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# ANNUAL REPORT OF THE QUALITY HEALTH CARE PROJECT OCTOBER 2011



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OCTOBER 2011

## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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# ACRONYMS

<b>ACSM</b>	Advocacy, Communication, and Social Mobilization
<b>AH</b>	Arterial hypertension
<b>ANC</b>	Antenatal care
<b>APMG</b>	AIDS Projects Management Group
<b>ART</b>	Anti-retroviral therapy
<b>ARV</b>	Anti-retroviral
<b>BBP</b>	Basic Benefits Package
<b>BSL</b>	Bio-safety Level
<b>CAH</b>	Community Action for Health
<b>CAR</b>	Central Asian Region/Republics
<b>CARHAP</b>	Central Asia HIV/AIDS Program - Kyrgyzstan, Uzbekistan, Tajikistan
<b>CBO</b>	Community-based organization
<b>CCM</b>	Country Coordinating Mechanism (Global Fund)
<b>CDC</b>	US Centers for Disease Control and Prevention
<b>CHSD</b>	Center for Health Systems Development
<b>CME</b>	Continuing Medical Education
<b>CP</b>	Clinical protocol
<b>CPG</b>	Clinical Practice Guideline
<b>CQI</b>	Continuous Quality Improvement
<b>CSW</b>	Commercial sex worker
<b>CVD</b>	Cardiovascular disease
<b>DOTS</b>	Directly observed treatment, short course
<b>DST</b>	Drug sensitivity testing
<b>EBM</b>	Evidence-based medicine
<b>EDL</b>	Essential Drug List
<b>EMOC</b>	Emergency Obstetric Care
<b>EPC</b>	Effective Perinatal Care
<b>EQA</b>	External Quality Assurance
<b>EU</b>	European Union
<b>FAP</b>	Rural PHC post without doctors
<b>FGP</b>	Family Group Practice
<b>FGPNA</b>	Family Group Practice and Nurses Association (Kyrgyzstan)
<b>FM</b>	Family Medicine
<b>FMC</b>	Family Medicine Center
<b>FMSA</b>	Family Medicine Specialists Association
<b>FP</b>	Family Planning
<b>FSU</b>	Former Soviet Union
<b>GDF</b>	Global Drug Facility
<b>GFATM</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GHI</b>	Global Health Initiative
<b>GIS</b>	Geographic Information Systems
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>GLC</b>	Green Light Committee
<b>GMS</b>	Grant Management Solutions
<b>GO</b>	Government Organizations
<b>HA</b>	Hospital Association
<b>HCDI</b>	Health Care Development Institute
<b>HIS</b>	Health Information System
<b>HPAC</b>	Health Policy Analysis Center
<b>HSS</b>	Health Sector Strategy or Health System Strengthening

