a new resource for physicians regarding high quality information on pharmaceuticals. In time, his leadership could place Tajikistan in the forefront of regional change toward modern medical practice.

For the reform agenda to progress, the government must increase budget allocations to

the health sector.

A complete discussion of Tajikistan's performance is found in Annex C.

D.3.2. Tajikistan: Recommended Priorities for Health System Strengthening over Next Two Years

The ZdravPlus II project has made impressive progress working with the government and donor partners to set the stage for implementing reforms successfully achieved elsewhere in CAR. The evaluation team is concerned the pace of reforms could be slowed by the recently appointed Minister of Health, who may not be as committed to the reforms as his predecessor. At the same time, our meeting with the Director of the World Bank Project Implementation Unit suggested the donor community might be able to prevail in maintaining the ongoing course of reforms. The donors have intervened with the President to reverse a decision by the Minister that would have threatened the success of the hospital reimbursement reform. It remains to be seen the extent to which the donor community and the new Minister will cooperate in moving forward the reform program.

The energy crisis might also influence the pace of reforms, possibly quickening them as the crisis more dramatically exposes the health systems weaknesses. Lastly, all donors should continue persuading the government to increase its annual budget allocations to health. Tajikistan is the second-worst performer in the region in this regard. As economic growth continues to improve and the reforms are institutionalized, the government must increase its allocations to support the health of its population.

Over the next two years, the project should continue its initiatives in all components, funding permitting. Assuming the same level of funding continues over the next two years, the team highlights the following activities in particular:

- Maintain close collaboration with the World Bank and other donor partners in encouraging the new MOH leadership to advance the reform agenda.
- Maintain the small, but significant progress that has been made in reforming primary care by establishing evidence-based family medicine as the clinical gold standard for the country.
- Assist the Health Financing Working Group and the MOH in implementing the National Health Financing Strategy; including implementation of the Basic Benefit Package, the primary health care capitation system, the hospital case based reimbursement system, the supporting health information system. Begin piloting improved hospital management systems. The initiatives are critical to making the health system more efficient, effective, and equitable--and attracting and maintaining a quality health care workforce.
- Stay the course supporting the Centers of Excellence and training and re-training

physicians and training of trainers in family medicine. Recruitment of trainees for family medicine training through CME should be ramped up. The team was impressed with the interactive class instruction followed by the direct application of what they learned in the polyclinic setting. The project should continue to persuade the World Bank and Asian Development Bank to adopt the same approach, as opposed to providing lectures only.

- Roll-out the Safe Motherhood and Arterial Hypertension CQI programs to a few selected rayons and oblasts. The pilot sites the team visited demonstrated clearly the successful acceptance—by health professionals and patients—of the new safe motherhood practices based on international standards. Collaborate with the World Bank to provide additional equipment such as incubators for the intensive care wards, in facilities in and outside of Dushanbe.
- Launch publicity campaigns about the impact of EBM on maternal and infant mortality and morbidity. Involve the President, MOH and others in influential positions. Public interest stories should be organized through the press center about the satisfaction of patients and providers in the PHC sites where EBM is practiced. Strengthen the MOH CPG process and continue supporting the Evidence Based Medicine Center and the Drug Information Center in continuing their impressive work.
- Strengthen the MOH CPG process and continue supporting the Evidence Based Medicine Center and the Drug Information Center in continuing their impressive work.

If funding decreases over the next two years, the project should attempt to maintain as many of the above initiatives as possible and collaborate with the government and the World Bank to address critical gaps. The Bank should be able to continue work under the Service Delivery component. However, as elsewhere in CAR, the World Bank and the government remain highly dependent on ZdravPlus II technical assistance to provide the assistance under the Stewardship and Resource Use components.

Less funding is likely to be characterized by disproportionate funding for TB and HIV/AIDS programs opening up opportunities in the service delivery component. In this scenario, the project should direct more of its efforts to integrating TB and HIV/AIDS into PHC (as the project is already aiming to do). The project should continue supporting the Safe Motherhood and Arterial Hypertension programs at minimum levels to stay engaged and collaborate with the World Bank to expand implementation in other oblasts.

With more funding over the next two year, not distorted by disproportionate changes in the earmarked accounts, the project could invest it well in expanding the Service Delivery and Community Health components.

D.3.3. Tajikistan Recommendations for 2010 and Beyond

Tajikistan will continue to need USAID technical assistance beyond 2010, given Tajikistan's late start in pursuing the health reforms most of its neighbors are being implementing. In addition to building on the current activities, a follow-on project should consider the following initiatives:

- Review progress to date and collaborate with the government and other donors to chart the course for continuing the reform movement. Options might include a Sector-wide Assistance Approach (Swap) similar to the one in Kyrgyzstan or a State National Health Care Plan such as the one Kazakhstan is using to guide its reforms.
- Continue strengthening and broadening capacity at government and facility levels to implement health financing including health information system reforms.
- Assist the MOH to issue a Health Code as is being done in Kazakhstan to ensure Tajikistan's health care laws and regulations are consistent and complementary to one another.
- Complete the training and re-training of doctors in family medicine and roll-out nationwide the Safe Motherhood and Arterial Hypertension programs. Pilot additional clinical practice guidelines developed and approved by the Tajikistan School of Public Health or other appropriate institution.
- Strengthen and expand health promotion initiatives at government and facility levels.
- Explore opportunities for reforming the Sanitation and Epidemiological Service and ensuring its programs support new clinical practice guidelines.

D.4. Turkmenistan Country Findings

D.4.1. Summary of Performance Findings: From the beginning of the Zdrav series, the project has maintained an effective working relationship with the government, even as many other assistance programs made little progress or were ended. To a large degree, Zdrav's continued presence in Turkmenistan over this period reflects its responsiveness to the government, including low cost assistance such as providing training materials in Turkmen and supporting training costs. Senior officials expressed a high degree of trust in the project staff based on this experience. Recent political changes seem likely to accelerate the reform process.

While highly responsive to the needs and priorities of health officials, the Zdrav country team also pursued openings to advance health reforms. They have supported new

management systems, in particular health information, health financing and provider payment systems. Ministry and Medical Institute officials we met were enthusiastic about the performance of the new computerized information system Zdrav is supporting, and expressed interest in linking information with financing and payment systems.

In service delivery, Zdrav assistance has focused on the Integrated Management of Childhood Illness (IMCI) and a safe motherhood initiative that focuses on the birth process. These two areas are the subject of documented, quantitative improvements in health care. Both senior clinical leaders and front-line providers were strongly positive about these improvements, citing both data and patient comments.

IMCI and Safe Motherhood also provide the clinical subject matter for introducing the broader concept of Evidence-based Medicine. Based on this initial experience, officials at the Medical Institute expressed interest in expanding their EBM training program. Such an initiative would institutionalize EBM training in the established pre-service and continuing medical education program, a significant advance.

Turkmen officials also made multiple references to the benefits they received from learning about the experiences of other ZdravPlus II countries, and in some cases, the adaptation of tools from these countries.

A complete discussion of Turkmenistan's performance is found in Annex D.

D.4.2. Turkmenistan: Recommended Priorities for Health System Strengthening over Next Two Years

Stewardship

The new computerized information system is a dramatic improvement over the previous, paper-based system for hospital discharge information. There is widespread enthusiasm for a system that produces the standard Forum 66 in a few seconds, compared to about a week under the old system. Officials are cautious in projecting where the new system will lead, but insightfully raise the concept of "evidence-based management." Delegating the authority to make some decisions to local managers would be an important advance in a health system based on central directives. The project should pursue opportunities to demonstrate the benefits of such a management approach.

The development of a prikaz related to IMCI was a major achievement facilitated by Zdrav. If EBM is to become an integral part of health care, however, large numbers of guidelines need to be developed and regularly updated based on scientific advances and program experience. As experience in other countries shows, EBM will require the input of a wide range to medical specialists, experts in the guideline development process, regular providers, and patients. The development and updating of modern guidelines needs to be coordinated with the development of the prikaz, but should be an independent activity that is driven by evidence. Zdrav should work with the Ministry to analyze the implications of the IMCI experience and develop a viable process that can lead to EBM

for all types of health care.

Resource Use

Turkmenistan presents a wide range of resource issues, and this is an area where Zdrav has provided some awareness training. The new government has not requested assistance in financing issues, but senior officials did express openness to new proposals from the project. Historically, the project has approached sensitive issues in a cautious, stepwise manner, first developing an evidence base to support potential reforms. We encourage the project to propose specific steps to the government, moving from a general orientation to health financing reform concepts to country-specific information gathering and pilot testing of selected reforms.

Service Delivery

The project has emphasized provider training as its chief strategy for improving service delivery. This has been supplemented by assessment of knowledge gained from training and assessments of the impact of training on provider compliance with guidelines. The project has also conducted assessments of health impact. Considerable policy-related work was needed to support changes in IMCI and Safe Motherhood services. Building on this base, ZdravPlus II should now focus attention on the institutionalization of these evidence-based services, including ongoing efforts to measure and improve compliance with the guidelines. Quality improvement will be a new area for the Turkmen health system, but the project can draw on its QI experience in other countries. Like modern quality improvement in other countries, a QI initiative in Turkmenistan should go beyond monitoring and reporting to include testing changes in the organization of health care.

In addition to improving the quality of these priority services, Zdrav should also support the Ministry to apply the principles of EBM and quality improvement to at least one new service, in which the Ministry will be required to develop its own clinical guideline.

Also based on recent experiences with QI in other countries, ZdravPlus II should support expanded efforts to share QI interventions and results among providers. Such a “community of practice” is an important step towards institutionalizing QI as an integral part of health care.

Community and Population

Project work in this area has been limited to the Ministry Family Nurse program, which follows a health education strategy. This component has demonstrated changes in the knowledge of mothers of young children. In view of recent trends in this field, we recommend that ZdravPlus II propose to the Ministry a new initiative focused on supporting changes in health-related behaviors, rather than simply changes in knowledge.

D.4.3. Turkmenistan Recommendations for 2010 and Beyond

Allowing for the uncertainties of the current period of transition, the GOT appears to be poised to pursue a broad range of fundamental, progressive changes in its health system. In the medium term, substantial investments in health are feasible and likely. This general policy and financial setting is well-suited to the comparative advantages developed by the ZdravPlus II project: deep understanding of the country setting, responsiveness of GOT priorities, and highly specialized technical expertise in health systems issues.

An effective collaboration with the GOT should take advantage of several major resources:

1. The emerging policy openness of the GOT, particularly indications of favorable attitudes toward evidence-based policy making;
2. The substantial material resources, including finances and infrastructure that are expected to be available;
3. A growing body of experience in health reform that is accumulating under the ZdravPlus II project and other reform efforts in the CAR (with increased focus on documentation, analysis, and evaluation);
4. Recent advances in the state-of-the-art in quality improvement, evidence-based guidelines, and training technologies.

Compared to ZdravPlus II's earlier groundbreaking efforts, these additional resources create the potential for a more rapid and comprehensive transformation in the Turkmen health system, based on limited but strategic technical assistance. While maintaining Zdrav's established pattern of responsiveness, assistance beyond 2010 should include the following areas:

1. Support for the institutionalization of EBM in practice as well as part of pre-service training: The development and use of evidence-based guidelines should be extended through the health system, with an institutional base and a consistent approach that reflects the current state-of-the-art.
2. Related institutionalization of modern quality improvement as an integral part of health care in all facilities, with a specific focus on provider compliance with evidence-based guidelines.
3. Further development of the current hospital information system to incorporate financing and management issues.
4. Support for development of the interpersonal, preventive, and behavioral elements of health care.

D.5. Uzbekistan Country Findings

D.5.1. Summary of Performance Findings: With the assistance of ZdravPlus II and other donors, Uzbekistan has almost completed the roll-out of a rural primary health care program. The reforms that have been implemented include pooling of funds at the oblast level and capitated payment of primary health care facilities. In addition, they have begun case-based payment of hospitals. These initiatives, coupled with clinical training and introduction of quality improvement systems are expected to significantly improve

services and efficiencies. An urban version of this approach is currently being piloted. These changes have led to increased capacity to make budget decisions at the oblast level and have also given facilities more (though still quite limited) control of their finances and management.

A complete discussion of Uzbekistan's performance is found in Annex E.

D.5.2. Uzbekistan: Recommended Priorities for Health System Strengthening over Next Two Years

Assuming USAID maintains the current funding level for the project, we recommend that ZdravPlus II continue ongoing activities, giving priority to the following:

Stewardship

- Maintain the current manner of dialogue and engagement with the Uzbek government and local partners. ZdravPlus II has been very savvy in navigating issues that confront international organizations working in Uzbekistan and has gained the confidence and trust of the government, as evidenced by the fact that the government stepped in to ensure that ZdravPlus II was able to continue working in Uzbekistan during a time when many other organizations were leaving. This has been and will be critical to health reform success in Uzbekistan.
- Increase investment in M&E to generate evidence for policy decision-making. The Uzbek government seems to turn to evidence for its decision-making, therefore ZdravPlus II should ensure that data from the M&E systems which were set up to monitor rural PHC and urban PHC roll-out are maximized to inform policy and legal decisions regarding further uptake of these reforms. Further, use data to motivate and coordinate multiple stakeholders around an issue (for example, with the goal of improving rational drug use, link health facilities, Oblast Health Department specialists and the Drug Policy center through a discussion of data and promote coordinated efforts forward).
- Continue to advocate that the Uzbek government maintain or increase the share of the government budget for health and promote rational use of the increased funds. Allocation to the health budget is increasing but only in the area of salaries.
- Continue to engage in a united approach with the World Bank and Asian Development Bank partners on issues related to health governance reforms. The ZdravPlus II team should also be involved in the design of the potential World Bank Health III project, to the extent possible.

Resource Use

- Continue to prioritize the rollout of urban PHC, and continue to support the rural PHC process. Rollout of rural PHC has been successful and is nearly complete. Although rural PHC serves as a good model, the rollout of urban PHC is a much more complicated process given the politically-connected urban institutions that are very committed to their current ways of working. These issues require a great deal of negotiation in Tashkent and other urban areas, and it will be critical to the success of urban PHC that ZdravPlus II is able to provide stable investment and attention to this

activity through 2009.

- Emphasize the need of increased autonomy of facility managers. Facility managers have embraced the independence the reforms have provided to-date but there remains a need for them to take a more active role in actively managing the budget under their leadership and to have more discretion in how to plan and use extra funds. ZdravPlus II should utilize the recent survey of finance managers conducted by the Department of Finance within the X Institute and work with the Department to enhance their existing training programs for facility and finance managers.
- Promote national health accounts assessment, and ensure that comparative up-to-date information is discussed widely among policymakers.

Service Delivery

- Provide support for the development, introduction, and evaluation of evidence-based clinical guidelines in at least one new clinical area. Use this experience to plan future expansion of EBM through the health system.
- Review current approaches to quality improvement, including the design, documentation, and evaluation of improvement efforts. Include student projects in this review.
- Develop an improvement collaborative with teams from approximately 20 facilities, addressing IMCI, tuberculosis, or other suitable topic. This approach will allow various facilities to be linked on a common issue. Disseminate the activities and results of the collaborative using reports based on documentation and meetings.
- Develop strategies to provide recognition and other incentives to teams, based on QI results.
- Under EBM centers' technical guidance involve medical leadership (research institutes, professional associations) to create a synchronized process for development of evidence based CPGs.
- Further emphasize practicum in the GP training as the amount currently spent is not sufficient.

Community/Population

- Maintain existing civil society engagement to the extent feasible and capitalize on any opportunities to expand its role.
- Review the effectiveness of disseminating health education materials.

With more funding over the next two years ZdravPlus II should include the following activities in addition to those above:

- Promote a health policy unit at the Ministry to end the cross-department working group approach currently used to arrive at policy recommendations.
- Promote engagement with regional and global partners where Uzbekistan's experience can be shared, i.e. sharing their practice of performance incentives for PHC providers with the Center for Global Development working group and learning from Kyrgyzstan about its experience with health insurance.

If funds to ZdravPlus II decline, the project should focus its efforts on the rollout of urban PHC and the recommendations provided under Service Delivery.

D.5.3. Uzbekistan Recommendations for 2010 and Beyond

- Finalize the rollout of urban primary health care, and continue to utilize the M&E systems developed to inform necessary modifications in policy and implementation.
- There is an absence of a group of individuals that are lobbying for health reform in Uzbekistan, meaning there is a lack of individuals that could continue to shepherd the reform process after the project ends. In 2010 and beyond, the project should investigate ways to connect key Uzbek stakeholders with key stakeholders in other countries, and also to connect stakeholders in-country to generate more ownership of the larger process.
- In addition, the project and partners should advocate for the creation of a central health policy unit at the MOH, to ease the development and approval of policy and legal aspects of health reform, and to serve as a resource for other Ministries looking to model any of the reforms.
- Explore the possibilities of creating an insurance scheme within the health reform process.
- Although challenging in the existing political environment, the project should work to create and develop the capacity of professional and membership associations. In addition, to the extent possible, the role of NGOs in project implementation should be promoted.
- More autonomy of facility budget decisions should be promoted, and further analytical and management training of both finance managers and health facility managers is needed so that they can adequately capitalize on expanded budgetary freedoms.
- Identify an institutional base for a permanent QI program, including the authority, budget, and staffing.
- Expand QI activities, including the improvement collaborative, to several clinical areas, and promote its uptake through creative solutions (i.e. linking QI improvements to licensing and accreditation).
- Support QI training and dissemination of experiences through a series of reports, workshops, conferences, exchange visits, and study tours.
- Provide declining support for the development of evidence-based guidelines in all major clinical areas, coordinated by an EBM Center of Excellence.
- Continue to engage with the Mahalla community organizations. The Patronage Nurse program is also an excellent conduit for promoting community-level health care and health education, especially because it utilizes a cadre of health professionals that are less susceptible to leaving the country for higher salaries elsewhere.

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- In addition, the project and partners should advocate for the creation of a central health policy unit at the MOH, to ease the development and approval of policy and legal aspects of health reform, and to serve as a resource for other Ministries looking to model any of the reforms.
- Although challenging, the project should work to create and develop the capacity of professional and membership associations. In addition, to the extent possible, the role of NGOs in project implementation should be promoted.
- More autonomy of facility budget decisions should be promoted (rather than the one line item that is currently allowed independent modification by the facility that still requires the permission of the local government). Further analytical and management training of both finance managers and health facility managers is needed so that they can adequately capitalize on expanded budgetary freedoms.
- Continue to engage with the Mahalla community organizations. The Patronage Nurse program is also an excellent conduit for promoting community-level health care and health education, especially because it utilizes a cadre of health professionals that are less susceptible to leaving the country for higher salaries elsewhere.

D.6. Regional Findings

D.6.1. Introduction. The ZdravPlus II regional program includes six categories of broad activity: 1) management, 2) joint participation of two or more CAR countries, 3) research and development of products applicable to all countries, 4) activities related to the four components that are regional in nature, 5) policy analysis, monitoring and evaluation and research studies that are regional or involve cross-country comparisons, and 6) information dissemination.

According to the organizing framework of the components, strategies for stewardship and resource use are generic for the region, adapted for each country. Truly regional activities are identified under service delivery (family medicine and distance education regional faculty development, Council of Rectors, Council of Nurses, Regional Working Group on EBM/CPGs, and technical assistance to the Eurasian Drug Information Network (EDIN)) and population/community health (educating and empowering the population, policy

analysis, monitoring and evaluation and research studies and information dissemination).

D.6.2. Performance Findings: The regional budget was drastically reduced following the contract award due to unexpected funding shortfalls. As a result, the momentum related to many of the regional activities has dissipated. For instance, the Council of Rectors has not met for over a year. The potential to use that forum as a vehicle for gaining support from opinion leaders on EBM has been lost. Because the medical establishment is the primary obstacle to widespread acceptance of this important component of reform, this has been a great loss to the project.

Cross-fertilization of ideas continues to benefit the project even though funding has been cut. Examples that were cited apply to the service delivery component of the project. For instance, Kyrgyzstan is now the evidence-based medicine hub for the region, but their initial training came from the Kazakhstan Association of Family Physicians. When Kazakhstan was developing its pilot program for the treatment of arterial hypertension (AH), the Director of the Kazakhstan Institute of Cardiology went to Bishkek to observe one of the “schools” where AH patients learned how to become more proactive about protecting their health. Kazakhstan’s plan to implement the Kyrgyz outpatient drug benefit program has been delayed because of weaknesses in the information system at the oblast health department. Nevertheless, being able to learn the system requirements from the Kyrgyz has facilitated their efforts.

V. Technical Comments

Quality Improvement: The quality of health care is a broad concept that includes the scientific basis for services, the efficiency of the organization of those services, and the responsiveness of those services to the needs of patients and the community. ZdravPlus II has made significant progress toward improving each of these attributes of quality. The most well developed element is the introduction of recent concepts of evidence-based medicine (EBM). At the level of the health system, ZdravPlusII has provided training in current approaches toward reviewing scientific evidence on a given subject and summarizing this evidence in a practical guideline for the practicing clinician. Care that follows such guidelines is superior to practices that arise in other ways, such as the subjective opinion of prominent clinicians. Such practices were widespread under the Soviet health system. Changing these entrenched traditions is an ambitious and worthwhile goal.

Officials in country ministries and in health training institutions evinced strong support for the principles of EBM, which has been introduced into both in-service and pre-service training. ZdravPlus I has also supported the establishment of small EBM centers that are tasked with developing clinical guidelines for use in county health systems. To introduce practical guidelines early in the project, ZdravPlus II used widely-recognized WHO guidelines in a small number of services, such as the integrated management of childhood illness (IMCI.) These developments are only the beginning of the transformation of health care that will be needed if health care is to be based on the best available evidence.

One essential step is to support the expansion of EBGs beyond the small number currently in place, and establish EBM as a standard for health care generally. ZdravPlus II support is needed to support such an expansion, building the institutional capacity within the health system to sustain and update evidence-based standards for all of health care.

In the countries of the former Soviet Union, EBM may be perceived as in conflict with recognized experts who have traditionally promoted certain clinical practices without supporting evidence. Conflicting guidelines are clearly undesirable, and these experts should be included in the guideline development process. However, the development process must specify the central role of clinical and scientific evidence, rather than subjective opinion.

It is equally important that the development and updating of guidelines avoid unproductive work and costs. For virtually every clinical topic, there are many guidelines that have been developed in other countries, along with supporting literature and a defined process for developing the guideline. Consulting available knowledge on a given subject will greatly facilitate the work of guideline development in the CAR.

A second major requirement is effective health system support for health providers to actually follow EBM guidelines. ZdravPlus II has identified modern quality improvement practices as central to this objective. Clinical training, which has been the focus of QI activities to date, is necessary but not sufficient to achieve good compliance with clinical guidelines, based on a number of recent reviews.

ZdravPlus II has supported continuous quality improvement (CQI) applications along these lines, but the level of effort appears to be limited. Providers and trainers that we interviewed could not describe examples of the basic CQI process for improving care, testing specific changes that might yield improvement. A computerized information system did provide ongoing monitoring of quality indicators, but we found no documentation of concrete interventions to improve quality. Although reasonable steps were sometimes taken informally, such as instituting hypertension screening, these efforts merit more investment in documentation, evaluation, and wider sharing of useful experiences. The long-term sustainability of QI efforts also requires attention to providing providers with incentives to carry out this additional work.

Recent advances in the field of quality improvement focus on organizing facility CQI teams into a collaborative. The teams work together on the same topic and systematically share experiences. Extensive global experience suggests that the improvement collaborative methodology is likely to work well in the CAR region. Its potential benefits include more rapid improvements in compliance with EBGs and other quality measures and increased incentives for clinicians to participate in QI work. Well-documented improvements in health care on a large scale are feasible, and could provide added impetus to other health reforms supported by the project.

The structure of the improvement collaborative also facilitates participation by policy-level officials. Typically, senior officials are invited to sponsor a collaborative addressing

a topic under their authority. From the beginning, these officials are familiar with the quantitative improvement goals of the collaborative, and are recognized as the sponsor in collaborative reports. As the collaborative develops, these officials are provided with simple graphics (run charts) that summarize overall improvement in the selected indicators. Collaboratives also hold periodic meetings of participants at which the sponsors can learn about the concrete interventions that produced changes in various indicators. The sponsors can also observe the social dynamics of the collaborative, in which a large number of providers work together to improve health care. Sponsors are likely to be highly interested in improvements that could be spread through the health system. The collaborative methodology has a second phase, the spread collaborative, which is designed to scale up well-tested improvements.

The improvement collaborative methodology is also well suited for improvements in non-clinical health processes, such as facility management. Per capita based financing for example, provides facility managers with new opportunities to actively manage resources. These managers, however, have minimal experience with this kind of decision making, and do not appear to be taking advantage of these opportunities. A collaborative of managers could complement training strategies, providing shared learning from a group of peers.

Expanding ZdravPlus II's comparative advantage in QI in the CAR should also expand its role in tuberculosis and HIV/AIDS programs, which present a number of difficult quality issues.

Like the health systems in the CAR region, ZdravPlus II has focused much of its reform efforts on physicians. Where governments are open to considering wider use of less expensive providers, the project has established the basis for a robust reform strategy: Global experience suggests that academic credentials do not determine clinical performance for many common health services. With in-service training and ongoing QI, non-professionals can frequently attain better compliance with clinical guidelines than physicians. Such a strategy may address difficult issues such as physician emigration or staffing for rural clinics.

Training: Training activities are prominent in ZdravPlus II reports, and the USAID project monitoring plan emphasizes counts of the number of individuals trained in different areas. To a large degree, ZdravPlus II has used its technical resources strategically to support training on a large scale and in a wide range of technical areas. Examples include strengthening the teaching skills of trainers in academic centers, training of trainers, and the design of curricula. Based on the reports available to the team, it is difficult to estimate the extent to which ZdravPlus II's intellectual and financial resources are invested in direct training of providers and lower level managers.

The counterparts that we interviewed were universally in favor of more training of the kinds ZdravPlus II has supported in the past. From the perspective of institutional development, it would be appropriate for ZdravPlus II to develop a strategy to steadily transfer training responsibilities to national institutions, beginning with the direct training

of, for example, clinicians. But this process should also extend to transferring more sophisticated functions, such as curriculum development. One requirement of such a plan is the need for more clarity in defining the project's role in various training activities. A second requirement is greater emphasis on evaluating the effectiveness of counterparts in taking over these roles. Thirdly, USAID would need to revise the monitoring system that places a premium on counting trainees.

The project's emphasis on pre-service education is a noteworthy success. Officials observed that by incorporating training in EBM into the undergraduate curriculum, they are on track to reach national coverage on a permanent basis. This strategy promises to effect a cultural change that favors evidence-based practices in all services.

Evidence-based health reform: ZdravPlus II has been increasingly successful in facilitating large scale, rational change in country health systems. This rich experience now merits more attention to knowledge management. ZdravPlus II is uniquely positioned to describe, analyze, and evaluate how these changes are being implemented and how they are affecting health care. More detailed knowledge is needed to learn from this seminal experience. The potential benefits of such an initiative include improvements in the reforms themselves, evidence to build support for the new approaches, and to contribute to the global state-of-the-art. Such in-depth assessments require special efforts beyond routine monitoring, and this takes resources.

Community Activities: Though tailored to each country, ZdravPlus II devotes the Population/Community Health component to involving the population in caring for their own health and caring about their health care. This includes marketing the reforms to the population and informing them of their rights within the new system, and health promotion through Centers for Health Promotion or Centers for Healthy Lifestyles, health provider health promotion activities, and community level activities such as Village Health Committees (VHCs) or Mahalla Health Initiative Groups (MHIG). These activities complement the top-down reforms well, and are an important piece of the overall project. Community and civil society engagement were not strongly promoted during the Soviet times, and promoting the role of individuals in the health reform process and also in governance more broadly is critical.

However, it would be beneficial if the project would examine the existing organization and focus of the community and civil society activities. It is recommended that activities related to civil society development be folded under the Stewardship component. This would include the marketing of the reforms (i.e. press center, booklets) and the civil society aspects of the VHCs and MHIGs. The citizen voice in the political and legal reforms is best represented in this component, as well as efforts to promote patient rights under the new system.

Additionally, the project should be realistic and clear about what the objectives of the health promotion activities are, and determine what is achievable by the end of project. Activities should be focused accordingly.

Current PMP objectives focus on number of activities held or number of institutions that exist to promote healthy behaviors, but those types of achievements only serve to create an enabling environment for better health decisions. However, if ZdravPlus II is truly interested in seeing behavior change as an outcome of this component, the project needs to undertake activities that go beyond information sharing. Informational posters and brochures do not take into account the key barriers to behavior change and their messages are unlikely to triumph over cultural, economic, and social influences. An examination of behavioral determinants, barriers to positive health behaviors, and existing assets within the community that can be leveraged are needed if health promotion campaigns will truly succeed in modifying key behaviors. Existing health committees can be organized to work at a more individual level with community members to help them overcome these barriers and develop plans for tackling a variety of health issues.

Also, in order to ensure that the role of the community is maximized, a more concrete approach to dialogue between communities and health services may be helpful. Health service providers should be empowered to recognize the need for changes within the health system and be more able to implement those changes, and community members should be able to share concerns with quality or methods of service delivery. Dialogue between professional health service providers and community members supports effective institutional level behavior change. The Partnership Defined Quality (PDQ) methodology is a recommended approach to ensure this type of sharing. This type of activity should also complement the extensive efforts that are being placed on upgrading the technical training of providers, and further empower providers to maintain their new clinical knowledge. There are also opportunities to promote individual patient interactions with providers by utilizing data available from the QI efforts.

VI. The Value of the Regional Approach

The complex challenges of health reform in the CAR are well-suited to a regional approach to technical assistance because the restructuring challenges faced by the countries and their vision of how to reform their systems is quite similar. While officials in each country believe they have stand alone programs, they acknowledge that each country has much to learn from the reform experiences of its CAR neighbors. The team was convinced of the value of the regional approach for a number of reasons:

1. Improving the performance of health systems is a complex process requiring an extended period of time. While there are widely-accepted basic principles, the details of implementing reforms must be worked out based on program experience. If these reforms are to be based on evidence, policy makers need to examine whatever relevant experience is available.
2. USAID has demonstrated a commitment to helping the CAR countries achieve sustainable health system reform. Integrating relevant experiences from other countries not only increases its return on investment, but also will reduce the average cost of its assistance per country.
3. The general argument for considering the experience of other reform efforts is

- even more compelling in the CAR, based on their shared history, health system structures, language, and physical proximity.
4. The worldwide body of relevant experience in implementing reforms similar to those taking place in the CAR is extremely limited, so there are few other places to look for useful lessons related to making reforms work at a practical level. In this respect, the experiences of more technologically advanced health systems are less useful.
 5. The relevance of other country experiences is increasing as health systems move from policy debates to the details of implementing these complex changes. Further, strategies that were unsuccessful or problematic in other countries provide lessons that are as useful as those that were successful.
 6. Experiences in a range of fields address similar issues related to improving complex processes. Comparative analysis of different approaches builds a knowledge base for future experiments. For instance, it facilitates problem solving where similar concepts have been adopted. Like industry, science, and education, health reform is likely to benefit from a strategy of information sharing among peers with common goals.

ZdravPlus II staff also cite practical benefits from the regional structure of the project, including the ability to access highly specialized technical specialists, which would be far more difficult for small, unrelated country programs. This applies to both external consultants and long-term country staff.

The team learned about several examples of how ZdravPlus II has used its regional structure to good advantage, such as promoting exchange visits to facilitate policy change and using technical materials and approaches across countries with relatively minor adaptations. USAID funding constraints have reduced support for regional activities. Nevertheless, the team finds the technical relevance of work across countries to be of growing, not diminishing, importance. In response, ZdravPlus II should develop a more systematic strategy for moving these functions to local institutions and further developing their capacity for regional knowledge sharing.

VII. Lessons Learned and Best Practices

For the purposes of this evaluation, a lesson learned is seen as something that has led to an actual change, has had an impact on the policy environment, demonstrated an innovative or replicable approach, or demonstrated sustainability. These practices have not undergone rigorous evaluation but it is generally agreed that the decision to utilize these particulate activities and approaches was appropriate and successful.

- **Reform takes time.**
- **Well managed projects attract capital to the health sector** from the host country and other donors. As a result, this project has achieved impressive results with modest level of support. An average annual USAID investment of approximately \$950,000 per year per country over 15 years has leveraged

complementary funds in the hundreds of millions.

- Government counterparts and local community members perceive the support from ZdravPlus II as cooperation from USAID and from the people of the American people, creating an immense amount of **goodwill for the United States and USAID**.
- ZdravPlus II's innovative approach demonstrates that **health projects can contribute to progress in governance and civil society**. The project has made inroads in development of civil society, government capacity, transparency, participation, and press in countries where direct work toward these aims would not be as feasible.
- **Donor harmonization, project coordination and integration** will maximize the impact of each donor's efforts and reduce the host country costs of servicing the donors. In addition, coordination helps to create a united front when engaging in dialogue on policy decisions with the host government and has enabled the project to move more efficiently and effectively within the political arena. ZdravPlus II has worked to bring together the World Bank, Asian Development Bank, DFID, Swiss Red Cross, and governments united in support of common development programming.

The SWAp setup in Kyrgyzstan, the coordinated assistance to the Government of Kazakhstan in the implementation of the State Health Care Development Program and the Joint Program Implementation Board coordination efforts in Uzbekistan are models of donor harmonization as outlined in the Paris Declaration. Also, Zdrav's central role in advising the World Bank and the Governments of Tajikistan and Kazakhstan on the design of their new projects, has assured that USAID's investment in the direction of health reforms in these countries would be protected. Both countries as well as the World Bank are depending on ZdravPlusII's continued guidance during implementation of the projects as a form of insurance for their investments.

