

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

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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.	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

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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