<b>IC</b>	Infection control
<b>ICAP</b>	International Center for AIDS Care and Treatment Programs
<b>ICS</b>	Inventory control system
<b>IDU</b>	Injecting drug user
<b>IEC</b>	Information, Education, and Communication
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IPC</b>	Infection prevention and control
<b>IPCC</b>	Interpersonal Communication and Counseling Skills
<b>IPCS</b>	Interpersonal Communication Skills
<b>IPT</b>	Isoniazid preventive therapy
<b>IT</b>	Information technology
<b>IUD</b>	Intrauterine device
<b>KAFP</b>	Kazakhstan Association of Family Physicians
<b>KCH</b>	Keeping Children Healthy
<b>KfW</b>	German Development Bank
<b>KMPA</b>	Kazakhstan Association of Sexual and Reproductive Health
<b>KSMIRCE</b>	Kyrgyz State Medical Institute for Retraining and Continuing Education
<b>LED</b>	Light-emitting diode
<b>LMIS</b>	Logistics management information system
<b>M&amp;E</b>	Monitoring and evaluation
<b>MAC</b>	Medical Accreditation Commission
<b>MARP</b>	Most at-risk population
<b>MAT</b>	Medication-assisted therapy
<b>MCH</b>	Maternal and Child Health
<b>MCHI</b>	Maternal and Child Health Institute (Turkmenistan)
<b>MDR-TB</b>	Multi-drug-resistant tuberculosis
<b>MGIT</b>	Mycobacteria Growth Indicator Tube
<b>MHIF</b>	Mandatory Health Insurance Fund
<b>MIA</b>	Ministry of Internal Affairs
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>MOHMIT</b>	Ministry of Health and Medical Industry of Turkmenistan
<b>MOJ</b>	Ministry of Justice
<b>MOU</b>	Memorandum of understanding
<b>MSM</b>	Men who have sex with men
<b>NCC</b>	National Coordination Council of the Country Coordination Mechanism for the GFATM
<b>NCD</b>	Non-communicable disease
<b>NCTP</b>	National Center for TB Programs
<b>NDRA</b>	National Drug Regulatory Authorities
<b>NGO</b>	Non-governmental organization
<b>NICT</b>	National Institute of Cardiology and Therapy
<b>NRL</b>	National Reference Laboratory
<b>NTBC</b>	National TB Center (Kyrgyzstan)
<b>NTP</b>	National Tuberculosis Program
<b>OB</b>	Obstetric
<b>OHD</b>	Oblast Health Department
<b>OPHT</b>	Other public health threats
<b>OR</b>	Operational research
<b>P4P</b>	Pay-for-performance
<b>PA</b>	Professional Association
<b>PAL</b>	Practical Approach to Lung Health
<b>PD-3</b>	USAID Policy Paper on Population Assistance & Policy Determination 3
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief

<b>PGI</b>	Post-Graduate Institute
<b>PGMI</b>	Post-Graduate Medical Institute
<b>PHC</b>	Primary Health Care
<b>PIU</b>	Project implementation unit
<b>PLHIV</b>	People Living with HIV
<b>PMP</b>	Project monitoring plan
<b>PMTCT</b>	Prevention of Mother to Child Transmission of HIV
<b>PPS</b>	Provider Payment Systems
<b>PR</b>	Primary recipient
<b>PRA</b>	Participatory Rapid Assessment
<b>QI</b>	Quality Improvement
<b>QMS</b>	Quality Management System
<b>R&amp;R</b>	Reporting and Recording
<b>RBF</b>	Results-Based Financing
<b>RH</b>	Reproductive Health
<b>SDC</b>	Swiss Development Corporation
<b>SES</b>	Sanitary Epidemiological Service
<b>SM</b>	Safe Motherhood
<b>SNRL</b>	Supra-National Reference Laboratory
<b>SOP</b>	Standard operating procedure
<b>STI</b>	Sexually transmitted infection
<b>STLI</b>	Scientific Technology and Language Institute
<b>STP</b>	Standard Test Procedures
<b>SWAp</b>	Sector-Wide Approach
<b>TB</b>	Tuberculosis
<b>TB-IC</b>	TB Infection Control
<b>TOT</b>	Training of Trainers
<b>TSMU</b>	Tajik/Turkmen State Medical University
<b>TWG</b>	Thematic Working Group
<b>UIC</b>	Unique Identifier Code
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States Government
<b>VCRT</b>	Voluntary counseling and rapid testing
<b>VCT</b>	Voluntary counseling and testing
<b>VHC</b>	Village Health Committee
<b>WHO</b>	World Health Organization
<b>XDR-TB</b>	Extensively drug-resistant tuberculosis

## **1. INTRODUCTION**

The USAID Quality Health Care Project (Quality Project) is a five-year program to improve the health status of Central Asians by using a health systems strengthening approach to build the capacity of public health systems, institutionalize quality improvement methodologies at all levels of health services management, improve health outcomes in TB, HIV, maternal and child health and cardiovascular disease, and empower communities to respond to their own health needs.

The Quality Project will provide technical assistance, training, equipment and commodities to assist the Central Asian Republics to improve the quality, scope, and coordination of health services. By incorporating modern quality improvement techniques and evidence-based international standards into ongoing reforms of health systems, the Quality Project will assist Central Asian countries to improve their management, financing, and implementation of health services related to tuberculosis, HIV/AIDS, and maternal and child health services and cardiovascular disease.