- The intersection of disease/condition specific interventions and system components, or "**diagonal programming**" means that ZdravPlus II is tackling technical and clinical issues with a health systems improvement approach. Disease specific programming has seen lasting benefits with the ZdravPlus II's efforts. For example, when the DOTS approach to TB treatment fell out of favor with the MOH in Kyrgyzstan, ZdravPlus II successfully lobbied its government counterparts to continue supporting the approach. The effects on TB outcomes in the country could have been significantly altered without this dialogue. In addition, ZdravPlusII has found that self-contained, vertical disease-specific programs, such as those for HIV/AIDS, are not making use of all the available resources for treatment. By grounding these programs in the primary care system, they are able to readily access other resources, improving patient care and outcomes.

- ZdravPlus II's **bottom up and top down approach** is important to creating lasting change and ownership of reform efforts. The project approach to health reform is very comprehensive and it is unique to find a project that is addressing both the political and legal levels along with the community and service delivery levels. The attention to the multiple layers of change and intention to link the components in meaningful ways programmatically will serve well for sustainability.
- **Key stakeholders are important to change.** Well-placed advocates accelerate change once institutions in place. Significant investment in the knowledge, skills and capacity of health reformers at the operating level, such as facility managers, will sustain changes in health reforms as long as supportive policy change does not lag too much. But the establishment of institutions, acceptance of new methods by opinion leaders is only the first step. **Implementation challenges need a knowledgeable guide for success.**
- **Creating regular forums** (i.e., seminars, conferences, workshops) for sharing ideas and formulating new approaches facilitates understanding of the reforms and creates linkages.
- **Maintaining flexibility and agility with dynamic governments** has made ZdravPlus II very successful. Engaging in health reform efforts across five countries requires navigation of a variety of stakeholders and political climates and ZdravPlus II has been able to stay abreast of changing relationships, priorities, and personnel. Objectivity and consistency were also recognized as important project characteristics. ZdravPlus II is seen as a valuable technical resource rather than aligned with a particular political agenda.
- **Promoting innovative and comprehensive design elements that correspond to the abilities and needs of each country** has improved health reform efforts. For example, the creation of a mandatory health insurance fund in the Kyrgyz Republic, promoting performance incentives for primary health care workers in Uzbekistan, using global capitation based payment for primary care with differentials to adjust for population composition and burden of disease, integrating health and financial information systems in the Kyrgyz Republic, creating rayon level monitoring of clinical run charts for several key health issues in Uzbekistan, integrating PHC retraining into undergraduate training curriculum, and institutionalization of PHC CME, and privatizing the pharmaceutical sector in the Kyrgyz Republic.
- **Engagement of civil society organizations and professional associations** contributes to country ownership and sustainability. For example, the Family Group Practice Association, the Medical Accreditation Commission, the Hospital Association, Village Health Committees, and the Press Center within the MOH all play a key role in educating the public about the reforms and guiding aspects of

the reform process in the Kyrgyz Republic.

VIII. Project-wide Recommendations: Priorities for Health System Strengthening over next Two Years

A. Overall: This project has helped Central Asian countries make tremendous advances in structuring their health systems to improve population health. The next two years are a critical period to ensure the long-term sustainability of the advances to date, to fortify the national institutions to lead their health systems into the future, and to use the health sector as a vehicle for promoting the kinds of changes needed to move the countries along the continuum to the transforming and sustaining categories. The team has three technical recommendations and two recommendations related to project management to further strengthen the project.

B. Technical Direction.

1. Fortify the institutional capacity of local partners: ZdravPlus II has identified, organized and worked with a variety of talented and committed institutional partners, including a local consulting firm, and several professional associations. These next two years are important to ensure that these partners are prepared to sustain their institutional efforts after the project ends. This likely means investing project time and resources in helping these partners to develop business plans for operational and financial viability. Several helpful resources are available to work on this, including the Health Systems 20/20 Institutional Capacity Development framework and training course, the USAID GH Institutional Capacity Development literature review authored by Ligia Paina, and (get Jill's reference). It also means using available opportunities to foster linkages and networks among national institutions. It might be possible to begin to use national subcontractors regionally. It also might be possible to foster regional networks of national associations. Another important capacity development objective for the next two years should be forming the next generation of health system leaders. In the team's field visits, this younger generation of future leaders in training was not visible. The generation that had led this process over the past 15 years would ideally begin sharing their experience internationally and providing a new generation with the opportunity to build their health system expertise.

2. Incorporate new state-of-the-art approaches where available

In some areas, the project can benefit from incorporating new and innovative approaches. In service delivery, the team recommends that the project incorporate the improvement collaborative approach to quality improvement. The project should also seek to expand the concept of evidence-based medicine so that it becomes an integral part of all health care delivery. The project can also leverage its comparative advantage in quality improvement and evidence based medicine to make sure they are applied to tuberculosis and HIV/AIDS services.

In health promotion, the project can take advantage of available resources for assessment based approaches to identify and address behavioral determinants of health behaviors.

This is likely to be more effective than the distribution of pamphlets or community discussions where village health committees try to get their neighbors to stop consuming alcohol or smoking. The project might explore using the partnership defined quality tool to help facilities and communities jointly define quality standards and expectations. Another useful tool might be the Child Survival and Health Grants Program rapid assessment tool for assessing the quality of PHC.

In health information, the Health Metrics Network has now established standards for the types of information and processes that countries need to effectively manage the health information function. The HMN assessment tool and the network's guidelines can be of help in the region. The Health System Assessment Approach developed jointly by USAID and several partners can provide a helpful overview of health information also. The project has laid a valuable foundation for better health information availability and use. It can now work to foment more of a culture of information and learn from business intelligence solutions that allow for agile analysis of multiple linked databases. Such solutions would be particularly helpful in setting such as the rayon level to allow decision makers to simultaneously analyze population and service statistics in a variety of ways (for example, to see whether indicators dip for several services in the same setting for the same month).

In human resources, the global challenge of finding the health workers to deal with the HIV pandemic has generated a great deal of innovative thinking that may be of use to the project. Initiatives including the Joint Learning Initiative, Treat, Train and Retain, and recent work on task shifting may serve as useful resources for tackling some of the issues of workforce planning, education and training, incentives and migration that the Central Asian countries confront. In the area of human resources, the project needs to link retention incentives with human capacity development. For example, if fieldshers and midwives are less likely than physicians to migrate, would it be better to emphasize their preparation rather than that of physicians? The project should turn over the training function to national institutions and not take on direct responsibility for training.

In financing, the project can benefit from experiences elsewhere in mobilizing private sector resources for health. USAID's Private Sector Project provides many lessons. USAID's work to leverage private financing for development through the Global Development Alliance and work by RTI to build public-private sector alliances in health in Central America might also provide useful ideas. Another innovation that warrants reflection is the increasing emphasis on engaging civil society in the analysis, dissemination and interpretation of national health accounts. This engagement is increasingly recognized as important for taking National Health Accounting beyond a technical exercise to influence policy. Another important area of work is to build high-level health economics and finance capacity to manage the complex issues that financing reforms will bring (for example, how to mitigating perverse financial incentives for primary care in autonomous facilities with capitated payment). Chile and Colombia are among countries that have successfully built cadres of leaders in health economics and finance.

In management, the project can draw upon a host of valuable tools to tackle the daunting challenge of building health management skills at all levels, from the financial manager of a rural SVP to the facility manager of a large urban polyclinic. The project might explore organizing management improvement collaborative among polyclinic managers addressing similar circumstances. The project might also explore the online Virtual Leadership Development Program developed by Management Sciences for Health for its applicability and usefulness.

3. Assess prospects for rapid success on public health reform before proceeding

In principle, the idea of the project advancing from rationalizing individual health services to rationalizing public health functions and financing holds appeal. Yet, in light of the deeply entrenched interests in the public health subsector and the strong possibility of resistance to change, the project may not be able to successfully tackle this challenge in its final two years. The Team believes this is a critical piece of the reform effort and suggests that it provides a strong justification for continuing project activities in Kyrgyzstan and Kazakhstan beyond the next two years. If continuation beyond the next two years is not likely in those countries, the Mission should consider eliminating this task from the scope of work for the next two years.

C. Project Management

1. Shift from implementation mode to analysis and dissemination mode: This project has been very successful at implementation. In this last two year period, the project would do well to place its emphasis increasingly on analyzing project experience and disseminating lessons learned within and beyond the region. In part, this means transferring increasing responsibility for actual implementation to country counterparts while focusing project efforts increasingly on consolidating the evidence base for project interventions. For example, the project has worked a great deal to provide primary health care facilities and polyclinics with greater autonomy over resource decisions. Now would be a good time to analyze and document how facilities use this autonomy. Similarly, the project has invested considerable effort in training human resources. It would be very valuable to analyze their job performance to see what impact this training has had. Do trained feldshers perform some functions as well as or better than trained physicians? Carrying out such work may mean investing more resources in analyzing and documenting impact. One way to free up some resources for analytical and dissemination work might be to agree with USAID on a more streamlined and more quantitative reporting process focused on a few critical metrics. Reporting should link technical and financial information. Since the project staff members are most accustomed to working as implementers, it may be advisable to bring in an additional staff member who would oversee the analysis, documentation and dissemination of project experience.

The remaining two years are also important for helping country teams tell their stories and share their expertise outside the region. Much of what the project and the CAR's health reformers have worked on is cutting edge and of broad global interest. For example, the current global discussion on performance based payments for health

workers (e.g., the Center for Global Development’s working group, UNAIDS’ Treat, Train, Retain) could benefit from lessons about the use of staff incentives by SVPs in Uzbekistan. Similarly, the actual process of navigating the policy environment effectively to bring about the Kyrgyz Republic’s Mandatory Health Insurance Fund could be of great interest to other countries working to introduce universal social health insurance.

In addition to documenting technical state-of-the-art work, the project would do well to document its many front line achievements in management and implementation. The exceptional success that ZdravPlus II has had in donor coordination, particularly with the World Bank and the Asian Development Bank in Uzbekistan and with the Manas Taliimi and SWAp process in Kyrgyzstan could provide valuable lessons for others. One possible avenue would be to explore documenting the ingredients of this success for the Paris Declaration and current discussions about using health as the tracer sector for donor harmonization. With many now searching for ways to integrate disease-specific and health system work, the comprehensive work that ZdravPlus II had done (so called “diagonal programming”) could provide useful lessons for others. One illustration is how reform efforts have enhanced disease-specific results, such as in the Kyrgyz Republic where health reformers kept DOTS on the policy agenda and where they are designing differential hospital reimbursement rates by TB case severity to remove hospital disincentives for treating patients with more difficult cases. Another very interesting accomplishment to explore is how the project has managed to associate its accomplishments with the US Government identity. While many projects are known by their names or the names of the prime cooperating agency, the degree to which partners consider ZdravPlus II’s work to embody USG support for their countries is striking

2. Align project structure with consensus framework on health system components:

At the time of their introduction, the four project components of stewardship, resource use, service delivery, and population and community health were forward-looking. Over time, the global health community has come to a clearer consensus about the critical elements of strong health systems--governance, financing, information systems, human resources, service delivery; and drugs, commodities and technology. To the extent possible without contractual implications, the project would benefit from aligning its work more closely with this consensus framework. In particular, the project would do well to distinguish more clearly between project work that seeks to build community strength as a governance intervention, and work that seeks to promote healthy behaviors by the population.

IX. Conclusion

- Through the ZdravPlus II project, USAID’s continued investment in health sector restructuring in the five Central Asian Republics since 1994 is having a remarkable impact on addressing the health challenges facing each country.
- This success is due in large measure to the project’s ability to tailor its vision and strategy to each country; sequence reforms in response to changing political climates

and government priorities, and collaborate with other donors in leveraging and programming resources.

- All governments and donors regard ZdravPlus II as the indispensable technical expert in the region. The project earned this reputation through its unique knowledge of the region and the health issues gained over almost fifteen years of implementation.
- USAID is successfully supporting health reform initiatives even though congressional directives constrain the Zdrav budget and programming flexibility. As health reform moves from debating policies to implementing complex changes, the technical relevance of work across countries is growing, not diminishing in importance.
- Zdrav's success in the region has attracted international interest, its model of reform being the first of its kind in the world. It attracts many study tours from other countries; is the subject of numerous academic papers; and merits more documentation and dissemination. For example, comparing the health reform experience in Kazakhstan, a middle-income country, with Kyrgyzstan, a low-income country, will add substantially to the nascent body of knowledge on evidence-based health system reform.
- Zdrav's implementation strategy to strengthen health systems (a horizontal approach) and target specific diseases or conditions (a vertical approach) is of groundbreaking importance. This vertical approach (i.e., a diagonal approach) can make a valuable contribution to informing the debate about whether and how a combined approach can work to maximize health outcomes.
- At both the national and community government levels, the Zdrav series is benefiting areas of government beyond the health sector. Examples are reforming the Treasury system for disbursing operating funds; defining the roles and responsibilities of government institutions; and expanding the role of civil society.
- USAID should continue its commitment to supporting health reform in Central Asia through 2009 and beyond, both to reap the full benefits of restructuring the health care systems and growing Central Asia as a classroom for the world.

Annex A: Kazakhstan Country Findings

Background: Health reform in Kazakhstan began in 1992 when the Ministry of Health (MoH) issued their paper titled “The Concept of Health Care Reform.” Implementation of this program was getting underway in 1994 just as the first Zdrav project was gearing up. Zdrav program managers embraced the Ministry’s concept and quickly established a role as technical advisers to support the reforms. By 2001, prospects were good for rapid progress in health reform because the economy was growing, successfully attracting foreign investment, and progressive reforms had been undertaken in the financial and social sectors. But soon thereafter, an attempt to establish national health insurance failed when the fund encumbered large deficits, stalling health financing reforms for several years.

By 2004-2005 the favorable economic conditions and newly appointed, enlightened leadership in the Ministry of Health reenergized reforms in important substantive ways. Through a participatory process between the government, ZdravPlus, WHO and the World Bank, the State Health Care Development Program (SHCDP) (2005-2010) (also known as the National Programme of Health Care Reform and Development), was developed and adopted along with a well formed legal and regulatory base. This program increased the stability of the health sector, and included the foundations of the system reform that ZdravReform had promoted in the 1990s and had judiciously nurtured for almost 10 years. The elements included establishment of a Budget Code for funding the Guaranteed Benefit Package through oblast pooling of funds, rules on the new payment methods, patient choice of primary care facility and the Health Care System Law authorizing the single-payer system – the foundations of the system reforms. National implementation of the plan was initiated in 2005 just as ZdravPlusII was launched. In interviews we were told that the government’s top priority is to strengthen primary care. ZdravPlus II’s three part country strategy is 1) to support their Kazakh partners in the implementation of this plan and 2) to support the GOK and the World Bank in the implementation of the Health Sector Institutional Reform and Technology Transfer Project (IRTT) co-funded by the GOK and WB, and 3) to solidify family medicine and improve service delivery in priority areas.

Comment [U1]: Should this read Health Care Code as we refer to it at the top of page 3?

Deleted: Budget Code

With a goal of accession to the WTO, the government has been a highly motivated partner to ZdravPlus II as they have collaborated to improve the performance of the health care system. The Vice Premier has committed to doubling the budget for the health sector, but he wants the new funds to go into a reformed system. The GOK views ZdravPlus II as their “right hand” in health sector reform and consider the staff to be more important advisers than the World Bank because of their exceptional analytical, mentoring and interpersonal abilities. They greatly fear losing their help at this important time.

In their opinion ZdravPlus II’s assistance to them has been critical to the advances made thus far in transforming the Kazakh health care system.

Performance Monitoring Plan Analysis: ZdravPlus II is making exceptional progress in meeting the targets set in the Performance Monitoring Plan (PMP). For 2007, the project is almost reaching, meeting, and in some cases exceeding significantly its 2009 end-of-project targets. Particularly noteworthy is the progress towards increasing the percent of total outpatient visits in primary health care practices in the pilot areas (achieving 61% in 2007 compared to its 2009 target of 59%) and nationally (57% in 2007 compared to its 2009 target of 45%); the number of entities to empower a community or individual (192 in 2007 compared to the 2009 target of 160); the percent of post abortion women accepting modern family planning methods (71% in 2007 compared to its 2009 target of 41%); and the number of products used for public outreach and advocacy (24 in 2007 compared to 10 in 2009). Given the impressive progress against most targets, the Mission, ZdravPlus II, and the GOK should accept due credit for this performance but consider resetting the 2009 targets to higher levels. Doing so could also provide an opportunity for these and perhaps other donor partners to suggest the “critical mass” of achievement signaling the phase-over of replication responsibility to the GOK. Critical mass might be defined by indicators such as successful implementation covering 60% or 80% of the population; 80% performance against the EU indicators in the graph above; reaching 80% of Millennium Development Goals.

Stewardship: The Stewardship component includes six sub-components in Kazakhstan; and, within these, a total of about 18 individual initiatives to create a comprehensive and coordinated framework for stewardship of the health sector. One of the priorities of ZdravPlus II during 2005-2007 was to support and promote full implementation of the State Health Care Development Program (SCHDP).

Since 2005, the Ministry of Health (MoH) has formed implementation working groups and has shown a high level of commitment to embedding the reforms in the day-to-day operations of the health care system. The challenges faced by Kazakhstan over this period have been to translate the policies into implementation strategies, to identify additional areas of policy change needed to fortify the reforms, to fend off attempts to undermine the strategy with alternative financing proposals and to lock the reforms into the legal system.

With the appointment of a new Minister and other MoH leaders in early 2007, ZdravPlus II devoted the past year to broad policy dialogue and training for MoH leaders to inform and educate them about the SHCHP and the critical health reform priorities. In addition, Zdrav sought to build capacity in the MoH staff to promote competency in the implementation of the reforms.

ZdravPlus II's semi-annual reports document a highly active program in the policy arena. They cite progress in 23 substantive areas, a testimony to the multi-faceted nature of system reform and to the depth and breadth of their technical knowledge. Besides serving as advisers to 9 working groups at the Ministry, they have been intimately involved as neutral advisers to the World Bank and the Government of Kazakhstan regarding the design of the recently approved World Bank Health Sector Institutional Reform and Technology Transfer Project (IRTT), which is co-financed with the Government of

Kazakhstan. They have also provided technical support in the development and implementation of the new incentive-based provider payment systems for primary health care physicians and hospitals, the new roles and responsibilities of the different levels and institutions of government, oblast medical information centers, the National Integrated Health Information System, the Outpatient Drug Benefit Package, and the new Council on Standardization and Assessment of Medical Technologies, which is charged with reevaluating old clinical protocols. In other words, they are involved in every area of reform from visionary policy matters to the practical considerations of implementation.

Five examples where ZdravPlusII's analytical insights and technical guidance have been particularly notable are

1) Health Care Code - ZdravPlusII filled an instrumental advisory role to the Ministry in the development of the Health Care Code. The Health Care Code carries the highest level of legal force, and assures sustainability of the reform agenda in a way that the SHCDP (adopted as a President Decree) does not. Through their close involvement in the drafting process, ZdravPlusII secured improvements in the new provider payment systems, allocation of responsibilities between the levels of government and the conditions for private sector development.

2) National Budget Formation and Treasury System – These two national governance systems are presenting major obstacles to health reform. Kazakhstan's current budgeting and payment systems are rigid and based on the old Soviet style budget chapters for funding inputs. Through the pilot in Karaganda Oblast, ZdravPlus II learned that the full benefit of the new provider payment systems will not be achieved as long as the restrictive bureaucratic accounting systems are in place. For instance, Oblast Health Departments cannot now reallocate funds from hospitals to primary care, a critical prerequisite to system restructuring. Zdrav has reached across the government to the Ministry of Economy and Budget Planning and to the Vice Premier to explain how the reforms are constrained by these systems. They have successfully argued for revisions that are now being developed; and in the course of this effort, gained well-positioned allies to help advance the health reform agenda.

3) Public Finance Reform – a ZdravPlusII presentation on the aforementioned inefficiencies of the Treasury system prompted the Vice Premier and the Ministry of Economy and Budget Planning to meet further with the project on the issue. As a result, three other ministries are piloting new approaches similar to the one ZdravPlus II advocated for managing health funds. The project has thus influenced the government to look beyond the health sector to address public finance issues more broadly.

4) Maintaining pooling of funds at the oblast level and single-payer structure – These two elements of the reformed system are the centerpiece of moving money in new ways to increase efficiency, quality, responsiveness and equity of the health care system. In the past year, there have been efforts to undermine these structures through further decentralization of the pooling function to the rayon level (Kazakhstan is already the most decentralized country in the CAR), introduction of national health insurance and

other alternative financing mechanisms. As a result of ZdravPlus II's vigilance regarding developments in the Parliament and their access to influential leaders, they were able to sound the alarm that these pillars of the reform (that had been in place since 2005) were threatened. Had the sponsors of the alternative financing methods prevailed, years of investment on the part of USAID would have been lost, however, the direction of reforms is still on track. This incident highlights the importance of assuring that reforms have a strong legal authority and that successful models are publicized and rolled out as quickly as possible.

5) Intervening into crisis situations – A few years ago the MoH was planning to buy ineffective drugs for TB treatment. ZdravPlus II stepped in and appealed this decision and successfully had it reversed.

In a lengthy interview with the Vice Minister of Health, appointed about one year ago, and the Head of the Strategic Development and International Cooperation Department, they said that few people in the Ministry have mastered an understanding of the complex social and economic nature of the health care system. They cited multiple examples of the training and analytical assistance ZdravPlus II had provided to help them better grasp the challenges and opportunities inherent in reform of the health sector. These included analysis of the national Treasury System and its impact on financing reforms in the health sector, administrative reforms within the Ministry, strategic budgeting, efficiency of the hospital sector, development and improvement of indicators of performance, structural adjustments of the sector, among others. The results of ZdravPlus II's analysis have led to adoption of family medicine and evidence-based medicine as national priorities and have strongly influenced the final design of the World Bank's Health Sector Institutional Reform and Technology Transfer Project (IRTT).

Currently, the Ministry's objectives include the following: roll-out of reforms to more oblasts, which will require several more years; breaking down the walls between hospitals and primary care to further stimulate development of primary care; outcome-based budgeting, which is scheduled to be implemented over the 2008-2013 period; harmonization of the laws and regulations governing the health care system, including the Health Care Code; and work on National Health Accounts, part of the health information system that ZdravPlus II is helping to design and implement.

In a meeting with the World Bank, the MoH assessment of ZdravPlusII's contribution to the health system reforms in Kazakhstan was reinforced. The Senior Health Specialist for Europe and Central Asia Region, indicated that ZdravPlus II staff, Sheila O'Dougherty in particular, had brought substantial intellectual capital to health reform across the region. Most recently, in his work with her and the ZdravPlus II staff on the design of the new World Bank project, he found their contextual knowledge of the complex health sector operations an invaluable resource. He expressed alarm at the prospect of the Zdrav capacity not being available to the implementers of the World Bank project.

Impressive results have been achieved in the Stewardship area under the project to date. A comparison of the priority elements that ZdravPlus II identified in the 2007 work plan

with the six month reports of 2007, indicates that some of the elements mentioned in the work plan (i.e., the pharmaceutical activities in the service delivery component and the incorporation of evidence-based clinical content in the Basic Benefit Package (BBP)) are not addressed under the same component or title in the semi-annual report. A cross walk between these two documents is, therefore, not precise. A sample of references indicates that the work plan was fully implemented under one component or another.

Resource Use: Between 1999 and 2005, public expenditures on health care grew almost five fold and the capitation rate had been increased from its 1998 original level of 19.5 tengue per person per month (pp/pm) to 160 tengue pp/pm. With this increase, primary care physicians are now providing more service and more preventive care. Within the design of health system reform in the CAR, the pooling of funds at the oblast level and the oblast single payer system are a centerpiece. Documents prepared by *ZdravReform* in 1999 state that “the single most important issue for institutionalizing new provider payment systems and allowing them to drive the rationalization of the health sector is addressing the constraints to pooling of health care funds at the oblast level and allocating health care resources without budget chapters.” [Lessons Learned and Next Steps in Health Reform for Central Asian Republics, *ZdravReform* paper, October 1999.]

Since that time, the economic conditions within Kazakhstan have changed, and along with them the most compelling rationale for these three components of reform has changed. It has shifted from changing the providers’ behavior through new incentive-based provider payments to an emphasis on the single payer system and pooling of funds at the oblast level in order to “provide equity and relatively equal financial risk protection for the poor and vulnerable populations, critically important as both income and the income gap is growing.” (Work plan 2007)

The difficulty of achieving acceptance for transformational ideas is obvious from the concentrated effort that Zdrav has had to invest in this topic over the past 7 years; though as noted, from 2001-2004, the government did not support health reform at all. For the past three years, ZdravPlusII has defended and protected the single payer and oblast level pooling against those with vested interests in other approaches. By working closely with the World Bank and the MoH in the design of the new World Bank project, ZdravPlusII has nurtured support for these institutional mechanisms, established some political buffers and has greatly improved the prospects that the financing system will be durable.

The World Bank project also includes components to address two of the weaknesses in the current operation of the single payer system. Up to this point there has been inadequate human and technical capacity to perform the various management functions associated with this structure. Staff has not been well trained for positions in financial and general management or information systems management. Autonomous facilities also demand management expertise to survive. In addition, the information systems are not developed sufficiently to assure transparent and accurate flow of funds. Investments in human capacity and information systems development are included in the World Bank loan.

Essential to implementing the new provider payment systems is the development and implementation of a health information system. ZdravPlusII has helped establish Medical Information Centers as independent legal entities, determine their functions, and train their staffs. The evaluation team visited the offices for the original pilot HIS system located in Karaganda. Karaganda Oblast has the most developed Medical Information Center with three functions: 1) collecting monthly data from providers which is used for both clinical and financial purposes, 2) preparing analytical reports and funding requests for the Treasury, and 3) developing indicators for monitoring and analysis of the health care system. The GOK is now directing that the system be implemented nationwide. It will produce the data for the PHC two-step performance-for-pay system the GOK plans to implement soon.

The Director of the Medical Information Center in Karaganda, who has been engaged in the development of the Center and the health information systems since its inception, said she highly values the technical assistance and training provided by ZdravPlusII and predecessor projects, expressing her desire that they continue receiving assistance well beyond the next two years. The HIS system is to be implemented nationwide in 2010, but only two oblasts (EKO and Karaganda) currently have functional systems. Other oblasts are doing data collection, but forms are not uniform, creating significant technical challenges for the nationwide system. She attributed the successful development of the HIS in Karaganda Oblast to the long-term relationship she has had with the project, noting that while high-level MoH officials have changed often, those at the mid-level, such as herself, have enabled the government to successfully implement the HIS and other reform initiatives. ZdravPlusII assisted the World Bank in developing scopes of work for consultancies related to the HIS component of the World Bank IRTT Project.

Health system restructuring centered on primary care is another centerpiece of the health system reform strategy. As with all the reforms promoted by ZdravPlusII, the State Health Care and Development Program (SHCDP) Implementation Plan is the vehicle for formalizing adoption within the government. To provide incentives to oblast governors to support the strengthening of primary health care, ZdravPlus II successfully suggested to the MoH that their performance ratings include assessments of their commitment to institutionalizing primary care. The indicator adopted is “percent of expenditures to PHC of the oblast health budget.” [July-December 2007 WP] ZdravPlus II’s attention to this seemingly minor incentive “in the weeds” may turn out to be one of the most powerful tools for restructuring the health system.

ZdravPlusII concluded that the availability of affordable medicines is crucial to strengthening PHC and has assisted the GOK in establishing and expanding an outpatient drug benefit program (ODBP). A ZdravPlus II funded evaluation of the program’s performance in 2006 by the Drug Information Center (DIC) found that 1) procurement prices varied across regions; 2) drug needs were poorly estimated due to inadequacies in the information management system; 3) too few pharmacies were participating; and 4) most of the ODB drugs have A or B+ clinical effectiveness. After ZdravPlusII briefed the MoH on the findings and the Kyrgyzstan ODB experiences, the GOK decided to include ODB improvement in the WB project design. The project is developing a

methodology to establish national ODB drug procurement prices and modifying the program to improve access and affordability. Under its new loan, the WB is counting on ZdravPlus II to help with the design and implementation of an information system to manage the program, which will address one of the major weaknesses of the existing system.

The Drug Information Center (DIC) provides health providers and patients unbiased up-to-date information on clinical effects of medicine, side effects and possible interactions. In 2007, the DIC submitted a successful bid for an MoH grant to develop a National Drug Formulary Reference book, which lists all of the medicines that are on the National Essential Medicines List and provides a brief description of indications, dosage, common adverse affects, and counter indications for each medicine. The DIC has continued to issue quarterly drug bulletins and provide training seminars on rational drug use.

In the interview with the former head of Karaganda Oblast Health Department, she said the areas of greatest need for them to complete the implementation of reform are organizational management issues, implementation of partial fund-holding, efficient fund use, a critical mass of well-trained people who can be employed at health care facilities, rayon health departments and oblast health departments. The School of Public Health is in the process of developing a curriculum for management, information systems and health care financing and economies, but they need help. She noted other concerns as well, including implementation of hospital-based continuous quality improvement (CQI), still a new and unknown concept to Kazakh health professionals; design issues related to building and renovating hospitals as these impact on the quality of care; improving the infrastructure for primary care such as medical equipment, training in the use of financial information to make management decisions.

Service Delivery: To improve service delivery, ZdravPlus II has focused on improving the knowledge of physicians and use of CPGs by providing assistance through the KAFP, on strengthening medical school faculties, initiating a medical residency program in family medicine, and introducing family medicine departments into Medical Academies. Despite strong government backing, gaining legitimacy and full acceptance of family practice within the established medical institutions has been difficult. Academic leaders from the “old school” have been unwilling to totally embrace family medicine and EBM with the result that they are not yet institutionalized. Medical students have reflected this lukewarm reception. This year a family medicine residency program was initiated (which is a great step forward) and there were only 12 applicants for the first class. Six were selected and will finish their residency at the end of 2009. The quality of PHC and the benefits of PHC for the patients hinges on providers improving their clinical skills. The educational establishment must be a partner for this to happen; and thus far, it has been very slow to respond.

At the present time, the state of the art in education for physicians related to clinical practice guidelines is modular training. The National Center for Health Care Development monitors the implementation of CPGs. After initial assistance to help the

Institute expand, ZdravPlus II now has a role as adviser, providing technical papers when needed.

The Integrated Improvement Projects were established to combine training, CME, CPG implementation and quality monitoring at the facility level. The team visited IIP sites in Astana (Safe Motherhood) and Karaganda (Arterial Hypertension (AH) and Safe Motherhood), discussed the changes in practice with medical staff and patients, and reviewed the quality monitoring tools used to measure progress in implementation of best practices. At all of these sites, the program has been enthusiastically adopted and was working well with growing numbers of enrollees. The former head of the Oblast Health Department in Karaganda credited the pilot sites with causing a “revolution in thinking by the doctors.”

Cardiovascular disease is by far the leading cause of death in Kazakhstan (536/100,000 vs. 28/100,000 for infectious disease and 66/100,000 for cancer). ZdravPlusII’s goal is to increase the prevention, screening, diagnosis, treatment and monitoring of those with the disease or at risk for the disease. ZdravPlusII has been working to improve management of this disease since 2005 when clinical training of physicians first began. They served as advisers to the Cardiology Institute (CI), the leading research institute in Kazakhstan, and the Postgraduate Institute for Physicians (PGI) which developed the family medicine clinical practice guidelines (CPG) for arterial hypertension and conducted courses to train the trainers. Other partners include the Karaganda Oblast Health Department, KAFP, and the Drug Information Center. There is now a group of stakeholders who are trained in the EBM and CPG methodology and understand their role in development of future initiatives informed by EBM and CPG.

Outreach to patients with AH begins with counseling by their primary care physician regarding their condition and a referral to the educational programs conducted at the facility. The follow-up studies indicate that patients are responding favorably to the program.

KAFP is responsible for facilitating the implementation of the AH CPG. Six pilot sites in Karaganda oblast were selected for the initial implementation of the new AH program and it has now expanded to three additional oblasts.

ZdravPlus II taught KAFP how to do medical record audits and with these skills they are able to monitor quality at AH pilot sites in Karaganda Oblast, selecting one indicator at a time to monitor. Results show that in pilot sites case finding has significantly improved, physicians are prescribing appropriate meds more often, patient practices have improved, complication rates are lower and blood pressures are better controlled. The first indicator was blood pressure screening (2006-2007) and the second to be implemented thus far is measuring and recording patients’ body mass index (BMI). At the site we visited, the staff was enthusiastic about what they had learned about evidence-based medicine and proud of the opportunity to offer modern medical practices to their patients. They admitted that learning a new way to treat their patients was not easy, but they are now pleased with their heightened awareness of this medical condition. They expressed

concern about the lack of blood pressure cuffs and stethoscopes for visiting nurses. The reductions in death rates from cardiovascular disease at the pilot sites in Karaganda are expected to become apparent within the next three years. In 2008, KAPF will work through the family group practices to roll out the AH program CPG Clinical Training Module to two other oblasts and the city of Semipalatinsk.

Safe Motherhood is a WHO program designed for the former Soviet bloc countries and tested in Ukraine. Implementation began in the CAR in 2005. WHO and ZdravPlus II are collaborating on training. The team found that the Family Planning/Reproductive Health/Safe Motherhood IIP sites were well supplied to conduct their programs. They are reporting high satisfaction of providers and patients, which we confirmed in our interviews with both patients (one with a partner) and medical staff. A quality monitoring program is built into the SM pilots. It tracks 26 indicators of effectiveness which are linked to the three SM service training modules. Data on these indicators is compiled at least annually from patient surveys and chart reviews. Baseline data was collected at all 11 pilots; and the reports showed that overall care has improved. There were some areas at each site where performance was not sustained and where appropriate change was not occurring. The most important aspect of these reports is that problems areas are easy to identify for follow-up, though use of the feedback loop appears to be uneven.

Hospital leaders have already seen that the Safe Motherhood program can rather quickly demonstrate reductions in infant and maternal deaths. For instance, in Karaganda Oblast SM hospitals, the average length of stay (ALOS) and cost per delivery have decreased. The number of deliveries has increased from 18,000 in 2002 to 22-24,000 in 2007, while infant deaths have declined from 22/1000 to 12/1000 over the same period. Continuation and sustainability of these programs is highly probable because a well-structured training of trainers program has been established and trainers are willing to serve without pay. The cost of physician and patient training materials is absorbed by the facility budget.

Safe Motherhood is not yet part of the medical school curriculum in Kazakhstan, but a multi-disciplinary working group is developing of a prekaz for safe motherhood.

The Red Apple Hotline, implemented through the Kazakhstan Businesswomens Association and partially funded by ZdravPlusII, uses student peer trainers to provide family planning and reproductive health counseling services. During 2007, the Hotline responded to almost 45,000 calls. The Association began offering the hotline in Almaty and Karaganda and it is now available in 20 branches throughout the country. ZdravPlus II technical and materials assistance is valued highly. The Association welcomes continued support but is already identifying other funding sources to continue the hotlines after USAID assistance ends in 2009. These sources include local governments but other donors as well. The local branches have registered as NGOs and can receive local government funding. However, they still face funding issues. For example, in the Western region, the local government does not allow the MOH to allocate funding to NGOs. Similarly, the main association in Almaty can receive a national grant, but it can not distribute these funds among the branches. The Association seems well aware of the

need to strengthen the financial sustainability of the hotline program and is addressing constraints to doing so accordingly.

ZdravPlus II has been very successful in collaborating with Project Hope to integrate TB services into the PHC system. The PHC system is especially helpful in identifying new cases and providing DOTS services. The two projects and other counterparts participate in the national thematic working groups on TB. ZdravPlus II recently examined TB control in the prison system. Kazakhstan is a regional leader in penal reform, requiring the penal and civilian sectors to coordinate and assure that all infected people are followed and have access to meds. The project is also assisting with the development of the Kazakhstan National Guidelines on TB and MDR-TB Control in collaboration with the National TB Program and other international donor programs. The guidelines will contain detailed practical information for PHC and TB service providers. The collaboration between ZdravPlus II and Project Hope has the potential for developing new creative service delivery models that may have appeal within and beyond the CAR region.

Population and Community Health: According to the ZdravPlusII semi-annual reports, activities in this component focused on 1) promoting and marketing health care reforms to the MoH, oblast health reform implementers and health professionals and 2) educating the population on select health topics related to AH, FP/RH/SM, and the Exxon Mobile-USAID Global Development Alliance (GDA). The key implementers of these activities, besides ZdravPlusII, are three of its grantees, the Business Women's Association of Kazakhstan (BWAK), the Kazakhstan Association of Family Practitioners (KAFF) and the Drug Information Center (DIC).

ZdravPlusII has continuous interaction with officials in the government regarding the health reforms and the strategic vision they are working to achieve. This helps the GOK to maintain the focus when complexities and obstacles arise, such as with the Treasury System issues.

The Kazakhstan Association of Family Practice (KAFF) received its first grant from ZdravPlus in 2003. Its purpose is to promote the new profession of family medicine. They have become a successful training organization for EBM across the CAR. Their approach is to use clinicians as trainers and clinic sites as the classrooms. In this way, the training is practical, hands on with patients, and interactive between the physician trainers and the students. This is a completely new approach to medical training.

To implement the AH initiative KAFF supports the patient schools for AH, and promotes evidence based approaches to the treatment of asthma, and chronic obstructive pulmonary diseases. They produce posters that are displayed in public places, and use the radio to publicize information for the general public. ZdravPlusII is providing brochures and audio/video materials on AH to the National Healthy Lifestyle Center for copying and dissemination. Patient Clubs have been organized for a variety of conditions and these support groups are becoming more common.

ZdravPlusII has sponsored well-attended open houses at family group practices to attract public attention to these facilities and demonstrate the range of services available to patients.

Conclusion

ZdravPlus II has worked effectively with the Kazak government, helping them to develop a strategy for reforming the health care system and to gradually and sequentially begin implementation of that strategy. Its analysis and guidance has informed virtually all of the sweeping legal and policy changes governing the health sector in Kazakhstan. Its knowledge of systems operations has been skillfully applied to the design of pilot tests and troubleshooting of problems. Understanding the still tenuous nature of reform and the challenges that remain, government leaders are counting on ZdravPlus II to continue to have a central role. Under the new World Bank loan, both the Kazakh government and the World Bank see ZdravPlus II's role as critical to their success.

USAID is closely identified with the leadership position and deep respect that ZdravPlus II has gained with the GOK and the donor community. Though Kazakhstan's new wealth places it outside of the eligible range for funding beyond the current contract period, it is in the US national interest to continue its involvement with the Kazakh health reforms for two reasons. First, when the health care system is fully functioning, Kazakhstan will be an example of a "model" health care system, built from the ground floor to correct problems that were wasting scarce resources and poorly serving the health needs of the population. It has the potential to offer many global "best practices" in areas where international health experts are desperate for answers, such as how best to combine system strengthening with vertical disease/condition specific programs. The US's commitment to Kazakh reforms over an extended period merits well-deserved recognition for this breakthrough. Second, the project has generated enormous good will in an important part of the world. If the GOK is willing to provide a significant part of the operating budget while USAID maintains technical and management control, there will be a high return on the US investment as well as continued presence at a critical time in history.

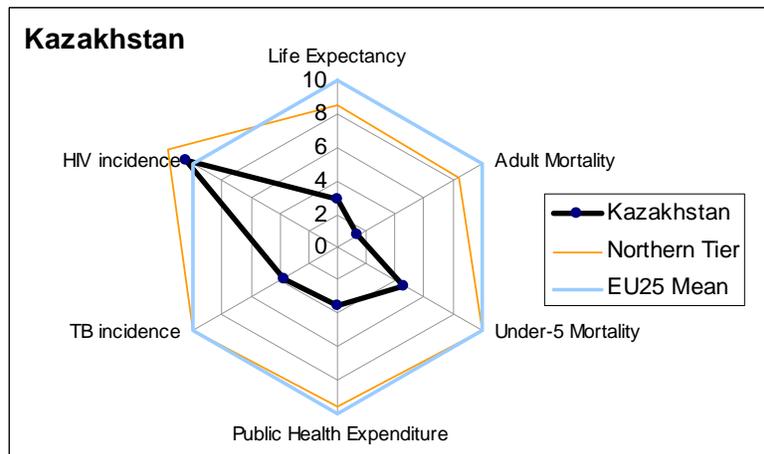
Annex A1: Kazakhstan: Expectations of Movement Along the Development Continuum over the Next Two Years

Kazakhstan's status as an upper-middle income country places it in the Sustaining Partnership Countries category of the U.S. Foreign Assistance Strategic Framework. However, it falls into the Developing Countries category judging by the assistance profile for the Investing in People (IIP) program area; namely, "Encourage social policies that deepen the ability of institutions to establish appropriate roles for the public and private sector in service delivery." The changes expected in the health sector over the next two years will not have an impact on the country's movement along the continuum from the "Developing" to "Transforming Country" category. Kazakhstan may achieve Transforming Country status over the next seven years in terms of the IIP assistance profile but is unlikely to reach Sustaining Partnership status.

Kazakhstan ranks 25 of 28 countries (higher number rankings are worse cases) in the 2007 Europe and Eurasia Health Vulnerability Analysis. See the report at:

http://www.usaid.gov/locations/europe_eurasia/dem_gov/docs/2007_ee_health_vulnerability_analysis_report_final.pdf

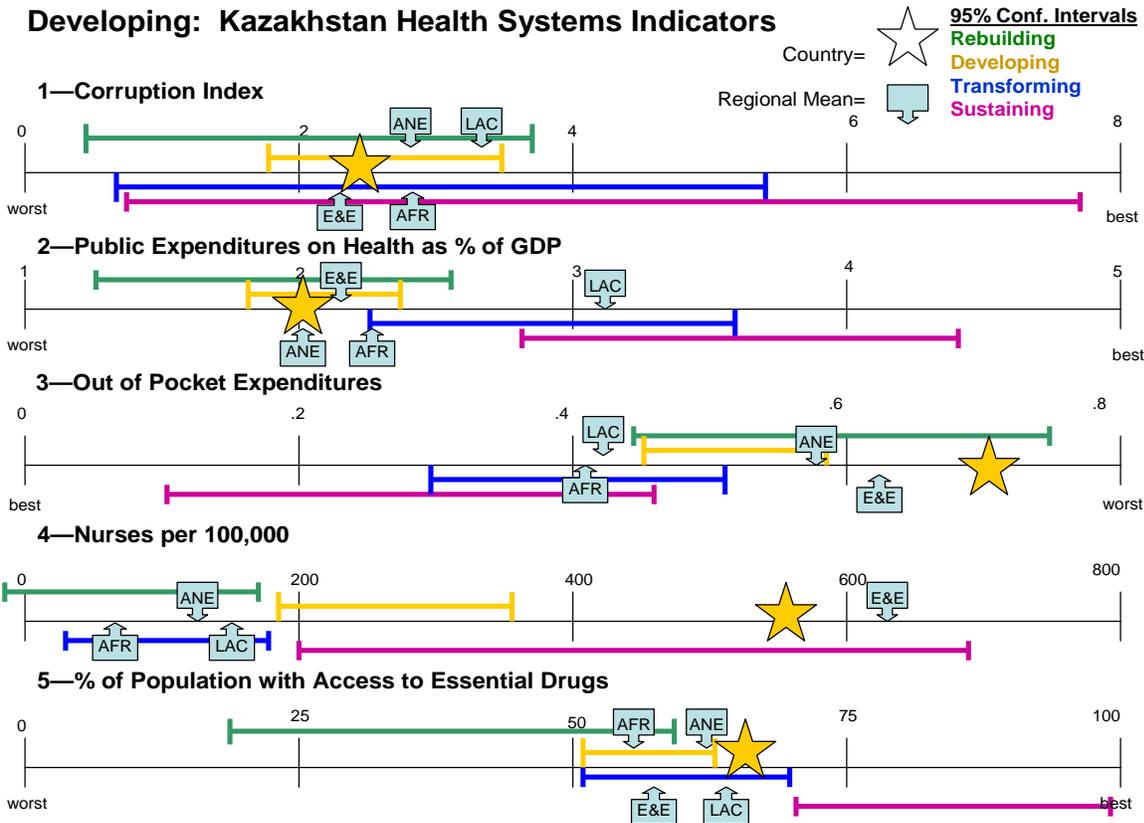
The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. The graph below draws on this data to compare Kazakhstan's health status to European Union and E&E regional averages. For each indicator, a score of 10 corresponds with the **EU average**, suggesting ideal performance. A score of 1 indicates the poorest performance in that indicator in the **E&E** region. The country's performance is then plotted against this scale. A score of 10 is ideal performance for all indicators and all countries.



Northern Tier refers to the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.

Kazakhstan is far from approaching the levels of health sector development achieved by countries in northern Europe and the EU25. It appears that Kazakhstan scores better than the EU average on HIV incidence. Since the number of confirmed HIV cases is highly dependant on the surveillance program in the country, HIV scores may be deceptively optimistic.

The graphic below shows Kazakhstan's performance on several key health systems development indicators relative to: (1) averages for Europe and Eurasia and other geographic regions, and (2) averages for country categories of the USG Foreign Assistance Framework. Indicators reflecting the extent of corruption and public expenditures for health put Kazakhstan into the Developing Country category. However, given Kazakhstan's increasing public expenditures in recent years, by this measure now it likely falls into the Transforming Country category. Out of pocket expenditures are very high relative to countries elsewhere in the region, and more characteristic of the Rebuilding Country category. It is not clear the extent to which these reflect formal payments by those with the ability to pay as opposed to informal payments by those for which these payments impose a heavy financial burden. Nurses per 100,000 are high, putting Kazakhstan in the Sustaining Country category. However, this is misleading as nurses receive low salaries and most require training to upgrade their skills. Access to essential drugs is high, reaching levels of the Transforming Country category.



Source: U.S. Agency for International Development, Bureau for Global Health; most data is 2006.

The GOK is increasing budgetary allocations to health annually and just contributed \$178.4 million to a \$296.1 million loan agreement with the World Bank. Nonetheless, Kazakhstan's ongoing health sector development requires technical assistance, in addition to money, so it can use these increases in resources efficiently and equitably.

The GOK is also demonstrating its commitment to health reform by implementing the State Health Care Development Program designed with ZdravPlus II technical assistance. As evidenced by interviews with GOK officials and health workers, much remains to be done to continue the reform momentum, including passage of additional key legislation and wider implementation of the reforms nationwide.

Given Kazakhstan's oil revenues and increasing per capita income, it is unlikely USAID can justify continuing its health assistance program beyond FY 2009 using traditional funding accounts. However, ongoing TA remains critical to sustaining and expanding the reforms to achieve a "critical mass" when USAID assistance is no longer required.

Annex B: Country Findings Kyrgyz Republic

Background: The Kyrgyz Republic has a population estimated at 5.1 million, one-third the size of Kazakhstan and one fourth the size of Uzbekistan. Its land mass is half the size of Uzbekistan and less than one tenth that of Kazakhstan. The country is four times as densely populated as Kazakhstan but about half as densely populated as Uzbekistan. While only 7% of land is arable, 86% of arable land is irrigated. This means that the population per square kilometer of irrigated arable land is on par with that in Kazakhstan and Uzbekistan. Based on the distribution of consumption by the top and bottom deciles and the Gini coefficient, the Kyrgyz Republic is slightly more egalitarian in income distribution than either Kazakhstan or Uzbekistan. The Kyrgyz Republic's population is two-thirds ethnically Kyrgyz and three-fourths Muslim. Its population growth rate of 1.35% figures between Kazakhstan's 0.3% and Uzbekistan's 1.7% rates.

At independence, the new government asked WHO to help develop a national health program and reform. In 1992, the new government issued three laws--for health insurance, the health system design, and sanitary wellbeing. These provided the structure for health reform and a new payment system. In 1994, 25 local experts were competitively recruited and trained by WHO to develop the health reform.

ZdravPlusII's stated approach in the Kyrgyz Republic has been to help national partners to implement Manas Taalimi, The Kyrgyz Republic's Health Sector Reform Strategy, and to help implement the donor Sector Wide Approach (SWAp) developed to support the Manas Taalimi health reform strategy. According to ZdravPlusII's own analysis, the environment in the Kyrgyz Republic had been consistently supportive of reform until recently. In 2005, popular demonstrations led to the election of a new president. Further demonstrations in 2006 led to the adoption of a new constitution. These changes have affected the balance of power between the legislative and executive branches, and called into question the country's vision for its future. This political instability and uncertainty could impact the continuation and deepening of the health reform process.

Kyrgyzstan PMP Analysis

The Kyrgyzstan PMP for ZdravPlus II shows that there are 31 indicators of performance for the SO and the four IRs, Population/Community Health, Service Delivery components, Resource Use and Stewardship.

An analysis of the Kyrgyzstan PMP indicates that it may not be the best barometer of progress for the project. Several of the indicator targets have been surpassed by large amounts, but many are either in suspension, show no projected targets, or need to be updated. As such, this disaggregated report does not provide a useful composite picture of performance. A summary page for each country would be advised, and could simplify forward planning.

Achievement of the target for the Strategic Objective indicator, “Percent of total outpatient visit share increased in PHC practices, relative to outpatient specialist care, from 56% in 2003 to 75%” could not be determined because the reported data covered only the first three quarters of 2007.

The three 2007 targets for the Population and Community Health component [IR 3.2.1 A and B] were exceeded by a significant percentage and targets for future years have already been overtaken by progress to date. Future targets need to be revised as they did not represent challenging goals. Also given the concerns described under Kyrgyzstan Country Findings regarding the sustainability of a number of vital associations, the VHCs and the Press Center, it might be more appropriate to change the indicators entirely and focus on tracking progress in finding sources of funding for these organizations outside of ZdravPlusII.

For the Service Delivery component there are 15 indicators that touch on almost every aspect of ZdravPlus II’s service delivery efforts. Of these, four targets were met [IR 3.2.2. E, F, I and M - “midwife training”, “TB-DOTS training”, “TB_DOTS outpatient care integrated into PHC” and “family medicine residency curriculum], one [IR 3.2.2 P “safe motherhood models in four oblasts” achieved the 2009 target, and one was partially exceeded [IR 3.2.2 N “admissions to family medicine residency program”]. One indicator, IR 3.2.2 E, “midwife training in family planning skills extended to reach 25% of rural rayons not covered by gynecologists” was particularly well constructed because it provided excellent contextual information. Of the six that have been met or exceeded, IR 3.2.2 F, I, M, P must be updated to show the on-going change expected. Four of the indicators had been suspended (IR 3.2.2 C, J, K, L – “minimum standards for primary care facilities,” “evidence based infection control practices in central rayon hospitals,” “STI surveillance established in SES,” “STI care in FGPs accessible in urban”]. IR 3.2.2 A, “adherence to select evidence-based CPGs or standards of care improved in FGPs by 50%,” is unclear because the timeframe is not stated (annually? by 2009?), the targets do not match the indicator and there is a minimal progression in the annual targets. The targets for IR 3.2.2 B and D, “adherence to select evidence-based CPGs for SM in pilot sites” and “CME established nationwide in FM training centers” are not clearly defined. IR 3.2.2 G, “reliable referral system developed between TB penitentiary and primary health care systems” was reported as of September 20, 2007 and shows no progress toward reaching the targets in 2007. Updated information is needed. One indicator, IR 3.2.2 O, “FGP package of services,” will be measured for the first time in 2008.

There are 10 indicators for the Resources Use component. Of these, one target related to payment of PHC practices and hospitals was partially met [IR 3.2.3 A], the target related to IR 3.2.3 G, “incentive systems to retain rural doctors and nurses and attract new students to family medicine” was set at one for 2007 and it was met. However, there are no forward targets for the next two years even though the indicator implies that there will be more than one system. The 2007 target for IR 3.2.3 I related to “human resource database analysis on staffing needs” was not met. The IR on oblast funding [IR 3.2.3B] was met in its first year, raising the question of why the same target is shown for 5

straight years. Similarly, through 2009 the targets for IR 3.2.3 C, “total expenditures allocated to primary health care” were exceeded in 2007, necessitating an updated target. It would be useful to add in the notes for this IR what is the ideal percentage for this allocation so that reviewers would know the context for these numbers. How close to the “ideal” are they? In 2006 the targets for the IR 3.2.3 H “SES restructured and savings retained” and IR 3.2.3 J “National Health Accounts established” were set for 2008. Finally, two indicators are in suspension, IR 3.2.3 D, “co-payments and some fees introduced at FGP level in some oblasts” and IR 3.2.3 K “referrals from family doctors to narrow specialists reduced from 30%-10%.” To provide context, a note should be added to IR 3.2.3 K as to whether 10% is considered the ideal referral rate under the reformed system.

The Stewardship component had two IR indicators. The target of one per year for IR 3.2.4 A “specifically identified policies or laws/regulations approved” was met for 2006 and 2007, but future targets have been recorded. The target for IR 3.2.4 B “number of products created by different mechanisms enhancing policy dialogue or policy marketing/participation submitted to government or used for advocacy or public outreach” was exceeded by over 100% but future targets have remained constant.

Stewardship: In the Kyrgyz Republic, ZdravPlusII has focused its work on stewardship on: (1) the Mandatory Health Insurance Fund; (2) the legal framework for the health system; (3) the development of the Manas Taalimi Health Sector Reform Strategy; (4) the Center for Health System Development; (5) associations including the Family Group Practice Association, the Hospital Association, and the Medical Accreditation Commission; (6) selected studies with WHO; and (7) the Ministry of Health Press Center. Across the board, counterparts and partners familiar with ZdravPlusII’s work in these areas judge it to be of high technical quality, implemented with a collaborative approach, and very often fundamental to the progress that the Kyrgyz Republic has made in each of these areas.

The project concept of stewardship incorporates some elements of the broader concept of health governance which USAID now uses. In a well governed health system, the Ministry of Health should operate as the steward of the health system, with oversight and accountability. Citizens, civil society, and the private sector should be empowered to provide input and to assume new health sector roles and responsibilities. Civil society and the media should have the skills and capacities to exercise oversight and hold policymakers and providers accountable. Mechanisms should be in place to create synergies between the government and these other actors in health. This vision of governance is radically different from the reality that the Kyrgyz Republic faced at independence and the system of governance the country inherited from Soviet rule. Instead, the state role went far beyond stewardship to encompass direct management of the entire health system. Citizens participated as recipients of services and were not empowered to provide input. The notion of independent organized civil society did not operate nor did the country have an independent press. In the health sector, ZdravPlusII

has made impressive contributions to fundamentally transforming health governance. The picture now is one of a greater diversity of voices engaging in health governance--including a variety of institutions and more active citizenry. Although the project components are organized differently, with elements of health governance woven into several components, ZdravPlusII's work has made critical contributions to improving health governance in the Kyrgyz Republic.

The creation of the Mandatory Health Insurance Fund (MHIF) as a single payer is at the core of the reform of the health system in the Kyrgyz Republic. Leaders of the MHIF, other partners and observers consider ZdravPlusII's technical assistance critical to its current capacity and successful operation. Local policy counterparts assess ZdravPlusII's technical assistance throughout the MHIF's development as "outstanding". From the earliest stages, ZdravPlusII worked actively to help iron out potential inconsistencies between health reform and the new insurance law of 1996, which otherwise could have created conflict between the Ministry of Health and the MHIF. In 2003, with legal support from ZdravPlusII, the MHIF reached a turning point with the passage of a law to pool local as well as national health funds into the MHIF. By 2007, 70% of state spending for health was channeled through the MHIF with 30% channeled through the Ministry of Health (MOH). The MHIF now covers 80% of the Kyrgyz population. A special additional drug benefit that provides discounts on drugs through private pharmacies has led to the substitution of less costly outpatient care for more costly inpatient care. The MHIF conducts quality assessment of its contracted health facilities by tracking hospital deaths, unusually short or long hospital stays, and hospital stays with multiple surgeries. The MHIF may still need technical assistance to develop a practice of routinely analyzing the information now at its disposal to detect and address any evidence of fraud or misuse of the health insurance fund.

The Kyrgyz Republic's health reform has required new laws, resolutions and Ministry of Health *prikazes* and new legal arrangements for civil society participation. The most compelling evidence of ZdravPlusII's critical role in building this legal framework is that the Ministry of Health issued a *prikaz* mandating the ZdravPlusII lawyer to coordinate all health legislation, effectively giving ZdravPlusII the role of guiding the Ministry's own two legal advisors. While project staff were the team's only information source on ZdravPlusII's legal contributions, the project's track record on the legal framework is very impressive. As noted earlier, one major accomplishment was the 2003 passage of the legal arrangements for a single payer system with all health service delivery funds under a single institution. The government resolution making it legal for health facilities to retain, invest and distribute revenues above expenditures was another important contribution. ZdravPlusII has contributed to greater transparency in health system employment by defining requirements for positions and establishing procedures for competitive selection. ZdravPlusII helped set up arrangements enabling the MHIF to transfer public resources to private providers meeting contracting requirements, although this has not yet been fully exploited. More work remains to level the playing field for private sector participation, by equalizing terms for licensing, accreditation and tax payment. So far, legal work has focused largely on establishing an enabling framework. One important future test of this framework will be to what extent it helps resolve

problems that emerge in implementation, such as resolving financial misuse of MHIF funds, violation of patient rights, or corruption.

The Kyrgyz Republic's Manas Taliimi represents the Kyrgyz Republic's vision and plan for ongoing reform in the health sector. This strategy forms the basis for the Sector Wide Approach that channels external donor resources in support of a common national health reform program. ZdravPlusII provided technical assistance to develop Manas Taliimi and the SWAp, helped organize health summits to build agreement about the strategy, and conducted technical reviews of it. A powerful illustration of the quality of the outcome of the Manas Taliimi strategy development and the SWAp is that the Ministries of Education and Finance have requested MOH help with the development of a SWAp for education. According to a World Bank representative, DfID studied the Kyrgyz SWAp and concluded that "it is the best and most successful example of a SWAp around the world."

ZdravPlusII developed the legal framework for the Center for Health System Development (CHSD), which carries out policy analysis for health. It has an evidence based medicine department and a medical library. This center has carried out studies with ZdravPlusII and WHO support that analyze key elements of the health reform, such as the financial sustainability of the state guaranteed benefits package. The creation of this center is an important step toward institutionalizing the health policy function and the capacity to conduct high quality health policy analysis. The evaluation team lacks information about how and how widely the results of CHSD work are discussed and how they are incorporated into health policymaking.

On the provider side, ZdravPlusII has helped the Kyrgyz Republic to constitute several dynamic institutions that offer health educators, facility managers, and health care providers with voice, support, and input into policymaking. These include the Kyrgyz Republic Medical Institute for Continuing Medical Education, the Medical Accreditation Commission (MAC), the Hospital Association (HA), and the Family Medicine Association (FMA). ZdravPlusII has supported all of these both technically and financially. Looking ahead, their shared vulnerability is the lack of plans for ongoing financial viability.

The Kyrgyz Republic Medical Institute for Continuing Medical Education is the main Kyrgyz institution responsible for training and retraining primary health care practitioners. It receives support from several donors and considers ZdravPlusII as having taken the lead in donor cooperation. ZdravPlusII played a critical role in helping the Institute introduce a new specialization in family medicine in the Kyrgyz Republic.

ZdravPlusII helped constitute the Medical Accreditation Commission as an independent body to accredit primary health care facilities, and secondary hospitals. The Commission also provides input into health policymaking. ZdravPlusII support included its legal constitution, grant funding for operation, and training of its members. MAC has begun to accredit dental, rehabilitation and laboratory services. The leadership of MAC established an affiliation with ISQUA on its own initiative. MAC is initiating its second round of

accreditation of primary health care facilities and secondary hospitals. In Issyk Kul oblast, facilities have begun to develop an understanding about accreditation.

Since the Kyrgyz Republic is building a health care model of consumer choice in facilities, more needs to be done to increase the public's awareness about what accreditation means and what level of accreditation each facility has earned, for example, by posting accreditation certificates at facility entrances and educating the public about the meaning of gold, silver and bronze accreditation status. More also needs to be done to make MAC a financially viable entity over time. At present, 90% of its funding comes from the project and only 10% from charges to facilities. In part, this is because ZdravPlusII has given the MAC resources to carry out project activities. Factoring out these activity-specific resources, the share of funding that MAC is able to raise from charges to facilities is still insufficient to cover its basic operations. The Commission has no plan for when or how it will reach financial viability. Unlike many other accreditation bodies, the technical assessment the commissioners make is not final but rather must be vetted by a policy level steering committee. This might make it vulnerable to external forces.

The Hospital Association includes all 85 public hospitals. It provides hospital directors with a common voice vis-à-vis the Ministry of Health and provides input into health policymaking. ZdravPlusII has helped the Hospital Association through legal advice and by providing the Association with funding to carry out activities. Like the Medical Accreditation Commission, the Hospital Association lacks a defined plan and timetable to achieve financial sustainability.

The Family Medicine Association is an association of the health facilities that employ family physicians. Of all family doctors in the Kyrgyz Republic, 2200 work for facilities that pay to join the Family Medicine Association. The Association provides input into health policymaking. For example, it helped develop legal regulations for health reform. The Association relies on ZdravPlusII for advice and support. This association is also vulnerable as it lacks a financial sustainability plan. In addition to the Family Medicine Association, the Kyrgyz Republic has a separate association for family group practices (the Family Group Practice Association (FGPA)). The respective roles of the FMA and the FGPA are not entirely clear to the evaluation team.

The Kyrgyz Republic is developing several civil society institutions that can provide a collective voice for patients. For example, the Diabetes Association represents the concerns of diabetes patients and is affiliated with Diabetes Associations internationally. The Kyrgyz Republic also has an Alliance for Patients Rights, which was formed with support from another donor. Patients can call upon the Alliance for help addressing issues of violation of their rights in health. Another emerging patient association is the Association for Women with Breast Cancer. ZdravPlusII has not yet worked with these patient associations. This might be worth exploring as a potentially important avenue for strengthening the voice of the clients and broader civil society in the health system.

Beginning in 2002, ZdravPlusII helped the Ministry of Health to establish a Press Center to share information on health reform and the health system with the public through engagement with the Kyrgyz press. Although the MOH was meant to take over staffing and operating this unit beginning in 2007, ZdravPlusII continues to staff the unit, which maintains contact with an estimated 35 journalists who report on health and has a listserv of 250 journalists for distributing health information. This press center has helped to establish journalist resource centers at the oblast level. Among accomplishments, ZdravPlusII has helped the media to learn to cover health issues constructively. The staff of the center think that members of the Kyrgyz public who follow health news most closely, for example retired people, are very familiar with the state guaranteed benefit package thanks to their work. The Center has focused considerable effort on the public relations function of covering specific activities of the Ministry of Health. It has also directly produced several educational video clips about the Kyrgyz health reform process, covering timely topics of public interest such as the co-payments with the Mandatory Health Insurance Fund. From the evaluation team's understanding, the MOH Press Center then had to buy airtime to show these videos. The evaluation team did not have information to indicate the impact of these videos among the Kyrgyz public.

Rather than directly producing videos, another approach might be to help television reporters to gain access to appropriate health facilities, workers, patients and the public to do their own coverage of these topics. Ideally it would be desirable for the local press to take ownership of health coverage and to develop their own materials, or at least for the television stations to run the MOH Press Center videos at their own expense. The fact that the MOH has not started to fund the Press Center from its own resources after five years is of concern. At a minimum, it suggests that the MOH has not developed a way to institutionalize this center. It may also indicate that the MOH has not perceived the Center to provide substantial value added to its work.

The single most important remaining challenge for ZdravPlusII in the stewardship component in the Kyrgyz Republic is to strengthen the institutional and financial sustainability of the many new and important entities it has helped to create or support thus far. This includes helping associations including the MAC, the FGPA and the HA to develop and implement sustainability plans. It also includes handing over the financing and operation of the Press Center to MOH. This center also could do more to ensure that patients are fully informed about the State Guaranteed Benefits Package and about patient rights. Beyond this challenge, additional efforts may be required to refine elements of the legal framework for reform. ZdravPlusII can help the government to move from developing legislation to demonstrating its effectiveness at resolving legal problems. ZdravPlusII would do well to take advantage of opportunities to strengthen civil society organizations, such as the Alliance for Patients Rights, and to help the state engage effectively with the private sector in health.

Resource Use: In the Kyrgyz Republic, ZdravPlusII has focused its work on resource use on core issues in human resources, health financing, and health information systems. It has also worked to improve Kyrgyz health system capacity in health management. Much of ZdravPlusII's work in these areas has been through ensuring that the Manas

Taliimi Health Reform Strategy and the SWAp address these issues appropriately. In human resources, ZdravPlusII has worked to improve understanding of the dynamics and scope of problems of out-migration of health human resources. It has also worked to develop the Deposit Doctor Program that provides incentives to attract physicians to work in rural areas.

As noted earlier, effective health financing should mobilize adequate funds to pay for health needs from sources that are reliable over time; should pool them to promote efficient purchasing and spread the costs of health care; and should allocate resources to optimize health impact, promote efficiency and enhance equity. ZdravPlusII has contributed fundamentally to greater resource mobilization, better pooling and more effective allocation. The most substantial achievement ZdravPlusII has helped bring about is the operation of the Mandatory Health Insurance Fund, which has a State Guaranteed Benefit Package, graduated co-payments, differential state subsidies to population subgroups, and national pooling of health funds. Under this system, the Kyrgyz Republic has achieved the remarkable goal of insuring 80% of its population and subsidizing an additional 8-11%. This system relies on capitation based payment for primary care and case based payment for hospitalization. ZdravPlusII has helped to develop and refine provider payment arrangements, including the development of differential coefficients for rural areas. ZdravPlusII contributed to the development, costing and analysis of the financial sustainability of the state guaranteed benefit package.

From the very beginning of the Kyrgyz Republic's health financing reforms, partners note that ZdravPlusII's piloting of case based payments and provider payment innovations in Issyk Kul formed the basis for the system the MHIF adopted and rolled out nationwide. Innovations in provider payments led the Kyrgyz Republic to successfully apply for \$1.15 million in grant funding from GAVI HSS to apply performance based funding at the family medicine center. ZdravPlusII is now helping the MHIF and MOH with second generation refinements in health financing such as making treasury regulations on funds flow compatible with the operational needs of autonomous health facilities and introducing program based budgeting in the MOH. ZdravPlusII is also now helping the MOH transform the way it finances public health services. ZdravPlusII helped bring about the success in the financing of individual health services that led the public health sector to seek to reform its own financing. ZdravPlusII is also helping develop differential hospital case based payments for different levels of TB care. This is critical so that hospitals do not face disincentives to treat more difficult TB patients. ZdravPlusII is also reportedly collaborating on national health accounts, although the evaluation team did not have information about the status of this work.

As noted earlier, effective health information systems should produce, analyze, disseminate and use reliable and timely information on health determinants, health systems performance and health status. ZdravPlusII has worked to improve the collection, management and use of information at all levels of the health system, from the individual facility to the national MHIF and MOH. This work has laid the groundwork for more sophisticated evidence-based decision making and accountability in the health

system. The many improvements in health information that ZdravPlusII helped to introduce are almost too numerous to mention. At the facility level, ZdravPlusII piloted innovations in Issyk Kul that have been rolled out nationwide. One impressive example is the set of clinical information forms that are now known nationwide as the “Purvis” forms after the *ZdravReform* consultant who developed them. The software ZdravPlusII developed to analyze health information is now used nationwide. ZdravPlusII trained health facility directors to use computers and e-mail and to analyze information. As a result, facility directors can now monitor results more effectively. ZdravPlusII helped the Ministry of Health do away with 65 forms for primary data collection and 30 forms for statistical reporting. It helped move the health system from manual to automated processing. At the national level, the Ministry of Health now finances a Medical Information Center established as an independent legal entity. This center operates a computerized information system that integrates medical, financial, service delivery, population and human resources databases. The MIC shares its data with the MHIF and provides access to associations like the Hospital and Family Group Practice Association. The MIC has branches in all oblasts. As an illustration of how far the Kyrgyz Republic’s health information system has progressed with ZdravPlusII assistance, a recent assessment using global Health Metrics Network standards for health information systems found Kyrgyz Republic’s health information system to be adequate overall. The Health Metrics Network has selected the Kyrgyz Republic as one of a handful of intensive pilot countries for health information system support.