From late 2010 until late 2012, the Quality Project will build upon the successes of past USAID health reform activities by continuing to improve access to quality public health and primary health care services. From late 2012 until late 2015, the Quality Project will sharpen the focus of its activities to strengthen public health responses to USAID health priorities in the region, especially tuberculosis and HIV/AIDS.

The project year of the five-year USAID Quality Health Care Project (Quality Project) project years is consistent with the U.S. Government fiscal year with Year 1 extending from contract signing date of September 7, 2010 to September 30, 2011. Year 1 activities focused on project start-up, strategy development and planning, and initiating program implementation. A procurement gap of more than one year made project start-up more difficult than average given additional management challenges and shifting USAID priorities. Nevertheless, project start-up was relatively quick and largely complete three months after the project started. The Quality Project Regional Strategy is contained in Appendix B (separate file attached). Project activities in all program areas were initiated and expanded as detailed in this annual report.

## **2. KAZAKHSTAN**

### **2.1 COUNTRY SUMMARY**

The overall Kazakhstan implementation strategy is to support the Government of Kazakhstan in implementing the State Health Care Development Program 2011-2015 particularly health systems strengthening and priority program quality improvement activities contributing to improving health outcomes in TB; HIV; maternal and child health, family planning, and reproductive health (MCH/FP/RH); and cardiovascular disease and other non-communicable diseases (CVD/NCD). Collaborations with other

projects and donors include the USAID Dialogue Project on HIV and TB; USAID TB CARE Project on TB; CDC Support Project on HIV; Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) on TB and HIV; World Bank Institutional Reform and Technology Transfer Project on health policy, health financing, health management, health delivery system restructuring and master planning, health information systems, evidence-based medicine, clinical practice guidelines, medical education, and quality improvement; WHO on health policy, health financing and MCH/FP/RH; UNODC on HIV; UNICEF and UNFPA on MCH/FP/RH; and the European Commission Central Asian Drug Action Program (CADAP) on HIV.

## **2.2 TB**

Despite having a high TB case notification rate ( $CDR^1= 80\%$ ), Kazakhstan's treatment success rate (64%) is the lowest in CAR. The country also suffers from a very high rate of relapse cases (23.5%). These low treatment success rates and high rates of relapse cases are contributing factors to Kazakhstan's continued high prevalence of TB and increasing rates of MDR-TB.

Meanwhile, Kazakhstan has been steadily increasing its budget for TB and has budgeted enough funds to improve the situation. Unfortunately, the structure of the vertical TB system itself is a barrier to effectively implementing the most effective TB control measures with these funds.

To address this situation, the Quality Project TB strategy is improving TB control by supporting implementation of a combination of QI processes and health systems strengthening activities to improve TB control by accelerating integration of services, improving the continuum of care, and strengthening management and coordination between services.

### **2.2.1 TB/NATIONAL LEVEL/LEGAL AND POLICY**

TB remains a serious public health problem in Kazakhstan, especially considering the high rates of TB drug resistance. MOH is coordinating TB control activities in the country through prikazes and national guidelines, as there is no separate national TB control plan in the country. All TB-related activities are included in Salamatty Kazakhstan, the State Health Care Development Program of Kazakhstan for 2011-2015.

In Year 1, the Quality Project assisted national partners in a variety of ways based on partner requests. At the national level, the Quality Project provided support to the TWG to strengthen TB policies and improve mechanisms for developing technical documents through participation in TWGs. At the request of NCTP, the Quality Project organized and conducted a five-day workshop on ACSM for specialists from

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<sup>1</sup> *Case Detection Ratio (CDR) = Total new + relapse cases/estimated incidence cases*

the national and oblast levels, international partners, and local NGOs, resulting in a draft national ACSM program for TB control.