In the face of all this progress, ZdravPlusII faces an important unfinished agenda in resource use. In human resources, the challenge is to develop human resource policies and plans based on realistic assessments of the serious risk of out migration of physicians. ZdravPlusII needs to ensure that its support for physician training goes hand in hand with effective measures for physician retention. An alternative approach in this context might be to train other types of health care professionals less likely to migrate, such as midwives. Such a strategy would need to be assessed for its political viability in the Kyrgyz context. In financing, two important challenges remain. One is to build measures that mitigate the natural tendency for capitated payment at the PHC level to provide less care or over-refer to the hospital level in order to save resources for improving facilities and staff salaries. While such measures can certainly be introduced, people at various levels of the Kyrgyz health system do not seem aware of any need to anticipate, monitor or mitigate this tendency. Another related challenge is for the MHIF to begin to mine the rich information now at its disposal to establish expected financing patterns, identify outliers, and address any issues of misuse or corruption underlying these exceptions. In information, the greatest remaining challenge is to help health institutions exploit the information at their disposal more fully for decision making and to disseminate more information to the public. Part of the answer might be to introduce more agile interfaces that would allow users to combine and analyze various databases with greater flexibility (for example, to analyze population and service information together).

Service Delivery: In the component of Service Delivery in The Kyrgyz Republic, ZdravPlus II’s efforts extended to the areas of medical education and training, EBM and

CPG development, quality assurance, pharmaceuticals, infrastructure, public health and SES reform, continuous quality improvement (CQI), safe motherhood and family planning, and infectious diseases (TB). ZdravPlus II has met the objectives to-date for each of these areas, with notable achievements in strengthening primary health care and prevention services and promoting EBM and quality improvement. However, there will continue to be challenges in these areas as ZdravPlus II moves toward the end of the project and more work to ensure sustainability in each of these areas is needed.

The medical workforce challenges inherited from the Former Soviet Union health system include an excess supply of health professionals who are overspecialized, exacerbated by the dearth of providers in rural communities. In order to strengthen the capability of Kyrgyz doctors and nurses to deliver primary health care services, ZdravPlus II works to improve human resources and workforce planning by promoting medical education reform, contributes selectively to improving information systems to provide better data for decision-making, and supports specific country level dialogue and programs to address the rural human resources crisis.

Efforts in medical education reform include both training for new medical professionals and continuing medical education (CME) for existing professionals. Advocacy to standardize the medical education system has been challenging as some are resistant to change. New medical graduates still lack appropriate training and also receive limited expertise in public health and health management. To increase the number of primary health care providers, a clinical residency in family medicine was established and ZdravPlus II has worked to promote this residency option to medical students. According to information from the Kyrgyz Medical Institute for Continuing Education, the Kyrgyz Republic had 4 residents in family medicine in 2007, 7 in 2008 and will have 18 in 2009. Though increasing, in the past, Institute informants note that enrollment has represented only 10% of medical graduates and only 50% of those have actually gone on to work in primary health care. Implementing partner STLI mentors family medicine, family nurse, and feldsher trainers who provide on-going clinical training to medical students and existing providers. Each oblast has a re-training branch for existing providers, which helps with efficiencies and travel requirements for providers. Currently 3,500 providers have been re-trained, and in-service training is held annually. However, low salaries compared with neighboring countries cause frequent migration among providers as well as trainers. STLI coordinates curriculum development for CME and is also developing distance-learning modules in a web-based format. Existing providers can raise their categorical rating by receiving additional training, therefore increasing their payment rate from the MHIF. STLI has also contributed to a concept paper for a national CME program that sets a minimum requirement of 150 credit hours of CME every 3 years for all medical doctors.

In addition to education reforms, attracting providers to rural areas and retaining them is challenging given low salaries. Not enough doctors are entering the public medical system; for example, at the Balykchi Hospital in Issyk Kul Oblast, 8 of the 44 active providers are eligible to retire but they continue to practice because no other doctors are available to replace them. The Deposit Doctor Program was set up in an attempt to

mitigate the rural provider shortages but challenges remain. The ZdravPlus II HR Specialist and the HA completed the development of a database module on both the oblast and national level in order to contribute to the development of options for mitigating the rural human resource crisis, human resources planning, and health facility management.

Beginning reforms to SES and promoting public health will also have important outcomes in shifting paradigms in the approach to health care in the Kyrgyz Republic. Although the reforms to health care have been in place for a number of years now, SES has had independent financing streams that precluded them from the reform process. However, better integration of SES into the health care system and modernization of their functions has become an inevitable next step. In addition, health promotion and disease prevention need to be developed, as patient ownership of health care had not been a priority under the Soviet system. It was decided that merging SES and health promotion would maximize the effects of each of these functions, resulting in a surveillance system with involves health promotion. Another key aspect of this approach is involving the community in the process.

ZdravPlus II has supported working groups on public health curriculum and skills training for SES staff, setting the political and legal structure and creating a pilot to improve the delivery of public health services and integrate the involvement of the community. A pilot was established in Ton Rayon of Issyk Kul Oblast. The pilot set up a Public Health Coordination Council which includes SES, the local village administration, the local providers, and the village health committee, and other key stakeholders. The Council meets quarterly with SES as its lead. SES has been trained in risk factor analysis and to develop integrated action plans. The next steps in this process are formalizing the Council within the MOH and SES, and establishing pilots in one rayon of each oblast. There is also a need to continue policy dialogues with the MOH and SES to institutionalize best practices learned at the pilot sites.

As the Kyrgyz move toward institutionalizing evidence based medicine, a structure has been set up for the development and implementation of CPGs. Committees include representatives from the MOH, MAC, special departments of the MOH, health providers, and medical/patient/professional associations.

Population and Community Health: In the area of Population and Community Health, ZdravPlus II undertook activities in the areas of Village Health Committees and Healthy Schools. These efforts were primarily to market the health reforms to the public but also include elements of civil society building that links closely to the Stewardship component. ZdravPlus II is rolling out the Swiss Red Cross Community Action for Health (CAH) model. Piloted in Issyk Kul Oblast, 276 VHCs are now active in Issyk Kul and Jalalabad Oblasts. The CAH activity is the core of the Manas Taalimi Population Involvement Component.

VHCs are formed when village members elect the committee members, and the committees then analyze the health challenges in the village and develop strategies for

addressing them. The VHCs work with the local primary health care provider, oftentimes the feldsher, who trains the VHCs and helps them to develop health promotion campaigns. The Swiss Red Cross has rolled out this model in the Oblasts where it works. This model is expected to be extended to all Oblasts by the end of 2008. Many of the VHCs have federated at the rayon level as Rayon Health Committees (RHC) in Issyk Kul Oblast and are registered as NGOs. The RHCs have participated in the development of the Kyrgyz Republic's GAVI grant application.

The VHCs also bring democracy building and civil society mobilization benefits. For example, one VHC lobbied for the construction of new FAP in Issyk Kul Oblast due to the low quality of the building and the local government undertook construction of a new facility. In addition, one Issyk Kul rayon allocated some of its budget to the VHC to conduct a malaria campaign as it was identified as an issue of importance among local residents. In addition, many VHC members have been elected to the local government and their increased role in the community and local government empowers citizens to ownership of their health care and in their governance.

The MOH is committed to the CAH approach, and this approach is written into Manas Taalimi. Currently, the MOH pays the salaries of the primary health care staff that engage the VHCs and ZdravPlus II pays for the trainings and transportation costs. An estimated 2.5-4.5% of the regional budget would be needed to maintain these functions. These costs are anticipated to be transferred in full to the MOH. This has not happened yet, and this move will be critical to the sustainability of this activity after the close of ZdravPlus II. The VHCs are still nascent groups and will need continued support to build their capacity as sustainable community entities.

Conclusion:

ZdravPlusII has made impressive contributions to the health system in the Kyrgyz Republic through all four components in fundamental and significant ways. The creation of the Mandatory Health Insurance Fund (MHIF) as a single payer is at the core of the reform of the health system in the Kyrgyz Republic. Under this system, the Kyrgyz Republic has achieved the remarkable goal of insuring 80% of its population and subsidizing an additional 8-11%. ZdravPlusII has contributed to the current understanding in the Kyrgyz Republic about issues and options for the health workforce. In service delivery, ZdravPlusII has had notable achievements in strengthening primary health care and prevention services and promoting EBM and quality improvement. By the end of this project, the Kyrgyz Republic health system will operate in fundamentally different and better ways because of ZdravPlusII's engagement. The remaining challenges are to ensure the sustainability of local institutions that will bear the responsibility of continuing to operate and strengthen the health system. The long-term viability of the health system will depend on continued political support, engagement of strong civil society entities, increased public spending on health, and solutions that engage the private sector and respond to the needs and interests of urban as well as rural residents. Special attention is warranted to tackle the threat of human resource migration.

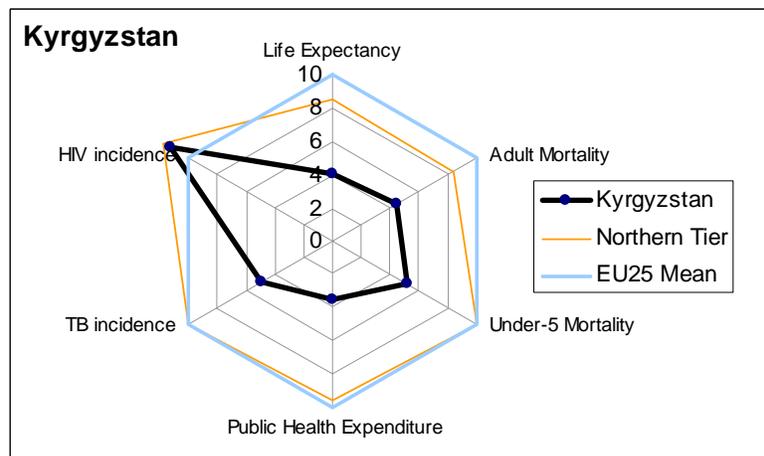
Annex B 1: Kyrgyzstan: Expectations of Movement Along the Development Continuum over the Next Two Years

With a gross national income estimated at \$490 per capita (\$2100 based on purchasing power parity) and risks of instability, Kyrgyzstan is classified as a low income developing country. In comparison with other developing countries, Kyrgyzstan does better at ensuring its population access to essential drugs. It has achieved population coverage with essential drugs on par with transforming countries. The FY 2008 Millennium Challenge Corporation (MCC) scorecard on the next page shows that Kyrgyzstan exceeds the median for its MCC peer group on both its immunization rate (94% coverage compared with a median of 84%) and public spending on health (2.61% of GNI compared with a median of 2.07%).

Kyrgyzstan ranks 24 of 28 countries in the 2007 Europe and Eurasia Health Vulnerability Analysis. See:

http://inside.usaid.gov/EE/dgst/h/docs/2007_ee_health_vulnerability_analysis_report_final.pdf

The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. The “spider” graph below draws on this data to compare Kyrgyz Republic’s health status to European Union and E&E regional averages. For each indicator, a score of 10 corresponds with the **EU average**, suggesting ideal performance. A score of 1 indicates the poorest performance in that indicator in the **E&E** region. The country’s performance is then plotted against this scale. A score of 10 is ideal performance for all indicators and all countries.

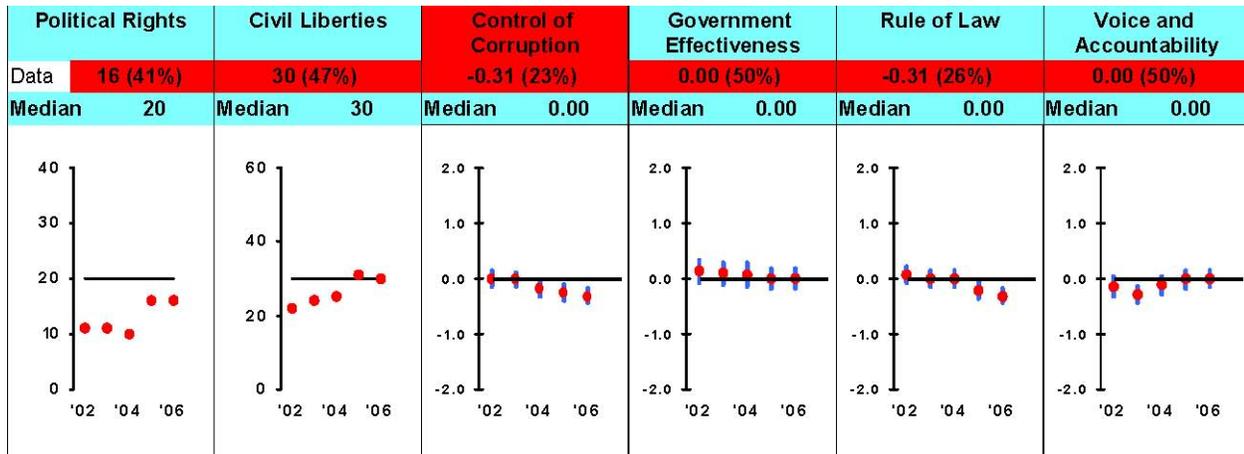


Northern Tier refers to the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.

Kyrgyz Republic FY08

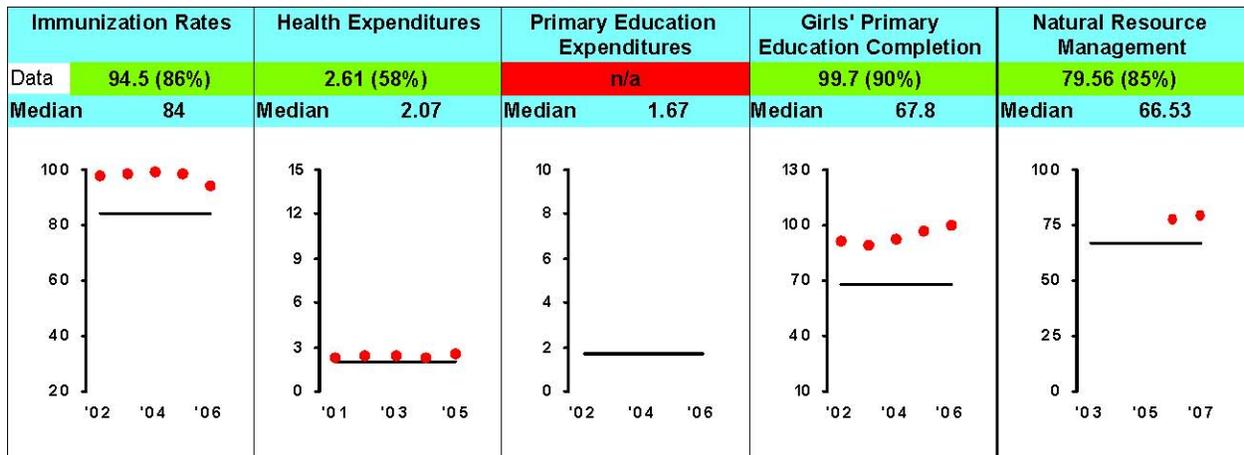
Population: 5,143,500
GNI/Cap: \$490 LIC

Ruling Justly



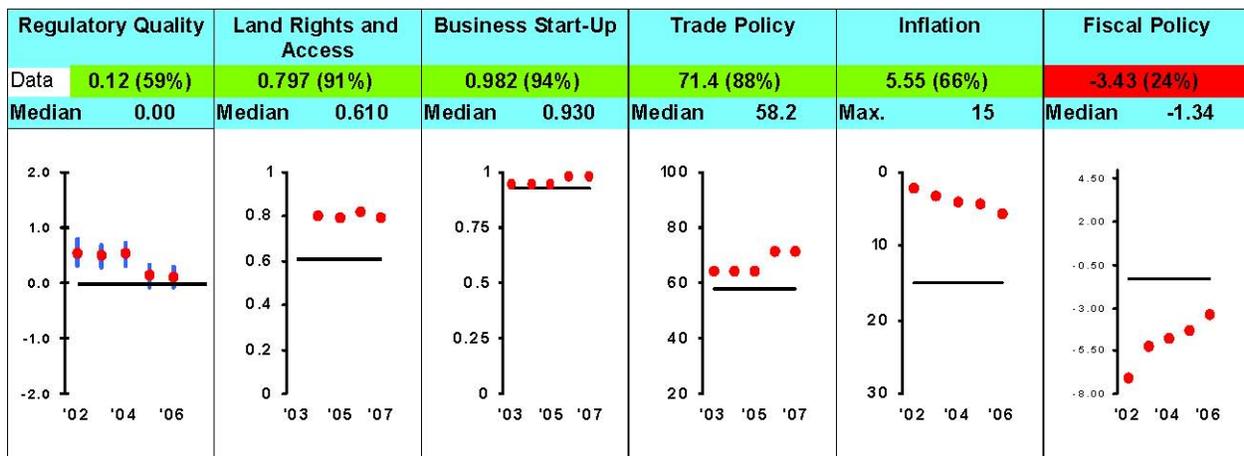
Sources: Freedom House Freedom House World Bank Institute World Bank Institute World Bank Institute World Bank Institute

Investing In People



Sources: World Health Org. World Health Org. UNESCO/National Sources UNESCO CIESIN/YCELP

Economic Freedom



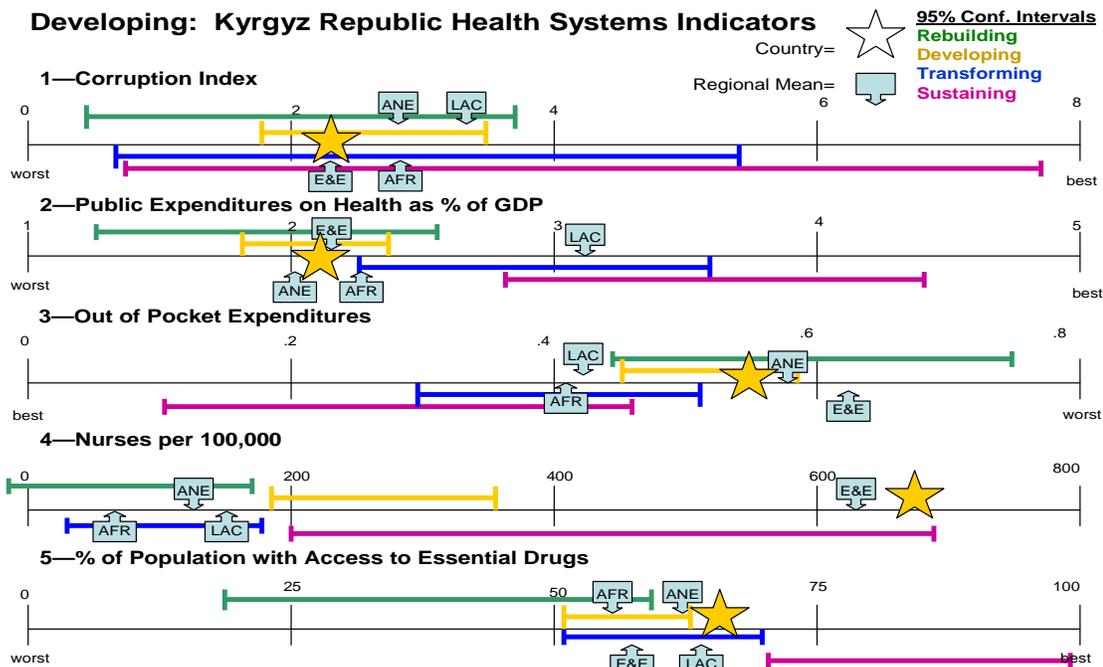
Sources: World Bank Institute IFAD/IFC IFC Heritage Foundation IMF WEO National Sources

How to Read this Scorecard: Each MCC Candidate Country receives an annual scorecard assessing its performance in 3 policy categories: Ruling Justly, Investing in People, and Economic Freedom. Under the name of each indicator is the country's score and percentile ranking in its income peer group (0% is worst; 50% is the median; 100% is best). Under each country's percentile ranking is the peer group median. Country performance is evaluated relative to the peer group median and passing scores, or scores above the median, are represented with green. Failing scores, or scores at or below the median, are represented with red. The black line that runs along the horizontal axis represents the peer group median. Each World Bank Institute indicator is accompanied by a margin of error, which is represented by the vertical blue bar.

For more information regarding the Millennium Challenge Account Selection Process and these indicators, please consult MCC's website: www.mcc.gov

The spider graph shows that Kyrgyzstan has a way to go before approaching the health status of Northern Tier and Western European countries. Life expectancy is 68, among the lowest in the region. Under-five mortality is high; 67 out of every 1,000 children born in Kyrgyzstan die before the age of five. TB incidence is among the highest in the E&E region and the TB control program is completely dependent on donor support for the supply of TB drugs. In November 2007, Kyrgyzstan reported 1385 HIV positive cases, but the true figure is estimated to be as much as 10 times higher. Underestimates result from the lack of proper diagnostic systems and the absence of an effective surveillance system.

The indicators below reflecting the extent of corruption, public expenditures for health, and out of pocket expenditures demonstrate that Kyrgyzstan clearly falls in the Developing Country category. Nurses per 100,000 are high, putting Kyrgyzstan in the Sustaining Country category. However, this is misleading as nurses receive low salaries and most require training to upgrade their skills. Access to essential drugs is high, reaching levels of the Transforming Country category.



The potential for instability in Kyrgyzstan is great and stems from political, economic and demographic factors. On the political front, popular demonstrations in 2005 led to the election of a new president. Further demonstrations in 2006 led to the adoption of a new constitution. These changes have affected the balance of power between the legislative and executive branches, and called into question the country's vision for its future. This political instability and uncertainty could also impact the future of what has been to date an impressive process of health reform. With an economic growth rate of 2.7% compared with Kazakhstan's of 10.6% and Uzbekistan's of 7.3%, Kyrgyzstan will fall further behind its neighbors over time. The unemployment rate of 18% in Kyrgyzstan

is six times as high as in Uzbekistan and about two and a half times as high as in Kazakhstan. This is particularly worrisome when coupled with the fact that 30% of Kyrgyzstan's population is under 15. Many youth will soon join a labor force already plagued by high unemployment. Kyrgyzstan's poverty rate of 40% compares unfavorably with Uzbekistan's 33% and Kazakhstan's 19%.

In this context of risk, Kyrgyzstan needs help to avoid declines associated with instability and to make progress toward achieving the health advances of transforming states. To be in line with other transforming countries, Kyrgyzstan needs to increase public spending on health while decreasing out-of-pocket spending, and improve health governance. From 1996 to 2005, Kyrgyz total spending on health has hovered at 6% of GDP, while the contributions from public funds have declined from 53% to 43%. Government spending on health has declined as a share of government spending from 12% in 1996 to 9% in 2005. The MCC's FY08 scorecard for Kyrgyzstan shows it performing below the median for its peer group on all dimensions of governing justly—including political rights, civil liberties, control of corruption, government effectiveness, the rule of law, and voice and accountability. It could also scale back the number of health professionals per population. While the high number of health professionals is partly a legacy of former Soviet management, Kyrgyzstan's ratio of nurses per 100,000 population is high even by regional standards.

With ZdravPlus II and other support, Kyrgyzstan has made impressive achievements in putting health insurance mechanisms and basic health services in place. It has worked to ensure equitable access to basic health services. It has worked to improve the quality of service delivery for the poor and other vulnerable groups. Kyrgyzstan is working to strengthen institutional capacity in health, particularly in the public sector. It has taken important steps to improve government policy-making, regulation, accreditation, and oversight. It has both the vision and the infrastructure to provide universal coverage with basic health services. Kyrgyzstan needs to further strengthen this infrastructure to protect it from instability, particularly in the areas of governance, finance and human resource planning. Continuing to build and strengthen this infrastructure should be the focus of the next two years.

Over the next two years, ZdravPlus II can contribute substantially to move Kyrgyzstan toward the transforming country category in health by focusing on a core set of interventions to strengthen the health reform and protect it from the threats of instability. However, the changes expected in the health sector over the next two years will not enable Kyrgyzstan to shift from the “developing” to the “transforming” country category.

Annex C: Tajikistan Country Findings

Background: Tajikistan is the second most vulnerable country in the USAID E&E region from a health standpoint. It ranks second worst in life expectancy and public health expenditures, and worst in new estimated tuberculosis (TB) incidence. It is a resource poor country, with little to contribute to meeting the health and health care needs of its citizens. Approximately 64% of the population lives below the poverty line, and 36% of the children suffer from chronic malnutrition. It is considered to have a high potential for explosive growth of HIV/AIDS incidence due to the number of injecting drug users.

Reform of the health sector began in 1994 when the President proclaimed a need for general reform, including the health sector. In 1995 a program for transitioning the country to a market economy was adopted, and in 1996 a policy for “Health care reform in the Republic of Tajikistan for 2001” was released. This was followed in 2002 by approval of “Health Sector Reform in Tajikistan,” which stated that primary health care (family medicine) was the top health sector priority. According to the World Bank, the Tajiks vision of reform is to have a health insurance system modeled after Kyrgyzstan.

Until recently, little had been done to move on the reform strategies as understanding of health system reform among policy makers was quite weak. But with the help of ZdravPlusII, the World Bank and the Government of Tajikistan completed a loan agreement. The project, “Community and Basic Health Care,” which is in its second year of implementation, supports primary health care, capitation payments to providers, and co-payments within the context of a formal Basic Benefit Package. Another hopeful sign is that there is now a commitment to increase public allocations to the health sector from 1% to 3% of GDP; however, due to a severe energy crisis, the government may have to use its funds elsewhere.

Donors have been moving to a sector wide approach (SWAp) in Tajikistan, reaching agreement on a comprehensive framework and country strategy that they will support. The concept for the Tajik SWAp does not include budget support because the consensus is that they do not have the fiduciary capacity for management.

Under the ZdravPlusII contract, the country strategy for Tajikistan is to work with other donors/projects to create synergy for linking national level initiatives, such as health financing with facility level activities (top-down, bottom-up). There is very little in place now, and the challenge is to begin building some pride of ownership to create advocates and stakeholders for change as they see differences in outcomes. To do this, the project will focus on using Centers of Excellence as models for how service delivery can be improved under a PHC based system.

Performance Monitoring Plan Analysis: ZdravPlus II is making steady progress in meeting the targets set in the Performance Monitoring Plan (PMP). The implementation indicators are considerably less deep and broad than those set for Kyrgyzstan,

Kazakhstan, and Uzbekistan where the project has supported reforms for over a decade. Nonetheless, the PMP reflects successful acceptance of many of the key reforms implemented in these other countries and early progress is encouraging for this resource-poor country. For 2007, the project is almost reaching, meeting, and in some cases exceeding several of its 2009 end-of-project targets. Noteworthy is the progress towards increasing the percent of total outpatient visits in primary health care practices in Polyclinic 8 Dushanbe (67% actual for 2007 compared to a target of 25% for 2009); the number of entities which serve as mechanisms or channels to empower health action by an individual or community (67 actual for 2007 compared to a target of 30 for 2009); the number of PHC workers receiving CME (6,545 actual as of 2007 compared to a target of 4,000). Progress is tracking more slowly but still above the target for the number of hospitals with standard health information systems (22 compared to a target of 25 for 2007 and 40 for 2009). The project fell short of their 2007 target for retraining PHC workers because the project increased the duration of the course to 7 months (38 retrained compared to 50 targeted in 2007). The PMP sounds no implementation alarms and reflects reasonable and often impressive performance.

Stewardship: ZdravPlusII's efforts to promote good stewardship of the health sector have been well targeted for increasing the potential for primary health care to be a strong foundation of the health care system. With the help of ZdravPlusII, the Ministry of Health has had significant achievements in the development of policies that form the legal base for implementation of primary health care per capita payment. It provided technical experts to help with the development of an implementation plan for the "Strategy of Health Care Financing in the Republic of Tajikistan 2005-2015." The strategy has been approved by three ministries providing a broad base of support within the government. A particularly positive feature of this strategy is that it led to a mandate that the PHC budget be separated from the overall health care budget, creating a political buffer for PHC.

The new system is being implemented in 8 pilot rayons based on regulations that ZdravPlusII developed with the approval of the local khukumats. The rayon pilots are sponsored by other donors, but ZdravPlusII has used them as demonstration sites for informing the Tajiks and donors about the implementation issues for the new system. In addition, they have facilitated the success of the pilots by drafting regulations to govern implementation.

One of ZdravPlusII's greatest achievements has been the reintroduction of the basic benefit package with formal co-payments in 8 categories to be initiated in pilot rayons. As the decree was moving to conclusion, there was an attempt to create 200 categories of co-pays which would have been confusing to patients and difficult to implement. This complication of the concept could have sabotaged the reintroduction of a basic benefit package. However, by its vigilance ZdravPlusII caught the last minute move (by the Vice Minister, now Minister of Health) and was able to have it corrected. Aside from the political maneuvers, the formal co-payments are a strategy to reduce corruption by eliminating under-the-table payments and creating transparency and accountability in the financial transactions between the patient and doctor. In the pilots, receipts are provided

for co-payments; and studies show a reduction in under-the-table payments and increased formal salaries of physicians. However, patient out-of-pocket costs are unchanged.

The World Bank views ZdravPlusII as an important partner to realize a return on their investment in Tajikistan. Zdrav has served as a technical adviser with deep knowledge of the local context of reform as well as a thorough understanding of health systems issues. The WB team leader for the project said that their help was invaluable because their intimate knowledge of the Kyrgyzstan reforms enabled them to advise the Tajiks on what was feasible for their context compared to the Kyrgyz context. For instance, Kyrgyzstan has small oblasts and Tajikistan has very large oblasts, so reforms would be more successful if first tested at the rayon level. This is one example of how they have become known throughout the regional for their ability to “contextualize.”

The key issue in the stewardship component is concern that the new Minister of Health may not be a supporter of efforts to reform and build a stronger primary health care system. Before being appointed minister, he was the deputy minister of health. He and the former minister spent much time debating health reform issues, and the government made slow progress with the reforms. It was not until the government negotiated the recent World Bank health sector loan that the reform movement gained traction. One observer stated that more progress has been made in the last four months than in the past eight years. Other informants the team spoke with believe the new minister will have to support the reforms, noting that the reform process is not dependent on the Ministry of Health alone, citing the Ministry of Finance and Ministry of Economy as other key players. In addition, donor partners will continue to insist that the reforms not be reversed. It is still too early to know; but even if the progress is slowed at the national level, ZdravPlusII has the ability to concentrate more of its attention and resources on strengthening local primary care facilities.

Resource Use: All financing reforms are in early stage of development. The PHC capitated payment is being implemented in 8 pilot rayons (406 facilities, 14% of PHC facilities nationally). ZdravPlusII is providing assistance with the legal/regulatory framework, technical methodology and tools, and implementation of the Basic Benefit Package and co-payments. Monitoring has found that implementation is going well, that the co-pays are understood and are being collected and that accounting systems have improved. Their findings and recommendations for next steps were submitted to the MoH, MOFinance and the Treasury.

The government plans to implement a case-based hospital payment system at the oblast level, and ZdravPlusII is working with the MOH Medical Statistics Department on the development of a health information system that will support this new type of payment. They will be working with the WB PIU to educate people at the rayon and oblast levels about this new information system prior to more extensive implementation.

Service Delivery: The service delivery component is the heart of the ZdravPlusII program in Tajikistan. This is the arena where the most activity is centered, and where ZdravPlusII technical assistance can get the most traction. To strengthen primary care,

physicians and nurses at this level are required to complete training in family medicine. Current estimates are that 4000 family doctors and 8000 family medicine nurses are needed. Thus far, 700 physicians and 700 nurses have been retrained through a 7-month course which includes classroom learning and practical interaction with patients. The team observed a family medicine Center of Excellence which is using evidence-based medicine CPGs and practical training of clinicians. This is the model of practice that ZdravPlusII aims to establish nationwide. Two other donors have already committed to financial support for replication of the model. The process is lengthy and labor intensive, but it will gradually take root as increasing numbers of trainers, medical staff and medical school students are introduced to family medicine EBM and use of clinical practice guidelines. Though there is not yet a national initiative on family medicine, ZdravPlus II's work has the support of members of the medical profession who hold positions at TSMU where they are able to influence the adoption of modern medical practices.

The quality of medical education underpins this component. With strong leadership from the Rector, the Tajikistan State Medical University (TSMU), the only medical school in the country, will begin revising its curriculum to firmly establish family medicine and to teach EBM. He also plans to broaden the curriculum to include biostatistics, clinical epidemiology, computer and internet use for research. All of these disciplines reinforce the methodology of EBM. ZdravPlus II has been helpful to the TSMU in their effort to produce graduates with higher level qualifications. They organized a group of physicians from a prominent US medical school to review the structure of medical education at TSMU. A steering committee has been formed to consider the recommendations.

ZdravPlus II has also supported the Family Medicine Chair of the Postgraduate Medical Institute by providing trainers and materials for programs on evidence-based topics, such as DOTS and drug resistant TB. These programs are incorporated into the 7 and 11 month training, which covers 41 modules for trainers and 23 modules for family medicine.

The first family medicine trainers in Tajikistan were trained in Bishkek and Israel. Then ZdravPlus II provided international trainers to work in Tajikistan. They have also supported an 11 month training of trainers initiative that is both theoretical and practical. Training is conducted in a health center where international doctors mentor the physician trainers. The "students" see their own patients and are trained in evidence-based medicine through patient case studies every morning. These physician trainers are then sent back to their home facilities to conduct retraining programs for doctors interested in becoming family medicine physicians. The 7 month continuing medical education courses are held for physicians and nurses who want to retrain as family doctors. ZdravPlus II gives doctor bags and stipends to trainees and trainers. Graduates of these programs become not only better doctors, but also grassroots advocates for the new medicine. Over the past 4 years, 21 physician trainers have been trained and 11 more are currently in training (some in Bishkek).

Two model Centers of Excellence (COE) have been established by Zdrav as sites for demonstrating how vertical programs are integrated into a family medicine practice.

Arterial hypertension (AH), reproductive health and DOTS, an evidence-based treatment protocol for TB, are the first examples. Quality improvement teams have been organized at the COEs. They are learning how QI programs are implemented and how to make use of the data that is generated about patient care. With ZdravPlus II's help, the hypertension CPG for PHC providers was approved by prikaz in December 2007 and is already being implemented in the two centers. The COE initiative has attracted other donors who intend to introduce similar programs.

The team visited two of the 7 maternities serving as pilots for the implementation of Promoting Effective Perinatal Care (PEPC) program. These programs call for the use of WHOI-EURO standards of EBM to achieve reductions in maternal and neonatal morbidity and mortality. Baseline data is collected for these facilities to determine the impact of the program. Results thus far show a decreasing rate of postpartum hemorrhages, as well as home deliveries. In discussions with the medical staff and patients we found that the new methods for treating maternity patients have been well received. There have been impressive changes in the hospitals that have improved outcomes and satisfaction of both the patients and the medical staff. Constrained resources exacerbated by the power shortage revealed the extent to which the staff goes to extraordinary efforts to protect the mothers and babies from complications. There was some question as to how much attention the staff gave to the monitoring reports, and more attention will have to be devoted to using the QI reports effectively.

The Drug Information Center (DIC) was established to provide independent, objective, evidence-based information to promote rational drug use. ZdravPlus II provided assistance to the DIC and informed development of the essential medicine list (EML). Subsequently the DIC developed the first Tajik National Medicine Formulary (detailed information on the EML). A lot of information about these resources has been disseminated to medical professionals. The legal status of the DIC has not been formalized.

In the 28 countries of the USAID E&E region, Tajikistan ranks as having the worst rate of TB incidence, but efforts to improve and strengthen the capacity of PHC physicians to diagnose and treat TB have moved very slowly. ZdravPlus II researched the level of DOTS institutionalization into the retraining programs for PHC doctors at the post-graduate level. They followed up with a training seminar for TB faculty at TSMU in order to improve the DOTS component for family medicine retraining and residents at the graduate level. At the COE in Dushanbe, they have sponsored CME seminars to improve implementation of DOTS at the PHC level. While these appear to be ad hoc efforts, they have identified the few good opportunities to reach medical professionals and offer organized programs, which are the necessary first steps for raising awareness.

Population and Community Health: ZdravPlus II has worked with the MoH press center to develop strategies for publicizing the new reforms of family medicine and the BBP with co-pays. They have also helped the COEs to develop marketing skills for their facilities and their concept – preventive and family centered care. In addition, ZdravPlusII has developed material for the public on breastfeeding, IMCI and TB.

To assure that patients can perceive a difference in the new medicine of family practice and the old style medicine, providers have been given training on listening and interpersonal communication skills.

The Family Medical Association has applied to register as an NGO. They now have 600 members and represent family doctors and nurses, providing them with advocacy, CME and membership activities. One of their priorities is to have a new law on family medicine and CME approved.

Patient clubs have been established for hypertension, diabetes and lung conditions at the Family Medical Center #1, which the team visited. The Mahallas are helping to raise awareness in their communities about family medicine, the need to take responsibility for their health and to encourage people to get to know their physicians. They are credited with helping to reduce the rate of home deliveries over recent years from 4.8% of births to 2.2%. Mahalla leaders are also providing feedback to the Family Medical Center on the satisfaction of their population with the Center's services.

Conclusion

ZdravPlus II, as elsewhere in CAR, is playing a critical health reform role in Tajikistan, providing much of the technical analysis underpinning the reforms undertaken to date. In all four component areas of the project, Tajikistan is moving very slowly. It remains uncertain the extent to which the new Minister of Health will support the reforms. However, the reform movement and loan support from the World Bank are sufficiently established that his actions may delay progress, but will not reverse it.

ZdravPlus II should continue its top-down, bottom-up implementation strategy. Only a small part of the complete policy framework for restructuring the health care system is in place. ZdravPlus II's assistance is essential for Tajikistan to develop the policies and laws needed to create a foundation for health sector restructuring. Beyond that, the practical demands of restructuring call for experts in implementation, a role ZdravPlus II is uniquely positioned to fill. Active ZdravPlus II involvement in Tajik health reform is advised until there is a solid cadre of local professionals who have learned their skills from ZdravPlus II and other reform experiences in Central Asia.

USAID, its donor partners, and ZdravPlus II should continue to explore establishing a sector wide approach (SWAp) in Tajikistan patterned on the one in Kyrgyzstan. The SWAp may provide an opportunity to gain more buy-in from the Minister of Health, while at the same time introducing more transparency and accountability into the management of health sector funds.

Annex C1: Tajikistan: Expectations of Movement Along the Development Continuum over the Next Two Years

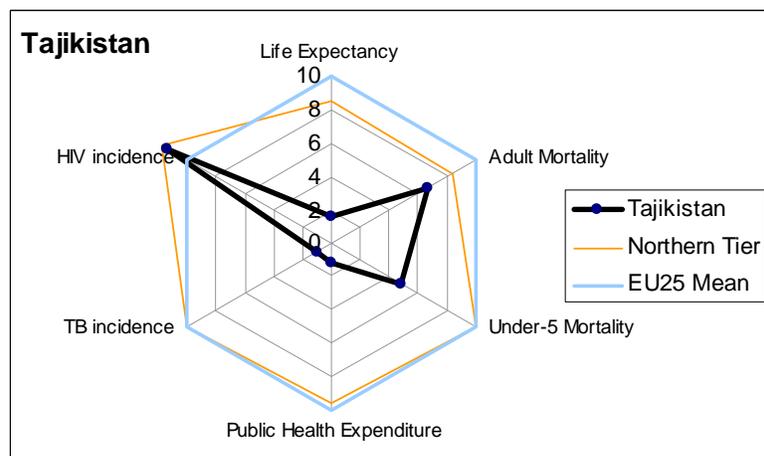
With a gross national income per capita of \$223 (\$2,000 based on purchasing power parity), Tajikistan is a Low-Income country within the Developing Country category. Its GDP growth rate of 10.6% is on par with neighboring oil-rich Kazakhstan's of 10.6%. Tajikistan has a population of 7.08 million, compared to 15.3 million for Kazakhstan and 5.3 million for Kyrgyzstan.

Several years of civil war impeded Tajikistan's health sector development. It is at least ten years behind the progress made in Kyrgyzstan, Kazakhstan, and Uzbekistan. Given its slow, though incremental, health reform progress, the changes expected in the health sector over the next two to seven years will not have an impact on the country's movement along the continuum from the "Developing" to "Transforming" category.

Tajikistan ranks 27 of 28 countries in the 2007 Europe and Eurasia Health Vulnerability Analysis. The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. See the report at:

http://www.usaid.gov/locations/europe_eurasia/dem_gov/docs/2007_ee_health_vulnerability_analysis_report_final.pdf

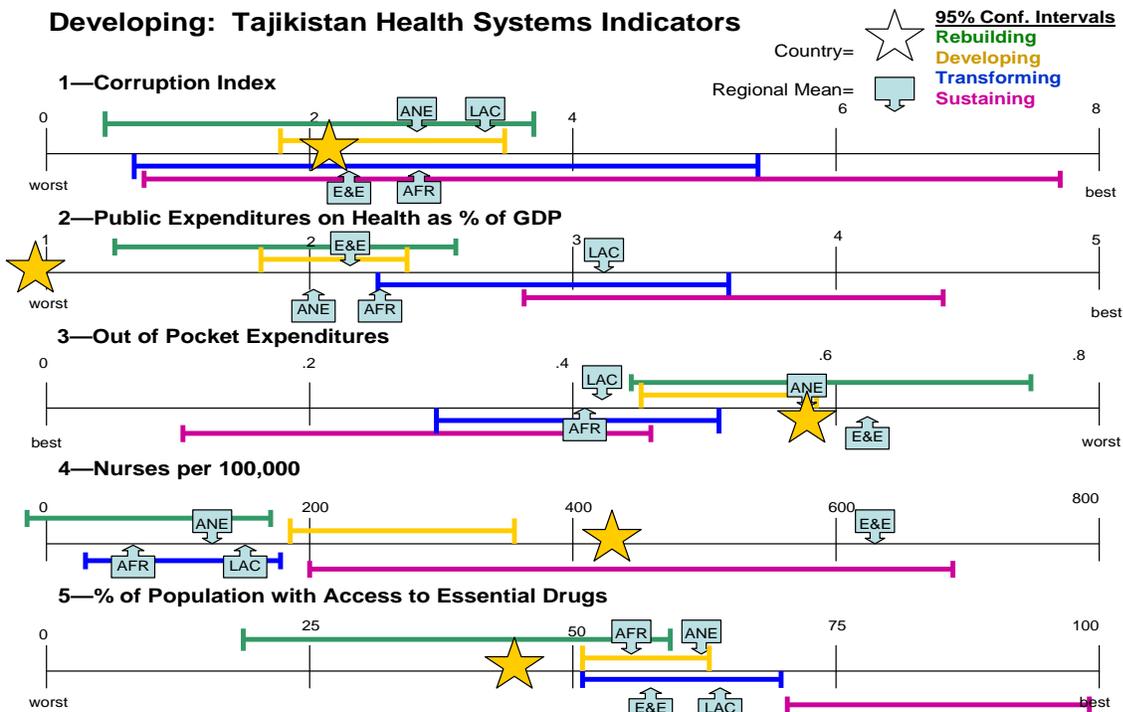
The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. The graph below draws on this data to compare Tajikistan's health status to European Union and E&E regional averages. For each indicator, a score of 10 corresponds with the **EU average**, suggesting ideal performance. A score of 1 indicates the poorest performance in that indicator in the **E&E** region. The country's performance is then plotted against this scale. A score of 10 is ideal performance for all indicators and all countries.



Northern Tier refers to the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.

Tajikistan is far from approaching the levels of health sector development achieved by countries in the northern tier. The graph reflects Tajikistan ranking as the second worst in the region in life expectancy and public health expenditures. It ranks last in TB incidence; is among the 25 priority multi drug resistant TB countries in the world; and has the potential for explosive growth in HIV/AIDS incidence. Tajikistan's resource-poor government is unable to contribute as much funding to health as its neighboring countries. Public expenditures as a percent of GDP were only 1% in 2004. Individuals must pay high out-of-pocket expenditures (76% of health care costs), often under-the-table, to compensate for the government's lack of resources.

The graphic below shows Tajikistan's performance on several key health systems development indicators relative to: (1) averages for Europe and Eurasia and other geographic regions, and (2) averages for country categories of the USG Foreign Assistance Framework. Indicators reflecting the extent of corruption and out of pocket expenditures put Tajikistan into the Developing Country category. The latter measure reflects the low level of public expenditures, which in Tajikistan, is more characteristic of the Rebuilding Country category. Nurses per 100,000 are high, putting Tajikistan in the Sustaining Country category. However, this is misleading as nurses receive low salaries and most require training to upgrade their skills. Access to essential drugs reflects the levels of Rebuilding Countries, reflecting the low level of public health expenditures and the limited ability of the population to pay for drugs.



Source: U.S. Agency for International Development, Bureau for Global Health; most data is 2006.

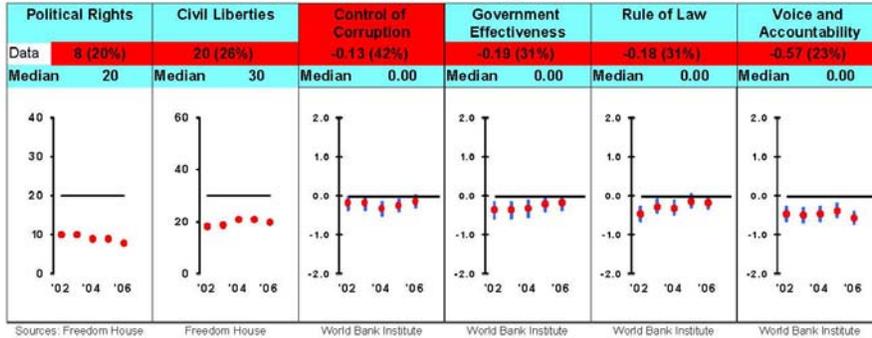
The FY 2008 Millennium Challenge Corporation (MCC) scorecard above shows that Tajikistan exceeds the median for its MCC peer group on its immunization rate (86.5% coverage compared with a median of 84%) but is far below the median for public spending on health (1.14% of GNI compared with a median of 2.07%).

Over the next two years, the project may be constrained by the political leadership and may not be able to maintain the pace of progress in restructuring the health care system. Instead, it may focus on issues where it has a strong local counterpart and champion of change. Examples are the Rector of the Medical Academy who is committed to introducing EBM into the curricula of medical schools and the head of the Drug Information Center who is using recently completed products to advocate for rational drug use. Other areas where there can be real headway in the next 2 years is in the expansion of the Safe Motherhood Program and integration of the educational program into services offered by primary care facilities. These focus areas are important to health sector reform, but will not represent the kind of comprehensive change needed to upgrade the category of this sector to the “Transforming Country” category.

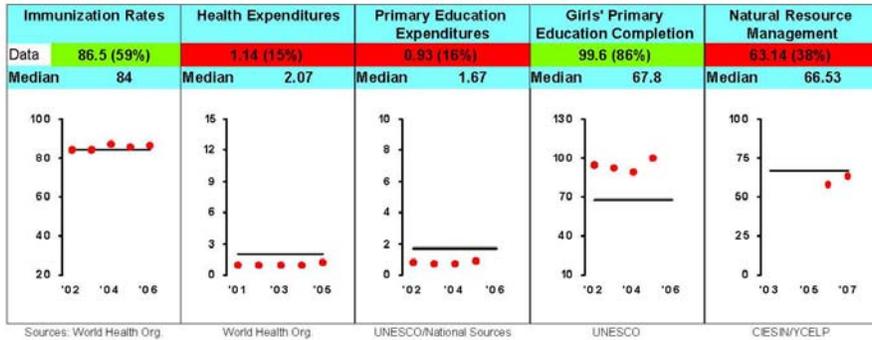
Tajikistan FY08

Population: 6,506,980
 GNI/Cap: \$390 LIC

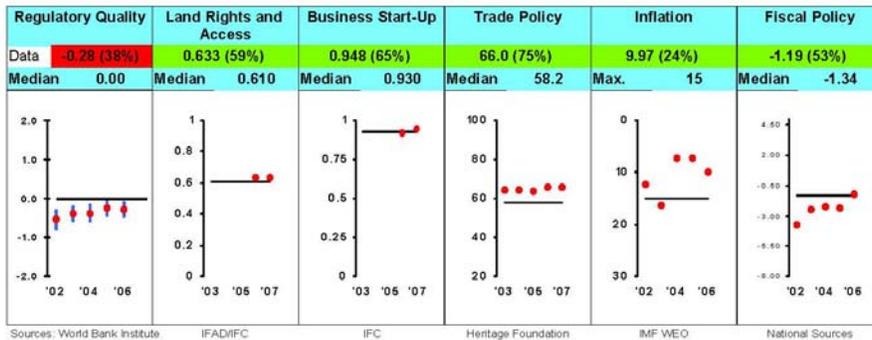
Ruling Justly



Investing In People



Economic Freedom



How to Read this Scorecard: Each MCC Candidate Country receives an annual scorecard assessing its performance in 3 policy categories: Ruling Justly, Investing in People, and Economic Freedom. Under the name of each indicator is the country's score and percentile ranking in its income peer group (0% is worst; 50% is the median; 100% is best). Under each country's percentile ranking is the peer group median. Country performance is evaluated relative to the peer group median and passing scores, or scores above the median, are represented with green. Failing scores, or scores at or below the median, are represented with red. The black line that runs along the horizontal axis represents the peer group median. Each World Bank Institute indicator is accompanied by a margin of error, which is represented by the vertical blue bar.

For more information regarding the Millennium Challenge Account Selection Process and these indicators, please consult MCC's website: www.mcc.gov

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Annex D: Turkmenistan Country Findings

Background: Turkmenistan has accepted only limited external assistance in health. The government has largely retained the Soviet era model of governance since independence. Until recently, Turkmenistan has shown little interest in a broad restructuring of the health care system. But in recent years, the President has strongly backed improvements in primary care. ZdravPlus II has been responsive and is working with the Ministry of Health and Medical Industry to implement service delivery and health information changes. The recognized success of this assistance may facilitate more extensive reforms. Senior officials in the new government express strong support for continuing current ZdravPlus II assistance and invited the project to propose new ideas. These are encouraging signs, and we encourage ZdravPlus II to explore the potential for further reforms over the next two years.

Performance Monitoring Plan Analysis: Zdrav's quantitative targets for 2007 for IMCI training, laboratory training, hospital HIS, Safe Motherhood, policy dialogue, and outreach were virtually met or exceeded. The major accomplishments of the project, however, are not well captured by these or other quantitative indicators. These accomplishments include: 1) Maintaining a good working relationship with the government during a difficult period for development organizations; 2) introducing evidence-based improvements in health care in clinical facilities and training institutions; and 3) introducing an effective computerized information system that is currently being scaled up. With recognized success in these areas, ZdravPlus II is well-positioned to support additional reforms.

Stewardship: Activities in this component have been limited due to GOT restrictions. ZdravPlus II has pursued legal and policy issues related to IMCI and maternal health through partnerships with WHO and UNICEF. A noteworthy achievement was the issuance of a policy directive (prikaz) that incorporated IMCI into medical school curricula.

Resource Use: Health care financing is an issue for Turkmenistan with funding for health at only an estimated 2.5% of GDP, including a large capital investment program. An unusual insurance arrangement and low family incomes (despite large natural gas revenues) impede effective public sector services. ZdravPlus II has provided initial awareness training from the regional office, but the GOT has not yet requested assistance in this area. The project's support for computerizing part hospital reporting of patient discharge information is widely recognized as a major improvement and is being scaled up. The new reporting system currently serves largely to update established procedures, but has the potential to support reforms in financing and management. The system is discussed below.

Service Delivery: ZdravPlus II has established an exceptionally effective working relationship with the health ministry, and is the only USAID partner with a formally approved work plan. As an indication of improved relations with the new government, in

2007, an unprecedented 9 policy directives (Prikaz) were issued to authorize ZdravPlus II work.

The Deputy Minister of Health expressed his gratitude for the full range of ZdravPlus II assistance, and urged the US to continue and expand project assistance. While he expressed a willingness to consider a broad range of health reform activities, he specifically mentioned health finance and evidence based medicine, as major future needs, and agreed that Turkmenistan should conduct a survey of multi-drug-resistant tuberculosis.

USAID attributes Zdrav's unusually good working relationships with the ministry to careful consultation with GOT counterparts and the resulting sense of GOT ownership. Ministry officials and representatives of international agencies offered similar assessments. ZdravPlus II activities are also extensively linked with those of other international agencies, such as WHO.

ZdravPlus II has used a very small budget effectively to support the ministry's interest in maternal-child health, introducing innovations in a highly conservative system. The ministry has requested expanded assistance, chiefly training, and USAID is considering additional funding. Providers have responded enthusiastically to technical training, which has been severely limited in recent years.

Officials at an operational level, and representatives of international agencies consistently credit ZdravPlus II for its flexibility and responsiveness in facilitating their programs. To a large degree, they view the project's comparative advantage in terms of its depth of knowledge of program implementation in the Turkmen health system, which is unique among international partners. Counterparts offered a number of examples of how Zdrav effectively used modest funds to facilitate policy changes or donor programs. For example,

- Safe Motherhood: ZdravPlus II facilitated a presentation of Safe Motherhood results that was soon followed by a national program. To help launch the national initiative the project funded WHO expert trainers and translated technical materials into Turkmen. ZdravPlus II then developed the monitoring forms that documented the impact of the program.
- Evidence Based Medicine: Although donors shared an interest in evidence based medicine, only ZdravPlus II had the flexibility to host the first workshop on this topic, which is now of widespread interest among senior officials. Evidence-based medicine remains a new concept for the ministry, but ZdravPlus II efforts have provoked expressions of interest and requests for more information. When learning of skepticism by the Sanitary Epidemiological Service (SES), which could have blocked new EBM practices, the project quickly responded by arranging for a workshop with global experts.

Officials from international organizations also consistently observed that ZdravPlus II's institutional capacity will become dramatically more valuable if, as many expect, the

ministry continues to expand its health reform initiatives in areas such as health financing, HIV/AIDS, and clinical guidelines.

ZdravPlus II training evaluations document substantial knowledge gains from this training, suggesting that it is of good quality. Limited efforts to monitor the impact of child health (IMCI) training on provider performance found an impressive 80% level of compliance with the IMCI clinical guideline, exceeding expected levels. ZdravPlus II surveys at the initial pilot Etrap (district) show a noteworthy decline in under-5 child mortality from 42/1000 in 2002 to 28/1000 in 2006.

ZdravPlus II supported the MCH Institute in developing a monitoring system with 27 quantitative indicators of the quality of care for pregnancy, labor & delivery, newborn care, and postpartum family planning, based on chart reviews and patient surveys.

By 2008, ZdravPlus II had trained 47 IMCI trainers and 15 medical school teachers as part of an effort to scale up and institutionalize this child health approach. In turn, 1000 family physicians and 520 have completed IMCI training. More recently, steps to introduce IMCI in hospitals have begun on a small scale.

Zdrav supports training for the most peripheral laboratories as part of a nascent strategy to support family medicine. Trainees include both family physicians, who often conduct their own lab tests, and physicians who specialize in this area. This strategy complements CDC's training program in referral laboratories. The impact of ZdravPlus II training is not well documented.

ZdravPlus II assistance in Tuberculosis directly observed therapy (DOTS) is minimal.

Starting in 2004, Zdrav conducted a series of policy level workshops on health information systems and health financing topics. In 2007, ZdravPlus II responded to a ministry request to pilot test a computerized patient discharge summary in 7 hospitals. The software is a modified version of one developed by Zdrav for other CAR applications. While the HIS has potential for application to a case-based hospital reimbursement system, its current application is chiefly on reporting. Officials were stunned to find that a core hospital report that required a week under the old paper-based system could be completed—with greater accuracy—in about 2 minutes. The ministry is currently scaling up the system, with one-third of all hospital statisticians currently trained at the State Medical Institute Health Management Training Center.

Based on this experience, the Rector of the Institute, which provides most of the continuing medical education in the country, expressed interest in expanding cooperation with ZdravPlus II. In particular, the Rector proposed institutionalizing EBM training in the Institute's program, which has national coverage. Incorporation of IMCI into the Institute's program is in its initial phase, with Zdrav support.

Community and Population: Community/population interventions have focused on a Keeping Children Healthy campaigns in 11 Etraps, starting in 2002. This initiative was

based on ministry Family Nurses, who reached over 50,000 mothers of young children with educational messages and materials. Before/after tests of relevant knowledge showed an overall increase from 54% to 88% in these areas.

Conclusions: The ZdravPlus II staff in Turkmenistan has skillfully supported health system improvements in a restrictive policy environment. Multiple signs point toward increasing openness by the government with regard to further reform of the Soviet era model, but this may be ultimately a Presidential level decision. Nevertheless, managers and providers that we interviewed were consistently enthusiastic about the project's assistance and clearly would like more. The basic resources potentially available for health are impressive, including an expanding infrastructure and the country's substantial financial reserves. At the same time, limited health information suggests a large unmet need for health services. If the policy environment for reform improves, ZdravPlus II is well-positioned to play a critical supporting role. The impressive potential health benefits of such an initiative justify continued assistance.

In the short term, ZdravPlus II can facilitate supportive policy changes while working within its current mandate. Direct evidence of improvement, chiefly in service delivery, is relatively modest, but it has made a strong impression in the officials we interviewed at all levels. The project should invest more in measuring the impact of reforms and in disseminating this information. This approach applies to ZdravPlus II support for laboratories and health information. In new areas, such as financing and management, the project should explore the Ministry's openness to baseline assessments of current systems. New areas where officials have already expressed interest, such as expanding evidence-based medicine, are also worthy of support. ZdravPlus II should also review its comparative advantage in addressing tuberculosis (including drug resistant varieties) and HIV/AIDS.

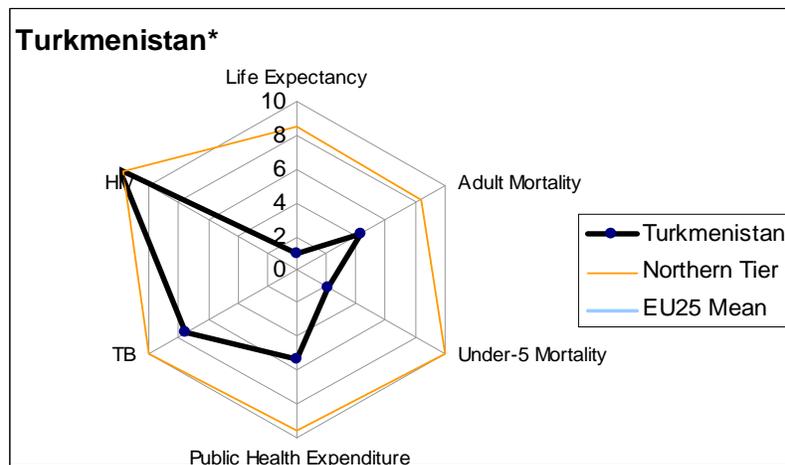
Annex D1: Turkmenistan: Expectations of Movement Along the Development Continuum over the Next Two Years

For the health system, the categories of developing transforming and sustaining represent major benchmarks in overall performance. Over its three projects, Zdrav has been directly addressing the profound changes needed to move the health sector from one category to another. This experience shows that health reform does not evolve in a linear pattern, but rather that its pace varies widely. In our interviews with policy level officials, donor representatives, and technical experts, the team found agreement that Turkmenistan is currently in a transition period where predictions are more difficult than ever. Nevertheless, the consensus judgment is that the GOT is entering a period of accelerating, progressive change in the health system. Even with this optimistic view, the changes expected in the health sector over the next two years will not have an impact on the country's movement along the continuum from developing to the transforming category.

Turkmenistan ranks 28 of 28 countries (higher number rankings are worse cases), making it the most vulnerable among the countries included in the 2007 Europe and Eurasia Health Vulnerability Analysis. See the report at:

http://www.usaid.gov/locations/europe_eurasia/dem_gov/docs/2007_ee_health_vulnerability_analysis_report_final.pdf

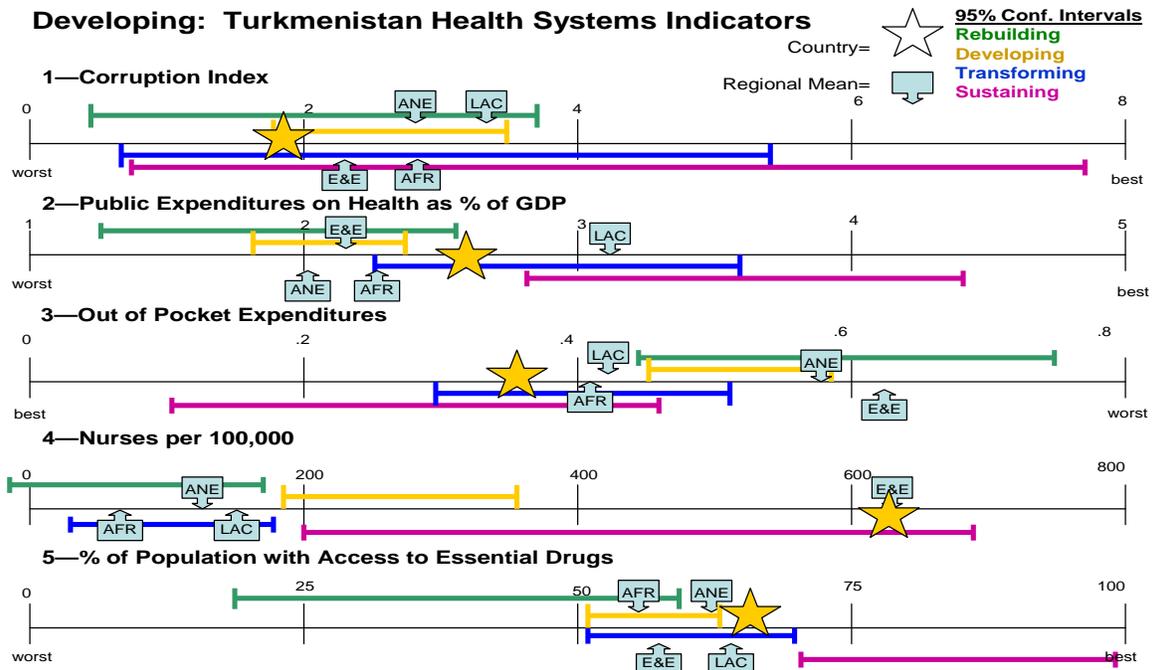
The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. The graph below draws on this data to compare Turkmenistan's health status to European Union and E&E regional averages. For each indicator, a score of 10 corresponds with the **EU average**, suggesting ideal performance. A score of 1 indicates the poorest performance in that indicator in the **E&E** region. The country's performance is then plotted against this scale. A score of 10 is ideal performance for all indicators and all countries.



Northern Tier refers to the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.

Turkmenistan is far from approaching the levels of health sector development achieved by countries in northern Europe and the EU25. Life expectancy is the lowest in the region and adult and child mortality is high. The tuberculosis (TB) epidemic remains serious and health workers continue to have limited access to training. It appears that Turkmenistan scores better than the EU average on HIV incidence. Since the number of confirmed HIV cases is highly dependant on the surveillance program in the country, HIV scores may be deceptively optimistic.

The graphic below shows Turkmenistan's performance on several key health systems development indicators relative to: (1) averages for Europe and Eurasia and other geographic regions, and (2) averages for country categories of the USG Foreign Assistance Framework. Indicators reflecting the extent of corruption put Turkmenistan on the low end of the Developing Country category and at a level characteristic of a Rebuilding Country. Public expenditures on health are representative of a Transforming country as are out of pocket expenditures and access to essential drugs. The relatively positive performance reflected in these indicators contrasts with those in the vulnerability index graph above, suggesting the need to improve the efficiency with which public health revenues are spent. Nurses per 100,000 are high, putting Turkmenistan in the Sustaining Country category. However, this is misleading as nurses receive low salaries and most require training to upgrade their skills.



Source: U.S. Agency for International Development, Bureau for Global Health; most data is 2006.

The FY 2008 Millennium Challenge Corporation (MCC) scorecard on the next page shows that Turkmenistan exceeds the median for its MCC peer group on both its immunization rate (98.5% coverage compared with a median of 84%) and public spending on health (3.56% of GNI compared with a median of 2.07%).

Turkmenistan enjoys large resource flows from natural gas exports, but the health sector receives only about 2.5% of GDP, with a large part of its share committed to infrastructure development. Until the 2007 change in government, ZdravPlus II and similar development organizations worked under the constraints of GOT policies that largely limited its activities to the service delivery component. Within these restrictions, however, ZdravPlus II developed an exceptionally strong working relationship with the health ministry. Senior officials and other donors alike acknowledged ZdravPlus II's credibility with the government and its reputation for responsiveness in a period when many development programs were ended.

With a new government now in place, senior officials expressed their willingness to consider new health reform activities that ZdravPlus II or USAID may propose. Based on previous ZdravPlus II work, technical leaders in the ministry have limited experience with evidence-based medicine, and are interested in expanding EBM practices. This is a potentially fundamental change in health care in Turkmenistan, and ZdravPlus II has already developed the technical base for its expansion.

The ministry has shown interest in making basic changes in health care financing and ZdravPlus II has responded with an initial policy-level workshop. Technical observers from other donors observed, however, that a critical mass of financing expertise in the ministry is yet to be developed. This can be expected to slow the implementation of new financing approaches.

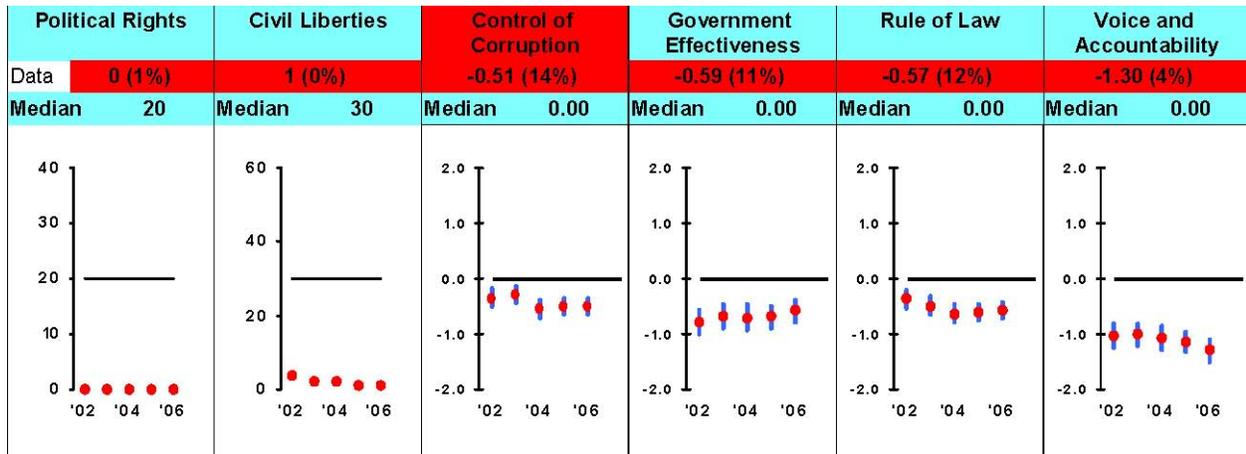
The contract SOW can accommodate the GOT requests that seem likely to emerge over the next two years. Funds with disease-specific earmarks would severely constrain potential work in health financing, but could support useful work in EBM and quality improvement.

In summary, there are multiple encouraging signs that Turkmenistan is entering a period of accelerated reform, and that ZdravPlus II is well-positioned to facilitate these changes. Some adjustments in contract priorities may further enhance ZdravPlus II's role in Turkmenistan over the next two years. In view of the scope of reforms that will be required to change categories, we expect Turkmenistan to remain a developing country partner for the next two years.