The presence of TB drugs on the open market is a serious problem in Kazakhstan. The Quality Project reviewed documents and regulations related to the availability of TB drugs in the open market to prepare recommendations for policy discussions with MOH and NCTP representatives.

While national TB manuals and M&E guidelines are available, they were published between 2008 and 2009, and need to be reviewed and updated based on the latest WHO recommendations.

Currently, Kazakhstan has no TB-IC manuals or implementation plans. At a joint meeting between the Quality Project, TBCARE, and NCTP, representatives created a TB-Infection Control (TB-IC) TWG to develop TB-IC documents that will include guidance for the PHC level.

### ***2.2.2 TB/NATIONAL LEVEL/DRUG MANAGEMENT***

An uninterrupted and sustained supply of quality-assured anti-TB drugs is fundamental to TB control. For this purpose, an effective drug supply and management system is essential. In Kazakhstan, MOH procures TB drugs (first line and second line) in a centralized way. PIU GFATM provides second line TB drugs through the Green Light Committee, and the Global TB Drug Facility has delivered pediatric dosages of first line TB drugs for the last two years. With the assistance of USAID, LMIS was first introduced and then implemented in Kazakhstan from 2007 to 2009, followed by national scale-up after MOH approved the system for first line TB drugs by prikaz. This LMIS now forms the basis for TB drug management in Kazakhstan.

The Quality Project conducted assessments of LMIS implementation in Almaty and East Kazakhstan Oblasts and identified problems with general TB drug management and with second line TB drug procurement, distribution, storage, and rational drug use. Findings and recommendations were shared with NCTP representatives in September 2011, and a plan to address recommendations has been agreed upon by national partners. The Quality Project also provided technical assistance to East Kazakhstan Oblast TB hospitals to prepare MOH requests for second line drugs in response to the coming amnesty for prisoners in 2011.

### ***2.2.3 TB/SERVICE DELIVERY/PHC LEVEL***

Integration of TB services at the PHC level in Kazakhstan began with the implementation of DOTS in 1998. One of the main objectives of the Quality Project TB Strategy is to solidify this integration through piloting and roll-out of PHC-level CQI on key TB topics with the support of KAFP. It is expected that these improvements will increase case finding; assure that the diagnostic algorithm is followed; improve observation of treatment; increase treatment success; and reduce development of MDR-TB cases.

The Quality Project, together with Almaty and East Kazakhstan Oblast representatives, identified four rural PHC facilities and two city polyclinics in which to implement CQI methodology (an additional nine

facilities were identified to be added in September). Quality Project staff conducted rayon-level introductory meetings to raise awareness of QI as an internationally-accepted methodology to improve the quality of service delivery. At each site, the Quality Project conducted participatory CQI trainings, resulting in prioritization of facility-identified quality gaps in TB care, concrete improvement plans, and monitoring plans. The Quality Project assisted in the development of QI instruments to improve the identification and management of TB suspects and conducted regular mentoring and follow-up visits.

The second level of the PHC per capita payment system has started in Kazakhstan, and the Quality Project has linked TB PHC CQI indicators to the PHC per capita payment system to ensure that proper TB indicators for the PHC payment system will be used.

#### ***2.2.4 TB/SERVICE DELIVERY/HOSPITAL LEVEL***

Like all countries in Central Asia, the TB system in Kazakhstan is in need of transformational reform. Fortunately, Kazakhstan is in a position to execute and finance such reforms. The Quality Project is working to catalyze reform and integration of health services, and is prioritizing facility restructuring to reduce the risk of nosocomial infections and the spread of MDR-TB.

The Quality Project conducted an assessment of Talgar Regional TB hospital with the WHO TB Mission and provided recommendations to improve TB-IC. The Quality Project also conducted a preliminary TB-IC assessment of TB hospitals in East Kazakhstan Oblast in collaboration with facility epidemiologists. The assessment highlighted a number of problems, including lack of patient separation due to building design; lack of equipment for measuring the effectiveness of environmental IC measures; and an expected shortage of respirators for staff.