Turkmenistan FY08

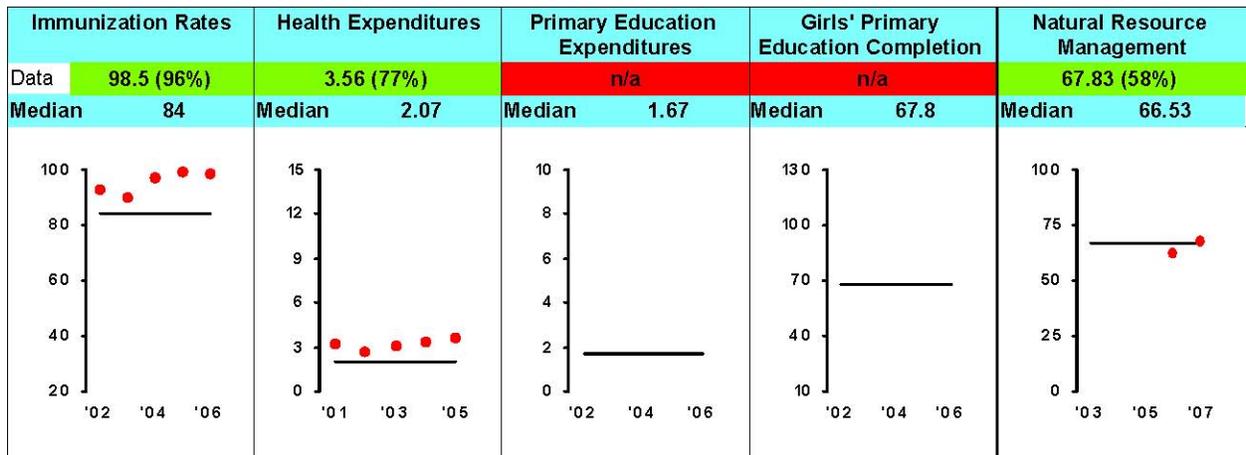
Population: 4,833,266
GNI/Cap: LIC

Ruling Justly



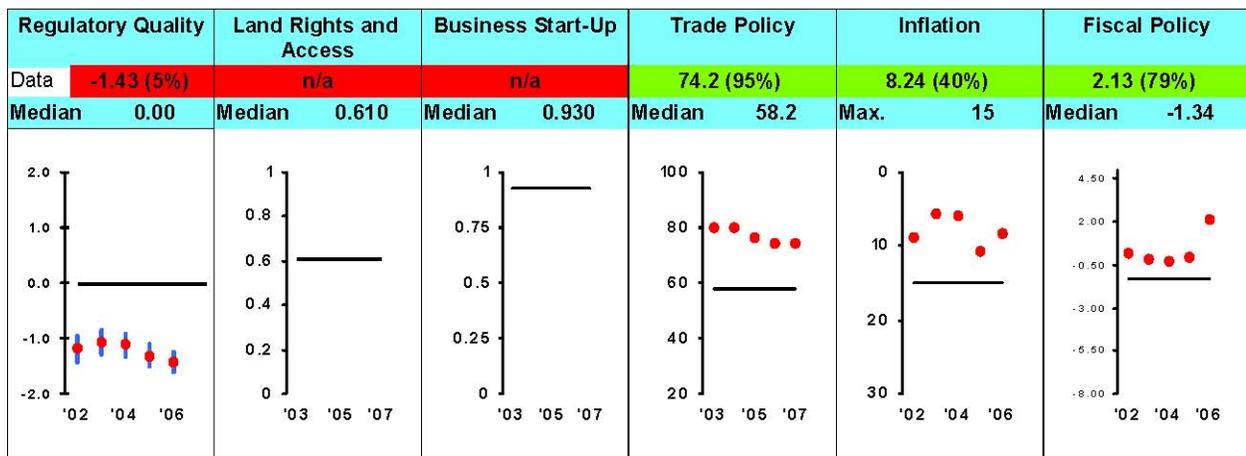
Sources: Freedom House Freedom House World Bank Institute World Bank Institute World Bank Institute World Bank Institute

Investing In People



Sources: World Health Org. World Health Org. UNESCO/National Sources UNESCO CIESIN/YCELP

Economic Freedom



Sources: World Bank Institute IFAD/IFC IFC Heritage Foundation IMF WEO National Sources

How to Read this Scorecard: Each MCC Candidate Country receives an annual scorecard assessing its performance in 3 policy categories: Ruling Justly, Investing in People, and Economic Freedom. Under the name of each indicator is the country's score and percentile ranking in its income peer group (0% is worst; 50% is the median; 100% is best). Under each country's percentile ranking is the peer group median. Country performance is evaluated relative to the peer group median and passing scores, or scores above the median, are represented with green. Failing scores, or scores at or below the median, are represented with red. The black line that runs along the horizontal axis represents the peer group median. Each World Bank Institute indicator is accompanied by a margin of error, which is represented by the vertical blue bar.

For more information regarding the Millennium Challenge Account Selection Process and these indicators, please consult MCC's website: www.mcc.gov

Annex E: Uzbekistan Country Findings

Background: Uzbekistan faces the same challenges regarding governance as the other countries in Central Asia. It also inherited the Soviet legacy of a health system that was over-regulated and punitive. Reforms not only required the creation of new policies and laws support the process, but also dramatic shifts in roles and responsibilities of government institutions. In addition, a monitoring and evaluation system that could provide data and evidence to guide policy decisions was also needed.

Performance Monitoring Plan Analysis: The Strategic Objective for Uzbekistan is to increase the percentage of outpatient visits for primary care, thereby decreasing the dependence on specialty care. There are 21 indicators of performance for the SO and four IRs. Of these, 17 were met or exceeded, 3 are in suspension, and one was not met. A discussion of the usefulness of these indicators is discussed below.

The SO indicator addresses the percentage of the population covered by the rural PHC reforms. While the percentage has been increasing, annual growth in the percentage of the population covered in the original pilot sites between 06 and 07 was very small at 2.5 percentage points or less. This slow growth in coverage contrasts with the oblasts added in the 2006 where over the first year coverage increased 30 percentage points in Khorezm and 21.5 percentage points in Karakalpakstan. The data also shows that the baseline for PHC coverage is quite high for the 4 oblasts where Zdrav will begin working on PHC reform roll out in 08 (55-68%). In these same 4 oblasts the baseline percentage of PHC outpatient visits is quite low (34.5% in one and less than 28% in the other three). The PMP tables do not provide information about the ideal target ratio of primary to specialty care. Without this context it is difficult to judge the significance of the targets for the growth in primary care visits thus far.

There are two indicators for the Intermediate Result pertaining to Stewardship, and both were met. The first is “Regulations permitting national roll-out of oblast funds pooling and per capital payment system for the rural PHC facilities, and urban PHC and case-based hospital payment system pilots critical to Uzbekistan to enable changes in financing and management of health facilities in the next phase of the reforms.” With such a broad scope, there was a modest target of one for 2007, with 2 being achieved. The second indicator was “number of products created to enhance policy dialogue or policy marketing/participation submitted to government or used for advocacy or public outreach.” The target of 10 was overshoot, with 31 such products being created. As with the indicators for the SO, it is not clear from the Stewardship indicators what the end point would be. It might be more useful to have a list of reform provisions that are vulnerable without further governmental action. The targets could track the number and/or quality of these that are in place. It is not clear whether a Cabinet of Ministers Resolution on oblast pooling and per capita financing has the force of law that will assure enduring change. This change in selection of targets would help USAID to be more focused about the pending legal and policy priorities needed to protect USAID supported

reforms. The list of products is too broad to be useful. It shows a high level of activity, but is not helpful in gauging progress.

The six indicators for Resource Use are appropriate reference points for progress in establishing new systems for financing health care and managing health care utilization. However, three of the indicators, IR 3.2.3 C, E, and F, do not include contextual information regarding the total universe. Therefore, it is not possible to determine what the ideal outcome or end point would be. This contextual information should be added to the notes.

For the Service Delivery IR, the 8 indicators address all the priorities in this area with the exception of EBM, which should be explicitly referenced. One possibility might be the number of medical school disciplines (out of a total of x number of disciplines) that use EBM and CPGs in their curriculum. Three of the indicators for this IR are in suspension awaiting decisions of either the ADB or GoU. Of the other five, one of the two targets for IR 3.2.2 H was not met. IR indicator 3.2.2 H addresses the PHC practices with quality improvement systems. The two targets measure 1) the percentage of PHC practices with QI systems in the whole country and 2) the percentage for the Ferghana pilot only. While the Ferghana pilot target was exceeded (52.7% actual compared to a target of 40%), the percentage for the whole country has lagged for three years (e.g., 12.4% actual compared to a target of 15% for 2007). The presentation of the back-up data for the indicator is quite good as it includes data on the total number of PHC practices, thus providing context for an end point of performance for this indicator. Indicator IR 3.2.2.2 A, “Adherence to select evidence-based CPGs or standards of care improved in FGPs by at least 50%,” is ambiguous as to the intended denominator for the 50%.

The IR for Population and Community Health has 3 indicators that were well chosen, but the targets do not represent stretch goals. The indicator for IR 3.2.1 “Percentage of PHC practices enrolled or assigned population with knowledge about relevant health topics” has the same target of 60% through 2009 with a 2006 baseline of 61%. The targets for IR indicator 3.2.1B part A “number of entities which serve as mechanisms or channels to empower health action by an individual or community” was exceeded by over 100% in 2007. IR indicator 3.2.1 B Part B “Number of interventions which increase the capacity of the entities to serve as mechanisms or channels to empower health action by an individual or community” was exceeded by 80%.

Stewardship: In contrast to its regional counterparts, the Government of Uzbekistan (GoU) was slower to open its doors to health reform. Health reform was launched in 1998 through a Presidential decree on state reform of the health care system in Uzbekistan. Addressing social reforms broadly, this decree included the framework for subsequent health reform legislation. Uzbekistan reform efforts are assisted with loan projects from the World Bank (WB) and the Asian Development Bank (ADB), which provide \$40 million each in loan funding. The WB loan is intended to facilitate the health reform process and the ADB loan focuses on strengthening maternal and child health services. The work of the two banks is harmonized through a Joint Program Implementation Board (JPIB). Tensions between the U.S. and Uzbek governments and

minimal civil society engagement present continued challenges for success in the reform process, however.

ZdravPlus II focused its Stewardship efforts in Uzbekistan on 1) legal and policy change, 2) institutional structure, roles and relationships, 3) policy marketing and public relations, 4) monitoring and evaluation, and 5) donor/project collaboration and coordination. ZdravPlusII's role as a key partner of the JPIB has been to assist the GoU by drafting seminal policy and legal documents and conducting studies on operational issues to improve and support the legal and policy decisions related to reforms. Key achievements have been COM resolution #217 (2005) which accepted oblast pooling and recognized the Oblast Health Department (OHD) as the health purchaser, MOH order #484 (2005) which put forward guidelines for roll-out of rural capitated financing reforms, MOH order #12 (2006) which outlined urban PHC reform model concepts, MOH order #432 (2007), which provided guidelines for budget calculation of reformed PHC facilities. In addition, legal documents for case-based hospital payment system pilots are pending, and policy concept papers have been developed for urban PHC, hospital payment systems, QI, EBM, and CME. These achievements represent important steps in improving efficiency and effectiveness of health care services and are remarkable achievements given the operating environment.

The coordinated efforts of the JPIB and ZdravPlus II have been critical to making progress with governance reforms in Uzbekistan, but the government structure regarding policy decision-making creates challenges and makes the process more labor intensive. There is no health policy unit within the MOH. Instead, a department for each topical area (i.e. MCH) handles policy issues that relate to their topic. Cross-cutting policy changes, such as rural PHC, require the creation of a working group that involves all relevant departments.

The Stewardship function is critical to the progress of ZdravPlus II's work in the other components as little is accomplished in Uzbekistan without prior legal and political authorization, making Resource Use, Service Delivery and Population/Community Health inextricably linked to Stewardship. Continued efforts in Stewardship will certainly be needed to refine the legal and policy structure in order to ensure continued reforms in the other component areas. The Resource Use and Service Delivery components have seen some successes to-date under the legal frameworks created by ZdravPlus II's assistance with governance improvements. The national roll-out of the rural PHC financing and management reforms is largely complete, and this has been ZdravPlus II's primary accomplishment in Uzbekistan especially as it now serves as the model for the pending urban PHC roll-out. Indicators and monitoring systems have been set up to capture both rural and urban finance and management reforms, and quality improvement components are being incorporated into these reforms. However, the development of civil society has suffered under the tenuous situation in Uzbekistan. There is very limited NGO activity, with the GoU revoking the registration of many international and local NGOs. In addition, community organizations are almost always quasi-governmental. This has significantly limited ZdravPlus II's plans for civil society

activities and the Population/Community Health efforts had to be significantly restructured.

Resource Use: ZdravPlus II activities in the component of Resource Use focus on 1) improving the efficiency of PHC, 2) increasing the equity of health financing, and 3) increasing provider responsiveness to the community. These objectives are addressed chiefly through scaling up a rural PHC financing and management model, establishing a similar program for urban PHC on a pilot scale, and developing a case-based payment system for hospitals.

In earlier contracts, ZdravPlus II supported the development of a per capita financing system for rural PHC centers (SVPs), with pooled contributions at the oblast level to increase equity across rayons (districts). Also for the first time, this model provided the SVPs with some limited flexibility in spending excess funds (i.e, those not consumed by service delivery). The scope of changes in financing and management required establishment of the SVP as an independent legal entity. Once this complex development process was completed, expansion of the model greatly accelerated under the current contract, reaching 2867 SVPs in 2007, with complete national coverage expected in 2008. This is a remarkable achievement in the reform of a system that has long been characterized by perverse incentives to waste resources.

This large-scale expansion reflects ZdravPlus II's long-standing and highly effective cooperation with GoU and major donors in Uzbekistan. The \$30 million World Bank Health I Project supported expansion of the rural PHC health financing model until 2004. Under the subsequent Health II Project, accelerated scale up of the financing model took place in spite of reductions in ZdravPlus II funding levels. Officials from the World Bank described cooperation with ZdravPlus II as critical to the Health II loan health financing component, particularly the project's role in convincing the Ministry of Finance to support reform of rural PHC financing by providing a documented, functioning model for replication under the World Bank loan. USAID's modest, but sustained, investment in ZdravPlus II has had a development impact in orders of magnitude greater than the project's budget.

Further, bank officials credit ZdravPlus II technical assistance with more than achieving an effective health financing reform model for replication. They describe ZdravPlus II's role in the successful implementation of their loan projects as vital. While these large projects could certainly finance a broad range of technical assistance (TA), the mechanisms to do so are cumbersome and provide TA of variable quality and effectiveness. In particular, these mechanisms cannot duplicate ZdravPlus II's comparative advantage of an established country presence, excellent working relations with government and academic counterparts, and cultural competence. In addition, they rate the technical competence of ZdravPlus II staff as excellent. One official summarized this impression: "You can't divorce Bank accomplishments from ZdravPlus II."

Country and regional Bank officials also observed that the difficult and complex reforms in health financing and other areas supported by ZdravPlus II provide models for other

sectors. The underlying principles of basing policy on evidence apply broadly to other sectors, such as agriculture and education. For example, ZdravPlus II's support for accreditation approaches in health may influence approaches in the education sector.

The impact of ZdravPlus II's work in health financing also demonstrates its effectiveness in influencing major strategic decision-making, despite its small budget and its focus on concrete implementation issues. Bank officials observed that ZdravPlus II organized a pivotal conference on regional experiences in health financing, with presentations from advanced programs in Kazakhstan and Kyrgyzstan. This conference addressed tax issues as well as health issues, and attracted attendance by Ministry of Finance. These officials credit the conference with progressive changes in MOF policy.

Facility staff acknowledge that allocations to non-salary expenditures remain low. In the rural and urban facilities visited, managers described substantial constraints on their financial autonomy, even under the new system. In particular, staffing flexibility appears to be limited. The most prominent source of savings mentioned was from utilities. Guidelines for the use of excess funds further restrict the manager's options—25% for staff incentives, 75% for “material and technical” improvements. A challenge that remains to be addressed is developing the ability of facility directors to take a more active role in managing the budget under their control.

Service Delivery: In accordance with GoU priorities, ZdravPlus II's focus is on the development of a cadre of general practitioners (GPs). This category of physician did not exist in the Soviet era, adversely affecting the efficiency of health care and impeding the access of patients to needed services. The project's focus in this area includes developing basic GP training and continuing medical education, introducing evidence-based medical practice, and developing modern approaches to quality assurance (QA) in health care. Quantitative targets for QA activities in 2007 were exceeded in the initial implementation area (Ferghana), but expansion fell slightly short of national targets.

ZdravPlus II has coordinated the development of rural GPs posted in SVPs with its support for reform in resource use and management, creating many potential synergies.

The large scale training of GPs has been accomplished through a 10 month course designed to retrain specialized physicians to provide primary care. World Bank projects have financed training costs, but Bank officials and counterparts in the ministry and in training institutions all agreed that ZdravPlus II's technical role in GP training has been central to the program. ZdravPlus II contributions include a focus on the quality of training, institutionalizing both pre-service and in-service GP training beyond the Bank project, introducing critical content areas (especially the principles of evidence-based medicine and of modern quality improvement), and supporting efforts to measure the quality of care provided under the GP program.

As it has with the World Bank Projects, ZdravPlus II has provided essential technical support to a \$40 million Asia Development Bank Woman and Child Health Development Project that started in 2005, focused on maternal and newborn health. The ministry's

Joint Program Implementation Board (JPIB) credits earlier ZdravPlus II work in MCH as the basis of the design of this project, which plans to extend this model to a national level. Beyond the overall design and testing of the model, ZdravPlus II also supports implementation by providing technical reviews, technical assistance on equipment specifications, advice on updating regulations, design of training, conducting IMCI training, and development of a QI training course for managers (to be given to 260 managers.)

JPIB officials cited specific results from quality monitoring based on Zdrav's assistance, and outlined plans to establish QI teams in all facilities supported by the project.

Population/Community Health: The Population/Community Health component in Uzbekistan supports health promotion and works to market the reforms to both the public and providers. There was little emphasis on and knowledge of prevention during Soviet times, and counseling patients to take responsibility for their own health was minimal. The ZdravPlus II project activities in this component aim to educate and empower the population to take more responsibility of their own health and to exercise their rights under the health care reforms. They also work to help the government better understand the concept of health promotion and build their skills in this area. Initially, ZdravPlus II had planned numerous community mobilization activities such as training of health providers on reform efforts, small grants programs for NGOs, and SVP community boards, but due to the climate regarding community action, this work has been scaled back and refocused through different channels. Currently, much of the health promotion work is taking place through the Patronage Nurse Training Program that is being implemented nationally by the ADB project. With ZdravPlus II support, the nurses were trained in Adult Learning Techniques and Interpersonal Communication Skills. They have now transitioned to the Basic Nurse Assessment Skills piece, learning one new 3-day module of health information every 6 months. The topics covered include IMCI, safe motherhood, family planning, TB, anemia, HIV/AIDS, and STIs. The nurses will also receive a bag with specific supplies included, which will help facilitate their role in the community.

ZdravPlus II is also promoting the Mahalla Health Initiative Groups (MHIGs) which are currently operational in 6 rayons of Ferghana Oblast. There are plans to expand this approach to the rest of the Oblast, but there are challenges to organizing the community members. Under the current climate, ZdravPlus II has had to suspend a variety of plans: to organize town hall meetings to educate the public on the reforms and their rights, to hold open houses at the facilities for community members to learn about the services offered at the SVPs, and to develop manuals on health to be used at schools.

Health promotion activities are included in the Patronage Nurse program, but otherwise are limited to pamphlets and DVD soap operas. These efforts are informational only, and it is unlikely that they will result in significant behavior change. There is also little data regarding community members' knowledge of health reforms and their rights.

Conclusions: Despite the restrictive political environment in Uzbekistan, the ZdravPlus II team has made impressive progress in health reform. The cooperation with the World Bank and Asian Development Bank presents a united front to the Uzbek government, and counterparts respond to their collective efforts. While working with the Uzbek government does require tenacity and persistence, the Uzbek government clearly values the technical inputs of the ZdravPlus II, as was evidenced when they intervened to ensure ZdravPlus II could continue working in-country. There has been a great deal of effort to lay the political road map for reform, and by the end of the project the rollout of both rural and urban PHC should be complete. However, additional inputs are needed to further refine the skills and responsibilities of those working within the new system; for example, promoting expansion and creativity within EBM and allowing for more ownership and autonomy of facility financial management. ZdravPlus II is well-positioned to address these topics, provided that current funding levels and political relationships are maintained.

Annex E: Uzbekistan Country Findings

Background: Uzbekistan is led by a dictatorship and faces the same challenges regarding governance as the other countries in Central Asia. It also inherited the Soviet legacy of a health system that was over-regulated and punitive. In contrast to its regional counterparts, the Government of Uzbekistan (GoU) was slower to open its doors to health reform. Reforms not only require new policies and laws to support the process, but also dramatic restructuring of the roles and responsibilities of government institutions. In addition, a monitoring and evaluation system that could provide data and evidence to guide policy decisions is needed.

Health reform was launched in 1998 through a Presidential decree on state reform of the health care system in Uzbekistan. Addressing social reforms broadly, this decree included the framework for subsequent health reform legislation. Uzbekistan reform efforts are assisted with loan projects from the World Bank (WB) and the Asian Development Bank (ADB), which provide \$40 million each in loan funding. The WB loan is intended to facilitate the health reform process and the ADB loan focuses on strengthening maternal and child health services. The work of the two banks is harmonized through a Joint Program Implementation Board (JPIB). Tensions between [levels of?] governments and minimal civil society engagement present continued challenges for success in the reform process, however.

Stewardship: ZdravPlus II focused its Stewardship efforts in Uzbekistan on 1) legal and policy change, 2) institutional structure, roles and relationships, 3) policy marketing and public relations, 4) monitoring and evaluation, and 5) donor/project collaboration and coordination. The coordinated efforts of the WB, ADB, and ZdravPlus II have been

critical to making progress with governance reforms in Uzbekistan, but the government structure regarding policy decision-making creates challenges and makes the process more labor intensive. There is no health policy unit within the MOH. A department for each topical area (i.e. MCH) handles policy issues that relate to their topic. For cross-cutting policy changes, such as rural PHC, a working group is created that involves all relevant departments.

ZdravPlusII's role as a key partner of the JPIB has been to assist the GoU by drafting seminal policy and legal documents and conducting studies on operational issues to improve and support the legal and policy decisions related to reforms. Key achievements have been COM resolution #217 (2005) which accepted oblast pooling and recognized the Oblast Health Department (OHD) as the health purchaser, MOH order #484 (2005) which put forward guidelines for roll-out of rural capitated financing reforms, MOH order #12 (2006) which outlined urban PHC reform model concepts, MOH order #432 (2007), which provided guidelines for budget calculation of reformed PHC facilities. In addition, legal documents for case-based hospital payment system pilots are pending, and policy concept papers have been developed for urban PHC, hospital payment systems, QI, EBM, and CME. These achievements represent important steps in improving efficiency and effectiveness of health care services and are remarkable achievements given the operating environment.

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Resource Use: ZdravPlus II activities in the component of Resource Use focus on improving the efficiency of PHC, increasing the equity of health financing, and increasing provider responsiveness to the community. These objectives are addressed chiefly through scaling up a rural PHC financing and management model, establishing a similar program for urban PHC on a pilot scale, and developing a case-based payment

system for hospitals. All five quantitative indicators for this area for 2007 have been met or exceeded (take out since PMP will be discussed at the beginning?).

In earlier contracts, ZdravPlus II supported the development of a per capita financing system for rural PHC centers (SVPs), with pooled contributions at the oblast level to increase equity across rayons (districts). Also for the first time, this model provides the SVPs with some limited flexibility in spending excess funds (i.e., those not consumed by service delivery). The scope of changes in financing and management required establishment of the SVP as an independent legal entity. Once this complex development process was completed, expansion of the model greatly accelerated under the current contract, reaching 2867 SVPs in 2007, with complete national coverage expected in 2008. This is a remarkable achievement in the reform of a system that has long been characterized by perverse incentives to waste resources.

This largescale expansion reflects ZdravPlus II's long-standing and highly effective cooperation with GoU and major donors in Uzbekistan. The \$30 million World Bank Health I Project supported expansion of the rural PHC health financing model until 2004. Under the subsequent Health II Project, accelerated scale up of the financing model took place in spite of reductions in ZdravPlus II funding levels. Officials from the World Bank described cooperation with ZdravPlus II as critical to the Health II loan health financing component, particularly the project's role in convincing the Ministry of Finance to support reform of rural PHC financing by providing a documented, functioning model for replication under the World Bank loan. USAID's modest, but sustained, investment in ZdravPlus II has had a development impact in orders of magnitude greater than the project's budget.

Further, bank officials credit ZdravPlus II technical assistance with more than achieving an effective health financing reform model for replication. They describe ZdravPlus II's role in the successful implementation of their loan projects as vital. While these large projects could certainly finance a broad range of technical assistance (TA), the mechanisms to do so are cumbersome and provide TA of variable quality and effectiveness. In particular, these mechanisms cannot duplicate ZdravPlus II's comparative advantage of an established country presence, excellent working relations with government and academic counterparts, and cultural competence. In addition, they rate the technical competence of ZdravPlus II staff as excellent. One official summarized this impression: "You can't divorce Bank accomplishments from ZdravPlus II."

Country and regional Bank officials also observed that the difficult and complex reforms in health financing and other areas supported by ZdravPlus II provide models for other sectors. The underlying principles of basing policy on evidence apply broadly to other sectors, such as agriculture and education. For example, ZdravPlus II's support for accreditation approaches in health may influence approaches in the education sector.

The impact of ZdravPlus II's work in health financing also demonstrates its effectiveness in influencing major strategic decision-making, despite its small budget and its focus on concrete implementation issues. Bank officials observed that ZdravPlus II organized a

pivotal conference on regional experiences in health financing, with presentations from advanced programs in Kazakhstan and Kyrgyzstan. This conference addressed tax issues as well as health issues, and attracted attendance by Ministry of Finance. These officials credit the conference with progressive changes in MOF policy.

ZdravPlus II's support for per capita financing involves **only public funds ? (not clear what other funds would be available)**, and staff acknowledge that allocations to non-salary expenditures remain low. In the rural and urban facilities visited, managers described substantial constraints on their financial autonomy, even under the new system. In particular, staffing flexibility appears to be limited. The most prominent source of savings mentioned was from utilities. Guidelines for the use of excess funds further restrict the manager's options—25% for staff incentives, 75% for “material and technical” improvements. A challenge that remains to be addressed is developing the ability of facility directors to take a more active role in managing the budget under their control.

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ZdravPlus II has coordinated the development of rural GPs posted in SVPs with its support for reform in resource use and management, creating many potential synergies.

The large scale training of GPs has been accomplished through a 10 month course designed to retrain specialized physicians to provide primary care. World Bank projects have financed training costs, but Bank officials and counterparts in the ministry and in training institutions all agreed that ZdravPlus II's technical role in GP training has been central to the program. ZdravPlus II contributions include a focus on the quality of training, **institutionalizing both pre-service and in-service GP training beyond the Bank project [have they incorporated EBM into the medical school curriculum? See PMP section and maybe change]**, introducing critical content areas (especially the principles of evidence-based medicine and of modern quality improvement), and supporting efforts to measure the quality of care provided under the GP program.

As it has with the World Bank Projects, ZdravPlus II has provided essential technical support to a \$70 million Asia Development Bank Woman and Child Health Development Project that started in 2005, focused on maternal and newborn health. The ministry's Joint Program Implementation Board (JPIB) credits earlier ZdravPlus II work in MCH as the basis of the design of this project, which plans to extend this model to a national level. Beyond the overall design and testing of the model, ZdravPlus II also supports

implementation by providing technical reviews, technical assistance on equipment specifications, advice on updating regulations, design of training, conducting IMCI training, and development of a QI training course for managers (to be given to 260 managers.)

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Health promotion activities are included in the Patronage Nurse program, but otherwise are limited to pamphlets and DVD soap operas. These efforts are informational only, and it is unlikely that they will result in significant behavior change. However, it has not been possible to collect baseline data about community members' knowledge of health reforms and their rights.

Add Conclusion

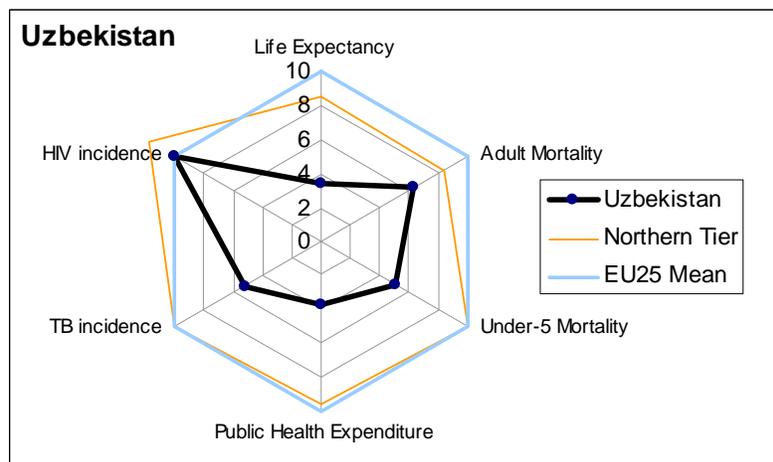
Annex E 1: Uzbekistan: Expectations of Movement Along the Development Continuum over the Next Two Years

With a gross national income per capita of \$610 (\$2,000 based on purchasing power parity), Uzbekistan is considered a low-income country within the developing country category. Uzbekistan has a GDP growth rate of 7.3%, which is slightly under neighboring oil-rich Uzbekistan's of 10.6%. With a population growth rate almost 5 times that of Uzbekistan, Uzbekistan is maintaining a much larger labor force than other countries in the region. It currently has an unemployment rate of only 3% but the poverty rate is at 33%. With increasing numbers of young people about to enter the economy (32.4% of the population is under 15), there are concerns of a stagnating economy. Uzbekistan is trying to lessen its dependency on agriculture and instead grow its mineral petroleum industry.

Uzbekistan ranks 23 of 28 countries (higher number rankings are worse cases) in the 2007 Europe and Eurasia Health Vulnerability Analysis. See the report at:

http://www.usaid.gov/locations/europe_eurasia/dem_gov/docs/2007_ee_health_vulnerability_analysis_report_final.pdf

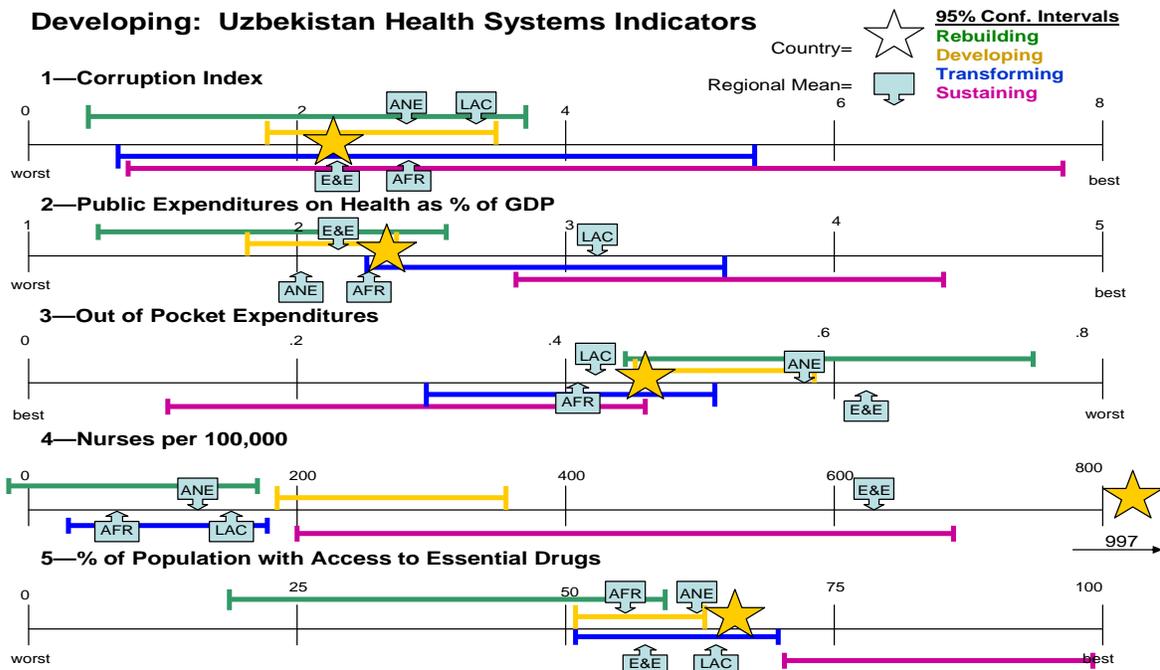
The analysis identifies those countries in the region where health status is the poorest and where the transition to democracy and free-market economies may be most vulnerable because of health factors. The graph below draws on this data to compare Uzbekistan's health status to European Union and E&E regional averages. For each indicator, a score of 10 corresponds with the **EU average**, suggesting ideal performance. A score of 1 indicates the poorest performance in that indicator in the **E&E** region. The country's performance is then plotted against this scale. A score of 10 is ideal performance for all indicators and all countries.



Northern Tier refers to the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.

Uzbekistan is far from approaching the levels of health sector development achieved by countries in northern Europe and the EU25. Poor nutrition is a major health issue for women and children. Uzbekistan scores in the lowest quintile for under-five mortality in the E&E region. Uzbekistan is 10th on the list of 25 priority countries for multi drug resistant TB. The number of injecting drug users has risen dramatically over the last few years, exacerbating the spread of HIV/AIDS through the sharing of syringes and unsafe sexual practices. It appears that Uzbekistan scores better than the EU average on HIV incidence. Since the number of confirmed HIV cases is highly dependant on the surveillance program in the country, HIV scores may be deceptively optimistic.

The graphic below shows Uzbekistan’s performance on several key health systems development indicators relative to: (1) averages for Europe and Eurasia and other geographic regions, and (2) averages for country categories of the USG Foreign Assistance Framework. Indicators reflecting the extent of corruption, public expenditures for health, out of pocket expenditures, and access to essential drugs put Uzbekistan into the Developing Country category. Nurses per 100,000 are high, putting Uzbekistan in the Sustaining Country category. However, this is misleading as nurses receive low salaries and most require training to upgrade their skills.



Source: U.S. Agency for International Development, Bureau for Global Health; most data is 2006.

Although Uzbekistan scores higher than most of its developing country peers on public expenditures in health and above its peers in terms of access to essential drugs and the presence of nurses, its challenges with corruption and high out-of-pocket expenditures limit its progress to becoming a Transforming Country in terms of health systems.

Broader governance issues related to those described in the discussion of performance findings in Annex E are also reflected on its Millennium Challenge Corporation (MCC) scorecard, shown on the next page. Problems with political rights, civil liberties, control of corruption, government effectiveness, rule of law, and voice/accountability overshadow its achievements in the health sector. Uzbekistan scores higher than its peers for 3 of the 5 health indicators, but scores at or below zero in 5 of the 6 indicators related to the political dimensions. The one score above zero is only at 3%.

In the Investing in People category, Uzbekistan exceeds the median for its MCC peer group on both its immunization rate (95% coverage compared with a median of 84%) and public spending on health (2.48% of GNI compared with a median of 2.07%).

In order to qualify as a transforming country, Uzbekistan's efforts need to focus on reducing corruption in health care and increasing public expenditures for health. It also needs to place emphasis on reducing out-of-pocket expenditures, but is already on par with transforming countries for this dimension. Between 1996 and 2005, total expenditure on health as a percentage of GDP was consistently around 5.5%, with slight fluctuations. However, contributions from public funds have declined from 68% to 48%. Government spending on health as a share of total government spending has remained more or less consistent at about 7%.

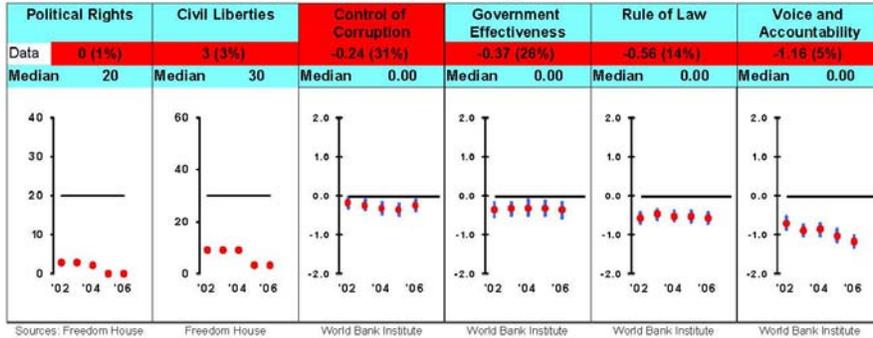
Although technically working to improve public health care provision, ZdravPlus II's work does also contribute to strengthening the scores for indicators within governance. Through its work on finance and management reforms, the project is promoting transparency and accountability of the government's health system, which includes budgetary consistency, quality policy formulation, and implementing programs according to agreed upon plans. To the extent possible, ZdravPlus II is also expanding the role of civil society through project activities.

Over the next two years, ZdravPlus II can help to move Uzbekistan toward the transforming country category in health by focusing on a core set of interventions to strengthen health reforms and protect them from the threats of instability. These interventions are discussed in the next section. However, the changes expected in the health sector over the next two years will not have an impact on the country's movement along the continuum from developing to the transforming category.

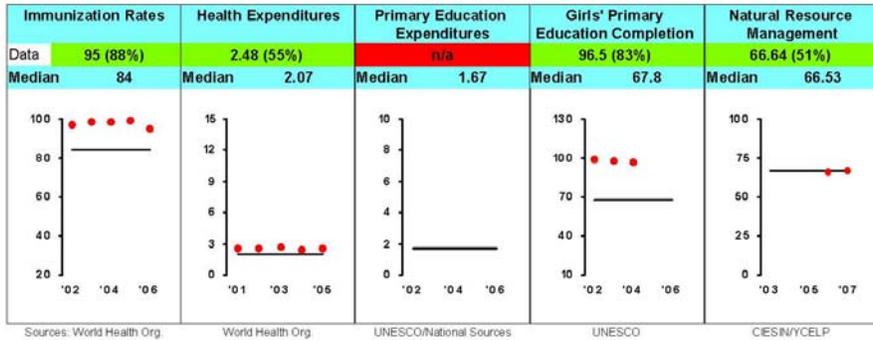
Uzbekistan FY08

Population: 26,167,370
GNI/Cap: \$610 LIC

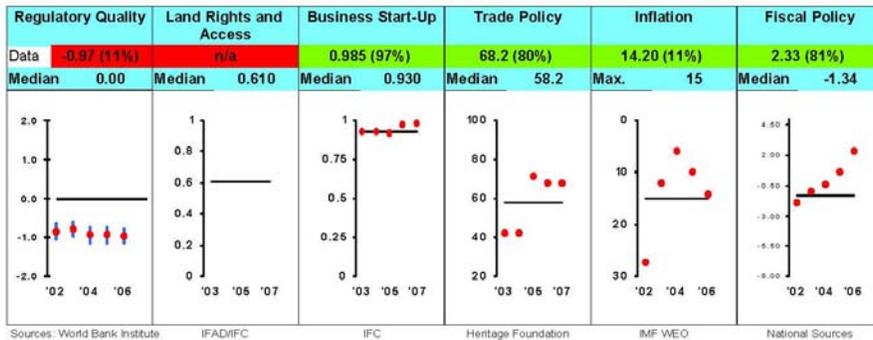
Ruling Justly



Investing In People



Economic Freedom



How to Read this Scorecard: Each MCC Candidate Country receives an annual scorecard assessing its performance in 3 policy categories: Ruling Justly, Investing in People, and Economic Freedom. Under the name of each indicator is the country's score and percentile ranking in its income peer group (0% is worst; 50% is the median; 100% is best). Under each country's percentile ranking is the peer group median. Country performance is evaluated relative to the peer group median and passing scores, or scores above the median, are represented with green. Failing scores, or scores at or below the median, are represented with red. The black line that runs along the horizontal axis represents the peer group median. Each World Bank Institute indicator is accompanied by a margin of error, which is represented by the vertical blue bar.

For more information regarding the Millennium Challenge Account Selection Process and these indicators, please consult MCC's website: www.mcc.gov

10100207

SO 3.2

Percent of total outpatient visit share increased in primary health care practices (FGPs) in pilot sites, relative to outpatient specialist care

Description	KZ National	Kotchetau	Aktubinsk Oblast	Almaty Oblast	Atyrau Oblast	West Kazakhstan Oblast	Zhambul Oblast	Karaganda Oblast	Zhezkazgan	Satpaev	Mangitau Oblast	South Kazakhstan Oblast	Pavlodar Oblast	Semey	East Kazakhstan		
															Oblast	Astana City	Almaty City
2006 Population of select sites	5,828,497	132,640	n/a	1,247,900	472,400	n/a	n/a	1,334,400	104,018	71,350	n/a	n/a	742,900	291,689	1,431,200	n/a	n/a
National Population	14,908,700																
% of National Population covered by select sites	39.1%	0.9%	n/a	8.4%	3.2%	n/a	n/a	9.0%	0.7%	0.5%	n/a	n/a	5.0%	2.0%	9.6%	n/a	n/a
2006 Number of visits to PHCP's	14,163,291	565,700		5,265,008	2,368,402			5,674,708	289,473	179,246			3,176,776	813,318	3,413,271		
Number of total outpatient visits	25,046,761	735,057		11,298,300	3,253,300			9,302,800	457,304	313,367			4,570,900	1,633,170	7,704,900		
% of total outpatient visits in PHCP's (pilots)	56.5%	77.0%	n/a	46.6%	72.8%	n/a	n/a	61.0%	63.3%	57.2%	n/a	n/a	69.5%	49.8%	44.3%	n/a	n/a
Description	KZ National	Kotchetau	Aktubinsk Oblast	Almaty Oblast	Atyrau Oblast	West Kazakhstan Oblast	Zhambul Oblast	Karaganda Oblast	Zhezkazgan	Satpaev	Mangitau Oblast	South Kazakhstan Oblast	Pavlodar Oblast	Semey	East Kazakhstan		
2007 Population of select sites	5,828,497	132,800	695,400	1,620,700	480,700	612,500	1,009,200	1,339,300	104,205	71,478	390,500	2,282,500	744,800	291,015	1,424,500	574,500	1,287,300
National Population	15,396,900	132,800	695,400	1,620,700	480,700	612,500	1,009,200	1,339,300	104,205	71,478	390,500	2,282,500	744,800	291,015	1,424,500	574,500	1,287,300
% of National Population covered by select sites	40.3%	0.9%		10.5%	3.1%			8.7%	0.7%	0.5%			4.8%	1.9%	9.3%		
2007 Number of visits to PHCP's	53,075,819	2,582,422	2,325,237	6,933,688	1,821,377	1,874,178	3,129,534	4,486,123	3,456,483	7,561,700	2,447,534	3,554,693	1,806,018	4,653,651	1,909,408	2,548,684	1,985,089
Number of total outpatient visits	92,405,226	4,908,800	4,364,100	10,800,800	3,218,300	3,745,200	5,306,700	7,811,122	4,797,800	11,595,000	4,595,700	7,485,900	3,409,204	8,232,700	3,682,200	4,985,200	3,466,500
% of total outpatient visits in PHCP's - national	57.4%	52.6%	53.3%	64.2%	56.6%	50.0%	59.0%	57.4%	72.0%	65.2%	53.3%	47.5%	53.0%	56.5%	51.9%	51.1%	57.3%
% of total outpatient visits in PHCP's - pilots	58.8%	52.6%		64.2%	56.6%			57.4%	72.0%	65.2%			53.0%	56.5%	51.9%		

Year	Target		Actual	
	Pilots	National	Pilots	National
2005 (baseline)	53.0%		53.6%	n/a
2006	55.0%	35.0%	56.5%	n/a
2007	57.0%	35.0%	58.8%	57.4%
2008	59.0%	40.0%		
2009	61.0%	45.0%		

2006 notes: 1) Data for 2005 covers the period of October 2004-May 2005; 2) 2006 data - MOH's statistical data on outpatient visits for calendar year 2005 (as of January 1, 2006). So, in the reporting year 2006 there is some overlapping of reporting periods. In the future we plan to use MOH's official data for each calendar year both for national and oblast level data eliminating overlapping.

2007 notes: Data reporting continues to be retrospective as it's difficult to receive the MOH statistical reports in time. 2007 data - MOH's statistical data on outpatient visits for calendar year 2006 (as of January 1, 2007). Consistent with the reporting year 2006 we use MOH's official data for MOH's calendar year (January 1, 2006 - January 1, 2007) both for national and oblast level data. In 2007 the data has been taken from a new Statistical Form #30, MOH, which was introduced in 2006 as recommended by ZdravPlus. This statistical form allows collecting data from all regions by outpatient visit type.

SO 3.2

Percent of total outpatient visit share increased in PHC practices, relative to outpatient specialist care, from 56% in 2003 to 75%

Description		Year	KR Nat'l	Issyk-Kul Oblast	Chui Oblast	Bishkek City	Osh Oblast	Jalalabat Oblast	Batken Oblast	Talas Oblast	Naryn Oblast	Osh City	
2005	% of total outpatient visits in PHCP's												
	Number of visits to PHCP's	2005	10,512,610	872,695	1,691,045	2,700,276	1,460,089	1,751,070	626,575	325,646	402,514	682,700	
	Number of total outpatient visits	2005	17,084,627	1,401,198	2,552,604	4,765,552	2,383,552	2,645,559	909,720	627,873	657,366	1,141,203	
% of total outpatient visits in PHCP's			62%	62%	66%	57%	61%	66%	69%	52%	61%	60%	
2006	% of total outpatient visits in PHCP's												
	Number of visits to PHCP's	2006 (submitted)	11,917,361	922,430	1,873,421	3,096,514	1,662,998	1,961,786	860,513	367,231	461,588	710,880	
	Number of total outpatient visits	2006 (submitted)	20,247,660	1,683,205	2,496,300	5,519,726	3,262,732	2,967,885	1,509,780	581,723	868,838	1,357,471	
	% of total outpatient visits in PHCP's			59%	55%	75%	56%	51%	66%	57%	63%	53%	52%
	Number of visits to PHCP's	2006 (revised)	11,659,201	924,233	1,749,012	2,473,487	2,349,291	2,087,681	775,297	322,396	360,870	616,934	
	Number of total outpatient visits	2006 (revised)	20,454,165	1,601,440	2,561,431	5,216,338	4,181,542	3,054,222	1,377,005	526,848	687,903	1,247,436	
% of total outpatient visits in PHCP's			57%	58%	68%	47%	56%	68%	56%	61%	52%	49%	
2007	% of total outpatient visits in PHCP's												
	Number of visits to PHCP's	2007	7,622,699	579,675	921,420	1,786,200	1,852,937	1,259,533	350,166	199,319	260,114	413,335	
	Number of total outpatient visits	2007	12,891,818	926,116	1,421,728	3,420,345	3,217,357	1,705,783	575,109	303,246	530,410	791,724	
	% of total outpatient visits in PHCP's			59%	63%	65%	52%	58%	74%	61%	66%	49%	52%

Year	Performance		
	Fee Targets	Revised Targets	Actual
Baseline 2005			62%
Target 2006	60%	60%	57%
Target 2007	63%	61%	59%
Target 2008	67%	62%	
Target 2009	71%	63%	
FINAL	75%	63%	

- 2006 Notes:
1. The results seem to have stabilized around 60% which may be the best that can be expected in the post-Soviet environment
 2. Additional substantial increases are likely dependent on significant regulatory changes, for example changing the requirement that army inductees must visit a substantial number of specialists rather than one PHC doctor
 3. Decreases in 2006 data may reflect the post-revolution migration of rural PHC workers and may well hamper future increases
 4. The 2005 increase from 56% to 62% was considered to be large and may be the anomaly with the increase from 56% to 59% being the more natural small, incremental increase expected in the current stage of development of PHC. Although ZdravPlus works to monitor data quality with the MOH Statistics Department, it is a difficult task as the system is so large and the KR calendar year reporting year doesn't match the USAID reporting year meaning some KR year-end data quality checks aren't included.

- 2007 Notes:
1. Data from 2007 is from first three quarters only.
 2. Two 2006 data sets are included above. 2006 (revised) and 2006 (submitted). 2006 (revised) are lower than those submitted last year, 2006 (submitted), due to the inclusion of data from all four quarters of 2006 and data checks and edits performed by the MOH Republican Medical Information Center.

2007

Tajikistan Target Indicators

SO 3.2

Percent of total outpatient visit share increased in primary health care practices (FGPs) in pilot sites, relative to outpatient specialist care

2006	Description	Polyclinic 8 Dushanbe
	Number of visits to PHCP's	129,141
	Number of total outpatient visits	177,981
	% of total outpatient visits in PHCP's	72.6%

2007	Description	Polyclinic 8 Dushanbe	Health Center #1 Kanibadam
	Number of visits to PHCP's	132,991	16,522
	Number of total outpatient visits	199,435	156,725
	% of total outpatient visits in PHCP's	66.7%	10.5%

		Target	Actual	Composite
Polyclinic 8 Dushanbe (CHC #1)	2006	25.0%	72.6%	72.6%
Health Center #1 Kanibadam	2006	0.0%	0.0%	
Polyclinic 8 Dushanbe (CHC #1)	2007	25.0%	66.7%	38.6%
Health Center #1 Kanibadam	2007	25.0%	10.5%	
Polyclinic 8 Dushanbe (CHC #1)	2008	25.0%		
Health Center #1 Kanibadam	2008	25.0%		
Polyclinic 8 Dushanbe (CHC #1)	2009	25.0%		
Health Center #1 Kanibadam	2009	25.0%		

2006 Notes: Data is for the period September 1, 2005 - August 31, 2006. Facilities included in this indicator will expand with future roll-out in 2007-2009. As other facilities are added, the % Actual score, which now includes Polyclinic 8 only, is expected to decrease.

2007 Notes: Data is for the period September 1, 2006 - August 31, 2007. Facilities included in this indicator will expand with future roll-out in 2007-2009. ZdravPlus began working with Health Center #1 in Kanibadam this reporting year.

Population and Community Health
IR 3.2.1 B Part A Number of Entities which serve as mechanisms or channels to empower health action by an individual or community

Year	Number of Entities	
	Target	Actual
2005 (baseline)		268
2006	437	437
2007	537	778
2008	637	
2009	737	

2006	Type of Entity	Description	Quantity
	PHC facilities which provide care for mixed population and have received relevant TA from Z+	Houses of Health/ During KCH Campaign we involve one nurse from all etraps' HOH available. We covered practically 100% of family physicians in old etraps as well	250
		Number of HOH in new etraps	180
	Other Health Care Facilities which have in some way had their service provision restructured so as to serve the community	Velayat Central MCH Hospitals	5
	Institutions under the MOH	MCH Institute	1
		Ashgabat Health Information Center	1
	Total		437

2007	Type of Entity	Description	Quantity
	PHC facilities which provide care for mixed population and have received relevant TA from Z+	Houses of Health/ During KCH Campaign we involve one nurse from all etraps' HOH available. We covered practically 100% of family physicians in old etraps as well	430
		Number of HOH in new etraps	341
	Other Health Care Facilities which have in some way had their service provision restructured so as to serve the community	Velayat Central MCH Hospitals	5
	Institutions under the MOH	MCH Institute	1
		Ashgabat Health Information Center	1
	Total		778

SO 3.2

Percent of total outpatient visit share increased in primary health care practices (SVPs), relative to outpatient specialist care

2006 Oblast-by-oblast coverage

Description	Total Population	Ferghana	Navoi	Syrdaryo	Khorezm	Karakalpakstan
Population covered by rural PHC reforms	3,921,686	1,918,447	518,208	416,508	610,823	457,700
Total population of the oblasts/regions where rural PHC reforms currently being implemented (not include urban areas or rural areas not yet covered)	7,297,956	2,860,000	726,456	679,000	1,460,700	1,571,800
National population (Total of Uz)	26,021,000					
% of population in the project oblasts/regions covered by Rural PHC reforms	53.7%	67.1%	71.3%	61.3%	41.8%	29.1%
% of national population covered by rural PHC reforms	15.1%					

2007

Description	Total Population	Ferghana	Navoi	Syrdaryo	Khorezm	Karakalpakstan	Andijon	Namangan	Bukhara	Surkhandaryo
Population covered by rural PHC reforms	9,980,583	1,957,117	534,030	435,655	1,067,139	800,623	1,606,128	1,183,993	1,051,200	1,344,698
Total population of the project oblasts/regions where rural PHC reforms have been rolled-out throughout the entire oblast/region	15,444,857	2,898,194	726,500	683,200	1,485,000	1,582,600	2,409,900	2,143,700	1,536,000	1,979,763
National population (Total of Uz)	26,485,000									
% of population in the project oblasts/regions covered by rural PHC reforms	64.6%	67.5%	73.5%	63.8%	71.9%	50.6%	66.6%	55.2%	68.4%	67.9%
% of national population covered by rural PHC reforms	37.7%									

% outpatient visits

2006 % of outpatient visits to the reformed PHC Facilities

	Total	Ferghana	Navoi	Syrdaryo	Khorezm	Karakalpakstan
Data from MOH and Regional Health Departments						
Number of outpatient visits to the reformed Rural PHCF's	18,826,000	7,849,100	2,033,100	1,896,600	1,152,900	5,894,300
Number of outpatient visits to the Urban PHCF's/Polyclinics	13,428,200	6,407,300	1,267,300	460,100	3,530,300	1,763,200
Number of outpatient visits to the specialty providers	18,618,700	8,202,200	2,833,100	2,606,400	3,655,900	1,321,100
Total of all outpatient visits	58,450,100	22,458,600	6,133,500	4,963,100	11,192,000	13,702,900
% of outpatient visits to the reformed rural PHCF's*	32.2%	34.9%	33.1%	38.2%	10.3%	43.0%

2007 % of outpatient visits to the reformed PHC Facilities *

	Total	Ferghana	Navoi	Syrdaryo	Khorezm	Karakalpakstan	Andijon	Namangan	Bukhara	Surkhandaryo
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Data from MOH and Regional Health Departments										
Number of outpatient visits to the reformed Rural PHCF's	43,162,695	9,620,595	2,975,752	2,058,948	4,550,500	5,010,550	6,659,900	5,023,750	3,845,600	3,417,100
Number of outpatient visits to the urban PHC polyclinics and specialty providers	87,669,255	17,599,705	5,845,048	3,257,352	6,597,500	6,873,900	11,920,600	13,623,600	10,354,400	11,597,150
Total of all outpatient visits	130,831,950	27,220,300	8,820,800	5,316,300	11,148,000	11,884,450	18,580,500	18,647,350	14,200,000	15,014,250
% of outpatient visits to the reformed rural PHCF's*	33.0%	35.3%	33.7%	38.7%	40.8%	42.2%	35.8%	26.9%	27.1%	22.8%

Year	3 initial pilot oblasts (ZdravPlus)	Targets within national rollout	Actual	
			Within	In 3 initial
Baseline 2005	34.0%			34.0%
Target 2006		30.0%	32.2%	35.0%
Target 2007		32.0%	33.0%	35.4%
Target 2008		34.0%		
Target 2009		35.0%		

2006 Notes: 1. The pilot column in the target and actual table reflects the 3 initial pilot oblasts. In ZdravPlusII, Uzbekistan is rolling out nationally so we are converting from pilot targets and actuals to national targets and actuals. The National target is defined as all oblasts in which the roll-out has started happening (step-by-step all UZ oblasts over the next 3 years)

2. Share of the outpatient visits to the reformed (rural) PHC facilities increased from 34% reported in 2005 to 35% in 2006 in the three initial pilot oblasts (Ferghana, Navoi and Syrdaryo). The national targets and actuals decline in the initial years of the country-wide roll-out because of : (1) Inclusion of new sites/regions where the rural PHC reforms have just started and naturally will need some time to attain higher utilization rates, and (2) Phased-in implementation of the roll-out in the new regions, which results in relatively lower shares of the outpatient visits to the reformed (rural) PHC facilities in the new project sites.

*Official data during the reporting time was available only through the end of Quarter-2, 2006. The reported annual numbers therefore cover the last two quarters of 2005 and the first two quarters of 2006. While the rural PHC reforms cover the entire oblast in Ferghana, Syr Daryo and Navoi, as of the reporting time they have been partly implemented in Khorezm and Karakalpakstan. Region-wide roll-out of the rural PHC reforms will be completed in Khorezm in end-2006 and in Karakalpakstan in 2007.

2007 Notes: 1. The pilot columns reflects the 3 initial pilot oblasts of ZdravPlusI In ZdravPlusII, Uzbekistan is rolling out nationally so we are converting from pilot targets and actuals to national targets and actuals. The national target is defined as all oblasts/regions in which the roll-out of the rural PHC reforms (initially, per capita finance and management systems) has been fully completed throughout the entire oblasts/regions (all UZ oblasts/regions are planned to be covered next year)

2. Share of the outpatient visits to the reformed (rural) PHC facilities increased from 34% and 35% reported in 2005 and 2006 respectively to 35.4% in 2007 in the three initial pilot oblasts (Ferghana, Navoi and Syrdaryo). The national targets and actuals decline in the initial years of the country-wide roll-out because of : (1) Inclusion of new sites/regions where the rural PHC reforms have just started and naturally will need some time to attain higher utilization rates, and (2) Phased-in implementation of the roll-out in the new regions, which results in relatively lower shares of the outpatient visits to the reformed (rural) PHC facilities in the new project sites.

* Official data during the reporting time was available only through the end of Quarter-2, 2007. The reported annual numbers therefore cover the last two quarters of 2006 and the first two quarters of 2007.

* Official data during the reporting time was available only through the end of Quarter-2, 2007. The reported annual numbers therefore cover the last two quarters of 2006 and the first two quarters of 2007.

2/3/2008						
Response to Tina's Questions -- Kazakhstan						
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	No broad policy framework although a number of efforts to develop a health sector strategy or plan, waivers of laws/regs to start oblast level pilots	Primary unclear policy environment especially for PHC but consistent dialogue correlated with development of State Health Care Development Program (SHCDP) and develop and approve legal base for health financing and single-payer	Consolidate legal/regulatory framework around SHCDP, solidify health financing and single-payer regulatory framework, development of overarching Health Code, gradual improvement in health policy dialogue processes and content	Continue solidify legal and policy framework, maintain pooling of funds at oblast level, expand health policy dialogue including a health sector strategy after the SHCDP ends in 2010	O
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	MHIF established as health purchaser, establishment of independent FGPs	Decentralization from MOH, lack of clarity in health financing/health purchaser after cancellation of MHI, health providers growing more autonomous, establish KAFP and other health sector NGOs	General discussion about ISRR including national vs. oblast roles, establishment of OHD as single-payer, establishment of Oblast MIC, general recognition of Institute of Health Care Development as leading EBM/CPG, more involvement of republican institutes, development of professional associations and other NGOs, more involvement of consumer-based NGOs, some capacity building in MOH	Solidify ISRR in health sector with separation and delegation of functions such that the health sector is more transparent and responsive and more intensive capacity building in MOH	O
Policy Marketing	Command and control, little dialogue	Policy marketing related to specific topics such as health financing reform and family medicine	Policy marketing broadened beyond the health sector contributes to development of SHCDP, policy marketing continues on specific topics	Policy marketing beyond the health sector continues especially related to health financing and pooling of funds; policy marketing continues on specific topics such as family medicine, family planning, and Safe Motherhood; dialogue with the MOH on a more systemic process to market their policies and programs	Great need and growing demand, activities should expand in general and also protect specific critical aspects of current law such as pooling of funds and PHC development	O
Monitoring and Evaluation	Politically driven	Minimal	Some incorporation of policy analysis into decision-making, development of Karaganda PHC monitoring system	Develop indicators to monitor SHCDP, continued expansion of policy analysis and special studies and connect to decision-making, initiate NHA, monitoring integrated into service delivery QI	Remains fragmented and a priority to strengthen	O
Donor/Project Coordination	None	Informal and relatively good	More fragmented due to nature of KZ, movement of capital from Almaty to Astana, and no pressing need for donors to collaborate in order to survive or function	In general, somewhat improved as linked around SHCDP but still no urgency on either MOH or donor side for greater collaboration and coordination. Significantly improved in some specific areas such as health financing and Safe Motherhood.	Given no great urgency on donor/project side due to relative openness and ability to work as well as no formal MOH coordination and the spread across Almaty and Astana, it's not clear what will drive greater donor/project coordination or even whether it's necessary	O
Resource Use						

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Health Delivery System Structure	Inverted pyramid	Piloted new independent FGPs, merger of oblasts and PHC backlash hampered formation of new PHC sector	KZ decision on PHC model of SVA's, mixed polyclinics, and some independent FGPs. Gradually the backlash dissipated and strengthening PHC became a greater priority.	Strengthening PHC priority of SHCDP and restructuring and investment continued to develop, design of WB project master planning element.	Continued gradual development driven by health budget investment	P, O
Human Resources Planning	None	Minimal	No systematic approach but some dialogue	No systematic approach but some expansion of activities and advocacy especially for rural PHC as PHC workers begin to retire and are not replaced	Is needed and likely to be incorporated into medical education reform in WB project	O
Health Financing	See writing on fragmented financing, no separation of purchaser/provider, wrong incentives in provider payment systems (PPS), etc.	Introduced mandatory health insurance (MHI), caused split of policy, funding, pooling, purchasing, BBP, health delivery system, HIS; enormous conflict between MOH and MHIF; MHI enabled some introduction of new provider payment systems (PPS)	Cancellation of MHI, decentralization of pooling to rayon level made health financing activities increasing equity and efficiency very difficult, Karaganda Oblast and a few other oblasts continued health financing reform and introduction of new PPS including capitated rate and case-based hospital payment systems	implementation of oblast level pooling of funds, OHD as single-payer and new PPS. Various threats to fragmenting the pool again including decentralizing to the rayon level again, re-introduction of MHI, and introduction of medical savings accounts which intensive dialogue have mitigated to date but there are still risks. Treasury System operations create significant difficulties for new PPS implementation and provider autonomy, design of WB project health financing element.	Maintain and strengthen single-payer system, refine PPS, resolve Treasury System issues and increase health provider autonomy.	P, R, O
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	Introduce new HIS connected to MHI introduction, pilot oblast HIS development linked to health financing reforms and PHC development	Zhekazgan City and Karaganda Oblast develop integrated HIS, continue linkages to PPS introduction and PHC development	Support Oblast MIC in HIS linked to national single-payer, deepen Karaganda Oblast integrated HIS, contribute to initial design of national HIS, design of WB project element.	Solidify HIS linkage to national implementation of single-payer, development and implementation of national integrated HIS built on Karaganda Oblast model	P, R, O
Health Management	Command and control, politics equated with management	Health management training linked to health financing reform	Health management training linked to health financing reform	health management training linked to health financing reform, support MOH in identifying sites for international health management training, begin development of plans for long-term medical education, design of WB project element.	Continued linkage to health financing reform implementation and establish and strengthen long-term health management education	O
Service Delivery						
General Health System Functions						
Postgraduate Medical Education	Old system collapsed	Not comprehensive family medicine (FM) introduction including TOT, establish FMTC, and PHC retraining as in other CAR countries. Extensive PHC training in pilot oblasts.	Post-Graduate Institute (PGI) and Kazakhstan Association of Family Physicians (KAFF) form partnership for FM faculty development and PHC CME	PGI and KAFF strengthen FM faculty development and PHC CME and begin development of computer-based distance education (CBDE)	development, strengthen PGI and MA FM Departments, solidify CME and link to attestation, and introduce CBDE. Begin more comprehensive medical education (ME) reform including developing structure to produce a better general doctor, broader linkages across levels, and better practical clinical training.	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	Minimal	Establish family medicine residency	Strengthen family medicine residency	Continue strengthening FM residency and begin more comprehensive ME reform (see above)	O

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	Minimal	Dialogue through regional Council of Rectors, difficult to initiate medical education reform or move toward integration enabling FM introduction and production of good general doctor	Movement with approval of Medical Education Reform Concept and dialogue and incorporation into WB project. Introduction of FM Department at Medical Academies may provide an opportunity although not yet clear, design of WB project element.	Direction not yet clear, priority for future	O
EBM/CPGs	Nature of clinical practice not based on evidence	Some analysis done showing that current clinical practice not based on evidence	Start promoting EBM and building capacity.	MOH tenders to Institute of Health Care Development to develop CPGs, initially required to develop unrealistic number of protocols in unrealistic timeframe, with dialogue process beginning to improve, approval of CPG development methodology, Specialty Associations/Republican Institutes such as Cardiology Institute and MCH Center becoming leaders with more acceptance of EBM, design of WB project element.	Continue current path with more clarify on roles and relationships including involvement of professional associations and republican institutes, more EBM promotion, and better CPG development	O
Quality Assurance	Punishment	Minimal	Minimal	Health professional licensing and attestation including involvement of KAFP, design of WB project element on health facility accreditation	Developing but future directions not yet clear... mixed messages concerning	O
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	Pharmacy privatization, essential drug list and formularies	Establishment of Karaganda Drug Information Center (DIC) providing information on rational drug use to providers and population, limited activities on drug registration and quality	Develop and implement outpatient drug benefit; DIC moves to Astana, works more nationally, continues providing information on rational drug use, and connects to EBM/CPGs; general drug policy including some dialogue on price controls; design of WB project element.	with broad strategy needed, continue outpatient drug benefit, rational drug use activities, and linkages with EBM/CPG, CME, and QI	O
Infrastructure	All owned by state, massive and deteriorating	Design lay-out of new PHC entities, other limited TA on equipment and renovation	Minimal	Large increase in health budget expanded dialogue on infrastructure investment including equipment, new facilities, etc.	Combine investment with ongoing restructuring and rationalization of the health delivery system possibly some regulatory framework for capital investment	O
Service Delivery Priority Programs						
General Practice/Hypertension	Problems inherent in system including weak PHC	Included in FM	Included in FM	Pilot and roll-out hypertension service delivery priority program	Continue roll-out, possibly expand across levels	P, R, O
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based	Some family planning	Some family planning	Pilot and roll-out Safe Motherhood, extensive family planning connected to Safe Motherhood and beyond including receiving and incorporating contraceptives	Continue roll-out	P, R, O
Child Health	Problems inherent in system including weak PHC and not evidence-based	Support for IMCI implementation	Include in FM	Include in FM	Strengthen in FM	O

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
TB	Excess capacity in vertical system, not evidence-based treatment, reach of vertical system no longer able to control all TB-related issues	Minimal	Minimal with some linkages in FM and health promotion	See Askar's program summary -- generally, policy dialogue, 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.	GF strengthened vertical TB system, a broad strategy is needed to integrate general health system and vertical TB system. KZ general governance moving in this direction, for example, as part of administrative reform the Government is currently requiring each Ministry/sector to develop an overall strategy (as compared to separate programs).	O, S
HIV/AIDS	Not yet emerge	None	Minimal with some linkages in FM and health promotion	Incorporate into Safe Motherhood and FP, some linkages FM/PHC development and health promotion	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						
Marketing the Reforms	Population role not seen as important	Free choice of FGP and enrollment	Continue free choice of PHC practice and enrollment, promote population benefits and rights, promote PHC/FM	Incorporate enrollment into health financing linked to capitated rate, promote benefits and rights, promote FM/PHC	Expand activities and link with more open society	O
Health Promotion -- Government	Not yet emerge	General health promotion including soap operas, etc. Fairly substantial support for new Center for Healthy Lifestyles (CHLS)	Continue support and joint implementation of activities with CHLS	Limited support for and joint implementation of activities with CHLS	Not clear, CHLS developed as vertical system, long-term probably optimal to develop broader linkages with individual and public health systems	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 PHC practices 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, not strong inherent community-based structure	Minimal, not strong, inherent community-based structure, some linkages with developing consumer organizations and patient clubs/associations	Potential to expand...	O

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

2/3/2008					
Response to Tina's Questions -- Tajikistan					
Not start work in Tajikistan until ZdravPlus					
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					
See ZdravPlus II Project Regional Conceptual/Technical Overview Paper Distributed to USAID Evaluation Team for General Definition of Project Components					Tina's
Just intended to provide a general picture, not fully specified, activities not always fit precisely across projects, generally allocated to time where most accomplished					Scale
				ZdravPlus II Remainder	For Z+II
				and Beyond	+R for
Project Component	At Independence	ZdravPlus	ZdravPlus II To Date		Roll-out
Stewardship					
Legal and Policy	No comprehensive policies, patchwork of laws/regulations, governing done by decree	Supported by WHO created Somoni Master Plan, generally good plan but created a semi-parallel MOH and a lot of conflict. Broad policy dialogue difficult. Started productive health financing reform dialogue with a multi-sectoral working group. Dialogue about family medicine also contentious.	President. Approval of regulations to start PHC per capita payment. Significant conflict over nature of BBP and copayments but ultimately approval of good policy. General service delivery and family medicine dialogue more productive although issues with approval of international consultants for SM. Surprisingly good openings for dialogue in EBM and ME.	Continue to strengthen policy dialogue processes and legal/regulatory base. Is talk of SWAp or at least development of Health Sector Strategy.	O
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	Substantial conflict over who has the leading role in introducing family medicine and retraining (PGI or new Republican Family Medicine Center) demonstrates problems with duplicative roles. Clear that building capacity in MOH will be long-term and difficult challenge.	Initiate productive dialogue on establishing a oblast-level health purchaser. Family medicine institutional conflict somewhat mitigated. It appears DIC and EBM Center in good institutional home in TSMU. Creation of Family Medicine Association. Center of Excellence (COE) model established.	Establish and solidify health purchaser and define health provider autonomy and public/private relationships. In service delivery, continue separating and decentralizing functions and establishing and clarifying roles and relationships	O
Policy Marketing	Command and control, little dialogue	Very controlled and politicized environment and not broad dialogue	Dialogue broadening but still very politicized. Try to support MOH in advocating and showing results to the Government to obtain more time and space for reform implementation	Priority to enhance dialogue and broaden participation.	O
Monitoring and Evaluation	Politically driven	Minimal	WB project and WHO working with Tajik partners to establish a Health Policy Analysis Unit similar to Kyrgyzstan	Objective data and analysis of reform implementation needed to depoliticize environment and move toward evidence-based policy-making	O
Donor/Project Coordination	None	Contentious at times. Possible some underlying tension due to who there during the war vs. who not and relationship humanitarian assistance and development. ZdravPlus contributed to donor coordination process.	Still difficult at times. Nature of Tajikistan does contribute to a divide and conquer mentality.	A major issue requiring a lot of effort. Unpredictable whether moving toward SWAp will improve or worsen in the short-term although likely good for the long-term.	O
Resource Use					

Project Component	At Independence	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Health Delivery System Structure	Inverted pyramid	Loss of time during war years really hampered development of bottom-up pilots and restructuring which was generally happening in other CAR countries.	Decision on rural PHC model -- Rural Health Centers reporting to PHC Network Manager under the CRH, working on establishing specific roles and relationships now. Cities mixed polyclinics which enables COE development. Minimal hospital level restructuring and given low level of funding the system continues to collapse under its own weight.	Expand PHC reorganization and restructuring. Hospital level restructuring needs to start and critical to long-term sustainability of health sector.	O
Human Resources Planning	None	None	None	Definitely a future priority	
Health Financing	See writing on fragmented financing, no separation of purchaser/provider, wrong incentives in provider payment systems (PPS), etc.	Initiated productive, multi-sectoral dialogue	Hard to agree upon first implementation step after National Health Financing Strategy approved. After long dialogue and development of multiple implementation strategies and plans, implementation of pilot PHC per capita payment started in 2007. Approval and pilot implementation of BBP with formal copayments. Most CAR countries generally improved pooling and purchasing arrangements first and then solidified BBP after payments could be matched to benefits. Tajikistan is introducing BBP and then will need to back down the chain to improve pooling and purchasing arrangements to realize the BBP, dialogue in process.	Just starting health financing implementation, substantial support needed in the future to continue to develop and implement TJ health financing model.	P, O
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	Initiated automated hospital database and HIS	Expand automated hospital database and HIS. Currently working on module to attach to hospital HIS to enable better planning and management of formal copayments	Continue implementation and expansion linked to health financing implementation	P, O
Health Management	Command and control, politics equated with management	Provided training to health providers on general health management principles and communicating the objectives of the health reforms.	Health financing and management training provided in pilot PHC per capita payment system sites. Dialogue on coordinating with health management training under WB project	Short-term -- capacity building training linked to health financing implementation Long-term -- health management education needed	P, O
Service Delivery					
General Health System Functions					
Postgraduate Medical Education	Old system collapsed	With expatriate doctors, started FM TOT, collaborated on formation of oblast FMTCs and starting PHC retraining process	Expatriate doctors continued FM TOT, ongoing faculty development, strengthened FMTCs/COE, supported retraining, and initiated short CME conferences very popular with doctors	Continue support faculty development, PHC retraining, and CME	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	Minimal	FM trainers graduating from FM TOT go to polyclinic affiliated with TSMU to start FM residency, mixed results in short-term largely due to personalities but structure in place and we expect it to progress	Continue development of FM residency, link graduate medical education improvement to general medical education reform	O

Project Component	At Independence	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	Early on it appeared that productive dialogue with TSMU on medical education improvement could be established earlier in the process than other CAR countries, dialogue through Regional Council of Rectors	Assessment of TSMU by international consultants, ongoing technical assistance to TSMU to develop Medical Education Reform concept and implement some early steps, work on medical education accreditation and adapting WFME standards	Expand medical education reform and improvement	O
EBM/CPGs	Nature of clinical practice not based on evidence	Minimal	EBM Center established in TSMU, productive dialogue and capacity building in EBM, started developing new CPGs.	Continue to expand activities	O
Quality Assurance	Punishment	Minimal	Some dialogue about facility accreditation	Possibly initiate facility accreditation and maybe QA linked to health purchasing	
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	A strength of initial donor inputs due to strong WHO pharmaceutical team and humanitarian assistance focused on drugs. Relatively strong MOH capacity. Drug Information Center (DIC) established in TSMU and provided objective evidence-based information to health providers and population	National Drug Policy developed and approved. DIC continue substantial activities on rational drug use. Broad picture confusing as working to reestablish central procurement of drugs. Donor commitment to provide drugs more uncertain. Should link to health financing reform but how not yet clear.	A broad strategy on financing mechanisms for drugs needed and ongoing rational drug use activities	O
Infrastructure	All owned by state, massive and deteriorating	Major issue as system substantially decayed. Hasn't been major investments in infrastructure especially for PHC as in other CAR countries.	Z+ limited investment in COEs. Some investment under WB and ADB projects but still major issue.	Infrastructure needs more upgrading to realize health system improvement	O
Service Delivery Priority Programs					
General Practice/Hypertension	Problems inherent in system including weak PHC	General family medicine introduction	Initiated pilots in COEs	More investment in pilots and eventual roll-out	P
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based	Minimal	Initiated pilots in COEs and working to solidify and start roll-out	Continue to solidify pilots and roll-out	P
Child Health	Problems inherent in system including weak PHC and not evidence-based	Incorporated into general family medicine introduction	Incorporated into general family medicine introduction	Continue to solidify in general family medicine introduction	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	See other writing -- generally, policy dialogue, 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.	Continue integrating into medical education and PHC. Gradually create more health system linkages including financing and vertical system restructuring	P, O
HIV/AIDS	Not yet emerge	Minimal	Incorporate into Safe Motherhood, some links to PHC training and health promotion	General strategy needed including addressing role of vertical system	O
Population and Community Health					
Marketing the Reforms	Population role not seen as important	Minimal	Established MOH Press Center but not yet mature and seems part of country environment is increasing desire to control information	Should be expanded if country environment allows	O
Health Promotion -- Government	Not yet emerge	Supported Somoni Team and Republican Center in health promotion	Limited support for Republican Center	Continue limited support....	O
Health Promotion -- Providers Linked to Service Delivery	Not yet emerge	Minimal	More intense and focused health promotion at health provider level for service delivery priority programs	Enhance and expand in concert with COEs and service delivery priority programs	P, O
Health Promotion -- Community-Based Entities	Not yet emerge	Minimal	Initial linkages with mahallas and other community-based entities	Should be expanded if country environment allows	O

2/3/2008					
Response to Tina's Questions -- Turkmenistan					
Not start work in Turkmenistan until ZdravPlus					
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					
See ZdravPlus II Project Regional Conceptual/Technical Overview Paper Distributed to USAID Evaluation Team for General Definition of Project Components					Tina's
Just intended to provide a general picture, not fully specified, activities not always fit precisely across projects, generally allocated to time where most accomplished					Scale
Project Component	At Independence	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	Receive approvals of activities and training participants	Still largely just to receive approvals but due to development of relationships and trust some broader dialogue on some topics	Almost totally dependent on general country environment	○
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	Minimal	Some thinking and discussion about roles, for example, role of Fund for VHI in broader health financing, institutionalizing HIS training in TSMU Health Management Center, relationships service delivery and medical education, etc.	Almost totally dependent on general country environment	○
Policy Marketing	Command and control, little dialogue	None as environment not allow dialogue	At start none, over time environment becoming slightly more open for dialogue	Almost totally dependent on general country environment	○
Monitoring and Evaluation	Politically driven	initially very difficult as partners not allow access for M&E	Improved significantly due to MCH Center increase in interest and confidence as well as collaboration with WHO to improve IMCI M&E	Continue to expand and improve	○
Donor/Project Coordination	None	Generally good although some quirks	Generally good although some quirks	Expect to remain generally good	○
Resource Use					
Health Delivery System Structure	Inverted pyramid	minimal. Strong Presidential support for PHC (probably strongest in CAR) resulted in development of PHC sector. Turkmenistan general perspective is right what but the how could use some support, for example, right that need to restructure hospitals but statement that close all hospitals outside of Ashgabat probably not right way to do it (didn't happen...)	Largely same as ZdravPlus	Almost totally dependent on general country environment	○
Human Resources Planning	None	None and minimal information	None and minimal information	Almost totally dependent on general country environment	○

Project Component	At Independence	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.	Co-sponsored seminar with WHO went well, strong Turkmen desire to retain universal coverage for all citizens and some understanding of health financing functions. Some dialogue on mandatory health insurance.	Second seminar on provider payment systems also generated interest, agreed to discuss HIS for VHI and distribute manual and discuss case-based hospital payment but no follow-up after death of President and change in MOH leadership. Turkmenistan showed WB some interest in engaging in health financing, probably connected to financial pressure due to reduction of health budget and allocation of funds for buildings required by the President but this door seemed to close...	Almost totally dependent on general country environment	O
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	None	Implemented automated hospital database and HIS first in pilots and then minimal roll-out	Can expand as far as resources will allow	O
Health Management	Command and control, politics equated with management	None	Institutionalized HIS training in TSMU Health Management Center, other opportunities may arise	May be some opportunities...	O
Service Delivery					
General Health System Functions					
Postgraduate Medical Education	Old system collapsed	Minimal	Some linkage with Family Medicine Training Center supported by AIHA	Potential to develop over time	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	Minimal	Minimal	Potential to develop over time	
Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	Initiated integration of IMCI	Largely completed integration of IMCI and engaging in dialogue on other programs	In contrast to other CAR countries there is movement on improving undergraduate ME early in the reform process	O
EBM/CPGs	Nature of clinical practice not based on evidence	None outside of WHO programs	One roundtable demonstrated a lot of interest	Potential to develop over time	O
Quality Assurance	Punishment	None	None	Unclear	
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	Some dialogue on sustainability of IMCI drugs	Some dialogue on sustainability of IMCI drugs	Unclear	O
Infrastructure	All owned by state, massive and deteriorating	None	None	Unclear	
Service Delivery Priority Programs					
General Practice/Hypertension	Problems inherent in system including weak PHC	Laboratory training (clinical) Healthy Pregnancy training to improve prenatal care and communication with population. Very close collaboration and cost-share with Healthy Family Project	Evolved laboratory training to a broader PHC training linking family doctors and laboratory specialists	Can expand geographically and programmatically (other PHC topics) as resources allow	O
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based		Evolved into broader Safe Motherhood, national program approved, initiated 1 pilot site, great acceptance and enthusiasm, want to expand. Some collaboration with Healthy Family.	Want to expand slowly to address issues and ensure quality but likely can expand as far as resources allow	P, O

Project Component	At Independence	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Child Health	Problems inherent in system including weak PHC and not evidence-based	Initiated and rolled-out physician IMCI. Very close collaboration and cost-share with Healthy Family Project	Continued roll-out of physician IMCI. Initiated and rolled-out nurse IMCI. Preliminary activities hospital IMCI. Very close collaboration and cost-share with Healthy Family Project	Can expand geographically as resources allow. Continue to integrate into broader PHC and family medicine	P,R,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, largely support for health promotion	Collaborated with Project HOPE on integrating TB DOTS into medical education, IPCS, and health promotion	Continue integrate into medical education, other activities may be possible over time...	O
HIV/AIDS	Not yet emerge	Minimal, largely support for health promotion	Link to Safe Motherhood and health promotion activities	Continue link to Safe Motherhood and health promotion	O
Population and Community Health					
Marketing the Reforms	Population role not seen as important	None	None	Almost totally dependent on general country environment	
Health Promotion -- Government	Not yet emerge	Healthy Lifestyles Center surprisingly active, collaborated on a number of activities	Healthy Lifestyles Center surprisingly active, collaborated on a number of activities	If current perspective continues, is potential for activities	O
Health Promotion -- Providers Linked to Service Delivery	Not yet emerge	Keeping Children Healthy Campaigns linked to IMCI and healthy lifestyles training for providers	Keeping Children Healthy Campaigns linked to IMCI and healthy lifestyles training for providers	Seems a lot of potential to continue or expand	P, R, O
Health Promotion -- Community-Based Entities	Not yet emerge	None	None	Almost totally dependent on general country environment	

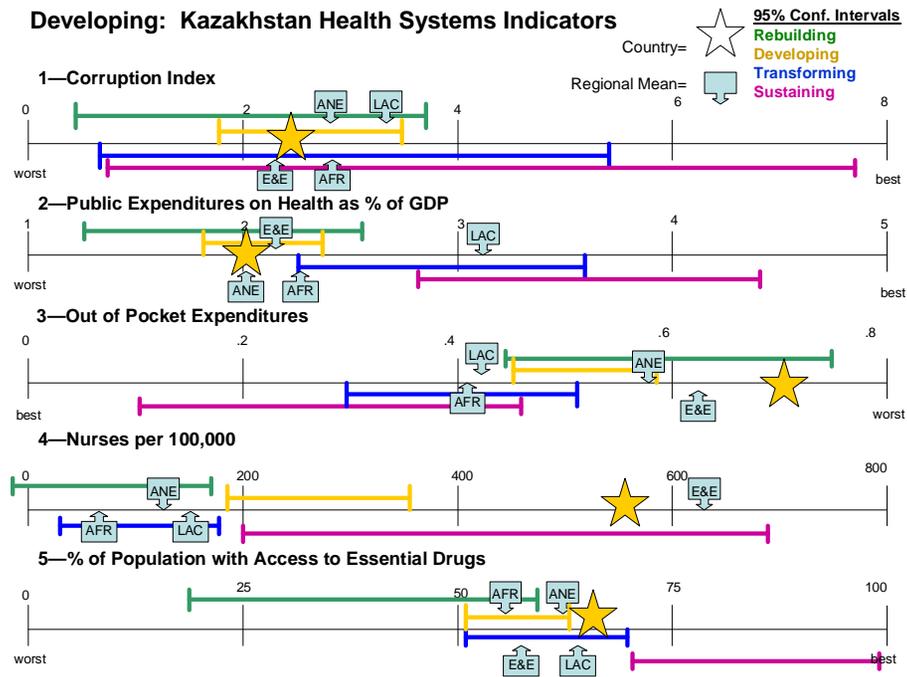
2/3/2008						
Response to Tina's Questions -- Uzbekistan						
Not start work in Uzbekistan until mid-way through ZdravReform and minimal activities						
Most activities done in collaboration with other donors/projects, documented elsewhere, not included due to space constraints						
Same situation 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	No general policy dialogue, focus is on the opening created by Uzbek desire to invest in and improve rural health care	Generally same situation, broad health policy dialogue not possible but dialogue expands as initiatives expand. Environment characterized by difficult struggle to reach agreement but then move forward and not go back.	Dialogue continues to expand as initiatives and scope of reform expands but still no broad health policy dialogue or a critical mass to create a general health sector strategy. Environment remains characterized by difficult struggle to reach agreement but then move forward and not go back.	In the short-term likely to remain the same, the scope of initiatives drives dialogue rather than a broad health sector strategy driving initiatives. Not too damaging as long as scope of initiatives continues to expand, it can even be seen as positive as time is given for initiatives to develop	O
Institutional Structure, Roles, Relationships (ISRR)	MOH monopoly with complete command and control	Only related to implementation of rural PHC model	No broad approach but progress in specific institutional structure and roles including establish health purchaser, some PHC facility autonomy, establish GP Training Centers, establish EBM Center. Some movement on forming or supporting NGOs and working with Mahalla's	Continue step-by-step establishment of institutional structure and roles. Substantial institutionalization and capacity building although how to realign the roles and increase the long-term capacity of the MOH central apparatus remains a concern. Government shut-down NGOs and didn't allow direct linkages to community so found alternative mechanisms. Began working with Republican Institutes as well as EBM Center and merger of two medical academies created some openings.	Likely Uzbek environment remains difficult and more conducive to step-by-step establishment of overall institutional structure, roles, and relationships and capacity building rather than broad realignment. No major issues with this approach and could continue to be effective. Expect continued shut-down of NGOs and lack of access to community	O
Policy Marketing	Command and control, little dialogue	Minimal, Government decreeing investment in rural health care	Minimal as govern by decree and very difficult to broaden participation. Not good for long-term -- agree on policy and then implement	Minimal as govern by decree and very difficult to broaden participation, current environment more difficult than ZdravPlus I.	In short-term likely to remain the same, hopefully in longer term there is more participation in policy dialogue and greater potential and need for policy marketing	O
Monitoring and Evaluation	Politically driven	Minimal	Developing through monitoring inherent in QI processes and special studies on health financing implementation	Developing through monitoring inherent in QI processes and special studies on health financing implementation. Generally, a growing interest from UZ partners to monitor the results of their reforms.	The Uzbeks are interested in assessing progress and potential for M&E activities should continue to increase	O
Donor/Project Coordination	None	Generally good and very close with WB	Generally good and very close with WB	Generally good and very close with WB and ADB	Unclear if more formal donor/project coordination mechanisms will develop	O
Resource Use						
Health Delivery System Structure	Inverted pyramid	Rural PHC model: establish independent SVPs in 1 oblast	Rural PHC model: establish independent SVPs in 3 oblasts	Rural PHC model: close to completing roll-out nationwide. Urban PHC model: pilot reorganization and restructuring. Lack of hospital restructuring troubling but inherent in Uzbek step-by-step approach	Rural PHC model -- solidify. Urban PHC model -- complete piloting and roll-out. Hospital: initiate hospital restructuring linked to financing	P, R, O
Human Resources Planning	None	Minimal	Some HR planning linked to PHC development and ME improvement	Some HR planning linked to PHC development and ME improvement	Unclear how it will develop...	O

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.	Rural PHC model: develop methodology for per capita payment system	Establish oblast pooling of funds and OHD as health purchaser. Rural PHC model: implement per capita payment system in 3 oblasts	Solidify oblast pooling of funds and OHD as health purchaser. Rural PHC model: close to completing roll-out of per capita payment system nationwide. Urban PHC model: pilot per capita payment system. Hospital: initiate design of case-based hospital payment system.	Rural PHC model: solidify. Urban PHC model: complete pilot and roll-out. Hospital: implement new hospital payment system. Solidify oblast pooling, continue strengthen OHD as health purchaser, ensure harmonization with Treasury System, strengthen linkage to BBP	P, R, O
Health Information Systems (HIS)	Excessive but data poor, politicized and not used	Rural PHC model: design financial and HIS	Rural PHC model: implement financial and HIS in 3 oblasts	Rural PHC model: close to completing roll-out of financial and HIS nationwide. Urban PHC model: pilot financial and HIS. Hospital: implementation of automated HIS in pilot oblast of Ferghana	Continue consistent with country implementation strategy -- solidify national roll-out of rural PHC model, continue piloting and plan roll-out of urban PHC model, and initiate pilot of case-based hospital payment system. Over time, integration and improvement of overall country HIS.	P, R, O
Health Management	Command and control, politics equated with management	Rural PHC model: design practical health management training and systems linked to health financing	Rural PHC model: implement practical health management training and systems linked to health financing in 3 oblasts	Rural PHC model: close to completing institutionalization and roll-out of health management training and systems nationwide. Urban PHC model: pilot health management training and systems. Hospital: develop health management training and systems. All health management training continues to be linked to health financing implementation	Continue consistent with country implementation strategy -- solidify national roll-out of rural PHC model, continue piloting and plan roll-out of urban PHC model, and initiate pilot of case-based hospital payment system. Over time, develop long-term health management education.	P, R, O
Service Delivery						
General Health System Functions						
Postgraduate Medical Education	Old system collapsed	Modular training courses in Ferghana to fill time gap while GP training process developed	GP trainer TOT, establishment of GPTCs, initiation of GP retraining for PHC doctors	GP trainer or faculty development, improvement of GP training curriculum including incorporation of priority or vertical programs, integration into medical education, dialogue on CME	Continue support GP faculty development and GP retraining, convert to a long-term CME system linked to licensing	O
Graduate Medical Education	Not based on EBM, no outpatient clinical bases	None	Minimal movement although general practice introduction extends across education levels in Uzbekistan better than other CAR countries so linkages established	Strengthen linkages related to general practice introduction	Solidify linkages in general practice introduction and continue broad strengthening of medical education	O
Undergraduate Medical Education	Not based on EBM, theoretical with little practical clinical training or patient contact	None	Link with TashME I and TashME II on general practice introduction, dialogue through Regional Council of Rectors,	TashME I and TashME II merge into TSMA, work with TSMA and TashPeds to unify the curriculum across the two institutes to gradually produce general doctors capable of serving adults and children, link to regional medical education accreditation dialogue and detailed specification and adaptation of WFME standards to CAR	Continue broad strengthening of medical education	O
EBM/CPGs	Nature of clinical practice not based on evidence	None	Begin promoting EBM, establish EBM Center	Continue promoting EBM, support EBM Center but also support broader participation in CPG development by involving Republican Institutes	Continue promote EBM, solidify CPG development process, obtain further recognition of facility level QI as CPG implementation process	O
Quality Assurance	Punishment	None	None	Establishment of health professional licensing	Unclear, broader strategy needed on licensing and accreditation and determination of linkages to health purchasing	O

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Pharmaceuticals	Pharmatsiya (some different names across country) monopoly	Minimal	Drug Information Center in Ferghana	Dialogue on how to ensure accessibility of drugs in PHC models, link drug-related information to EBM/CPG and service delivery priorities, minimal support for contraceptive logistics system	Unclear, broader strategy needed, sensitivities related to Dori Dorman and central procurement remain	O
Infrastructure	All owned by state, massive and deteriorating	Contribute to specification of WB equipment and SVP renovations	Contribute to specification of WB equipment. Uzbeks renovate or built SVPs.	Contribute to specification of WB equipment. Uzbeks renovate or built SVPs. Although tougher for local governments due to tightening budgets, has resulted in creating new rural PHC sector	Solidify PHC infrastructure, where possible provide TA on hospital level equipment and renovations	O
Service Delivery Priority Programs						
General Practice/Hypertension	Problems inherent in system including weak PHC	Modular courses in Ferghana	Piloted hypertension quality improvement (QI) projects	Roll-out hypertension QI projects including within Ferghana Oblast, through links to GP training, through links to other donors/projects	Evolve into long-term, sustainable linkages and synergies between system level EBM promotion and CPG development and facility level QI and CPG implementation	P, R, O
Maternal (Safe Motherhood) and family planning	Problems inherent in system including weak PHC and not evidence-based	Modular courses in Ferghana	Piloted anemia quality improvement (QI) projects. Piloted and rolled-out midife/IUD program. Developed and implemented contraceptives logistics system in Ferghana.	Roll-out anemia QI projects including within Ferghana Oblast, through links to GP training, through links to other donors/projects. Dialogue and initial activities for Safe Motherhood implementation. Continued limited support for midwife/IUD program and contraceptives logistic system.	Further support and solidify Ferghana Safe Motherhood site as Center of Excellence, collaborate and guide development of donor consortium supporting expansion of Safe Motherhood, link Safe Motherhood and FP, possibly expand FP.	P, O
Child Health	Problems inherent in system including weak PHC and not evidence-based	Modular courses in Ferghana	Piloted IMCI quality improvement (QI) projects	Roll-out IMCI QI projects including within Ferghana Oblast, through links to GP training, through links to other donors/projects. Link closely with Navoiy Oblast child survival project to expand QI.	Evolve into long-term, sustainable linkages and synergies between system level EBM promotion and CPG development and facility level QI and CPG implementation	P, R, O
TB	Excess capacity in vertical system, not evidence-based treatment, reach of vertical system no longer able to control all TB-related issues	None	Minimal	Not comprehensive activities initiating integration of general health system and vertical TB system due to strength of vertical system. Activities focused on integration into medical education, incorporation of IPCS, and health promotion	As Uzbekistan moves to Phase III of the reforms with a greater focus on hospital restructuring, the vertical health systems and their relationship to the general health system will likely become a higher priority issue.	O
HIV/AIDS	Not yet emerge	None	Minimal	Link to Safe Motherhood, link to GP training, include as priority health promotion topic in patronage nurse program	Many constraints and challenges but a comprehensive strategy needed on the relationship between the general health system and the vertical HIV/AIDS system	O
Population and Community Health						
Marketing the Reforms	Population role not seen as important	Minimal	Activities marketing the reforms through NGOs and CBOs such as Mahallas	Due to crack-down on NGOs, the mechanism changed from direct work with NGOs to reaching out from SVPS which are government entities to communities through town meetings and other activities	Need will grow, nature and scale of activities dependent on country environment	O
Health Promotion -- Government	Not yet emerge	None	Limited support for Institute of Health in their health promotion campaigns	Limited support for Institute of Health in their health promotion campaigns	Limited support for Institute of Health in their health promotion campaigns	O

Project Component	At Independence	ZdravReform	ZdravPlus	ZdravPlus II To Date	and Beyond	Roll-out
Health Promotion -- Providers Linked to Service Delivery	Not yet emerge	General health promotion activities in pilot oblast of Ferghana	Expand health promotion activities by establishing SVPs as community resource centers	Strengthen linkage between health promotion activities and service delivery priority programs. Initiate national patronage nurse program where nurses become a channel for informing the population.	Continue patronage nurse program and strengthen linkage with service delivery priority programs.	O
Health Promotion -- Community-Based Entities	Not yet emerge	Minimal	Establish Mahalla Initiative Groups (MIGs) and work with them to empower the population and involve the community in health.	Due to crack-down on foreign firms, activities are more limited and the mechanism changed from direct linkages to MIGs to reaching out to Mahallas from SVPs	Nature and scale of activities dependent on country environment	O

Developing: Kazakhstan Health Systems Indicators



Developing: Kyrgyz Republic Health Systems Indicators

95% Conf. Intervals

Country= 

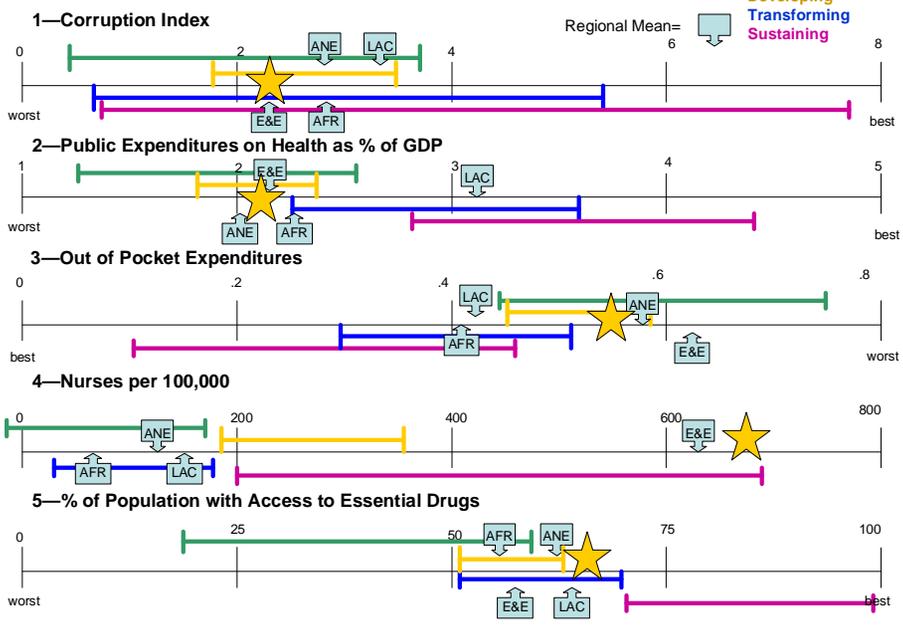
Rebuilding █

Developing █

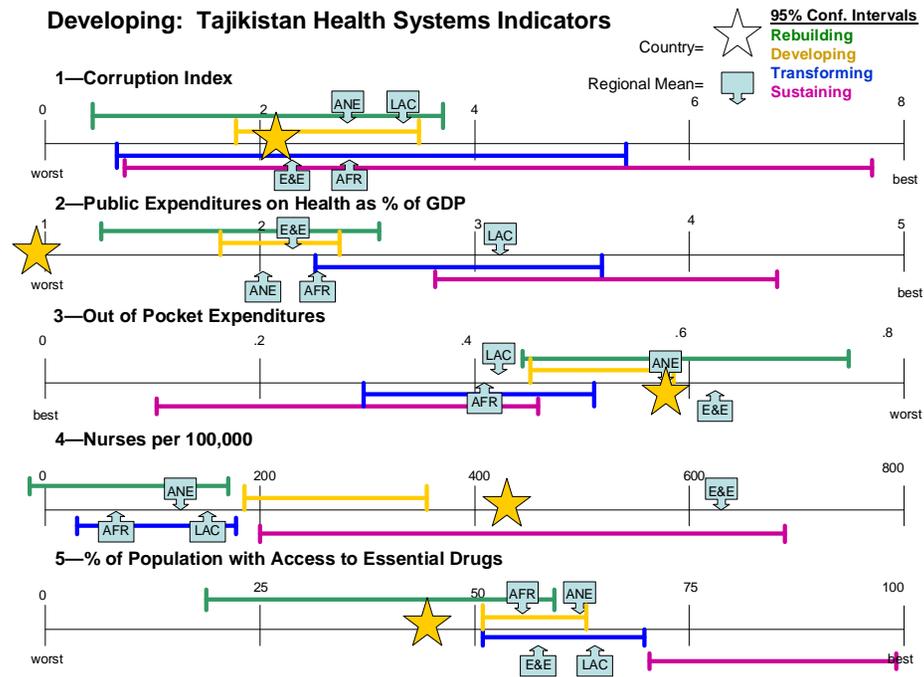
Transforming █

Sustaining █

Regional Mean= 

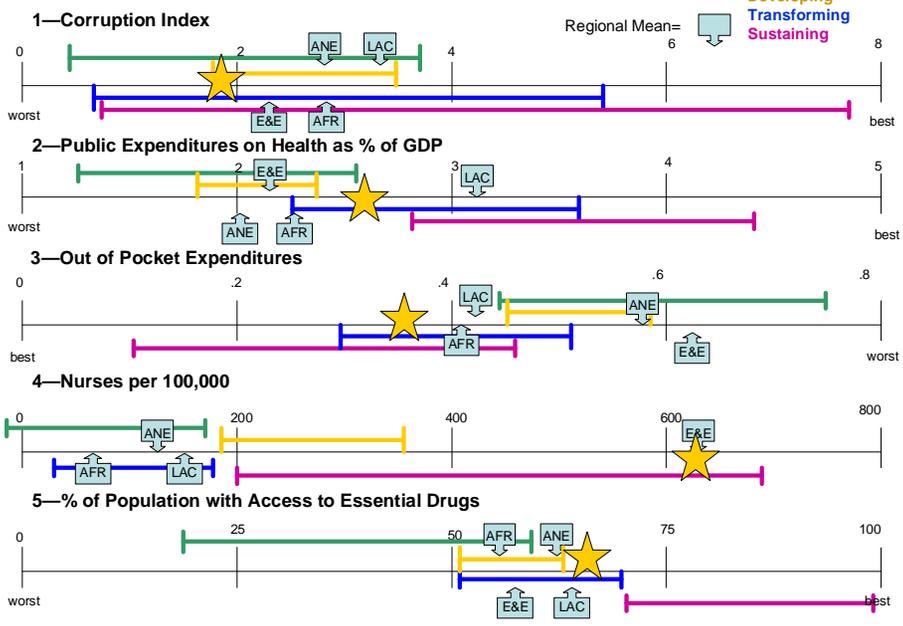


Developing: Tajikistan Health Systems Indicators



Developing: Turkmenistan Health Systems Indicators

Country=  95% Conf. Intervals
 Rebuilding 
 Developing 
 Transforming 
 Sustaining 
 Regional Mean= 



Developing: Uzbekistan Health Systems Indicators