#### ***2.2.5 TB/SERVICE DELIVERY/LAB***

The laboratory network of Kazakhstan is well equipped in comparison to other countries in Central Asia. However, there remains a need to strengthen all levels of the laboratory system through capacity building of staff; expansion of the blinded method of EQA to the entire country; development of a quality assurance system for culture; strengthening of various TB diagnostic methods (e.g. from microscopy to advanced methods); development of national laboratory training materials; and assistance in the creation of a national program to strengthen the laboratory system.

The Quality Project conducted an assessment of Kazakhstan's laboratory system, including QMS in Almaty and East Kazakhstan Oblasts. In line with the assessment results which identified weakness in smear microscopy work and at the request of the East Kazakhstan Oblast TB hospital, the Quality Project conducted two basic trainings on smear microscopy.

The Quality Project participated in preparation of the laboratory session at the National Conference on Modern Technologies in Diagnosis and Treatment of MDR-TB in the civil and penitentiary system of Kazakhstan and regularly participated in TWG meetings on the national program on laboratory development, national training guidelines, and SOPs.

### **2.2.6 TB/COMMUNITY ACTION FOR HEALTH**

In order to improve CAH, the Quality Project is working with a bottom-up and top-down approach to help empower communities to be more involved in addressing the health issues facing them. In Kazakhstan, many partners, national and international, are engaged in TB patient education and TB awareness among the general population and high risk groups. Their activities are planned to improve case detection and treatment adherence; combat stigma and discrimination; empower people affected by TB; and mobilize political commitment, communities, and resources for TB.

Despite strong collaboration among partners in CAH, vulnerable populations (MARPs) have been largely untouched by their activities. In partnership with the Dialogue Project, a comprehensive strategy is being developed to provide needed support to all patient populations. In addition, the Quality Project took the lead in facilitating a CAH TWG composed of national and international partners to identify best CAH practices, share tools and methodologies, and develop a national ACSM strategy to institutionalize effective approaches and introduce a system of M&E. To increase community involvement, the Quality Project conducted a preliminary mapping of CBOs and solicited increased involvement in TB-CAH activities.

To improve the communication and counseling skills of health providers, the Quality Project revised and finalized training materials on Interpersonal Communication and Counseling Skills (IPCC) with a particular focus on TB ambulatory treatment in order to prepare PHC providers to assume an expanded scope of services. After revising training modules, the Quality Project conducted a TOT on IPCC for national- and oblast-level specialists. TOT participants who demonstrated the strongest IPCC skills were selected to conduct cascade trainings for TB and PHC-level staff.

To raise awareness on World TB Day, the Quality Project, in collaboration with the National Center for TB, the Dialogue Project, Kazakh National Medical University, and NCHL, supported a number of World TB Day activities, including conferences, a training workshop for journalists, and a TB awareness and publicity campaign in Almaty.

The Quality Project also signed an agreement with Internews Agency to broadcast video clips on TB symptoms and treatment adherence that were developed through a previous USAID project.

### **2.3 TB/HIV**

HIV incidence is increasing and becoming a more serious public health problem taking into account the high TB/MDR-TB burden in Kazakhstan. MOH issued a prikaz on strengthening collaboration of TB and HIV services in 2009 which includes national recommendations for the management of TB/HIV patients, intensified TB and HIV case finding, and isoniazid preventive therapy (IPT) for PLHIV.

While nearly all TB patients are tested for HIV (96% in 2010), screening fluorography and initiation of IPT is low among PLHIV, despite the wide availability of isoniazid. TB/HIV working group meetings are held irregularly. In short, collaboration between TB and HIV systems needs to be improved.

In Year 1, the Quality Project became a member of the TB/HIV TWG, participated in meetings, and provided recommendations to update existing regulations on co-infection. The Quality Project also began work in East Kazakhstan Oblast to engage the TB and HIV services in regular dialogue to improve systems for detection and management of co-infected patients.

## **2.4 HIV**

While HIV epidemics are driven by individuals in complex, unique settings, the protocols and individuals that drive national responses are key to stabilizing HIV in Kazakhstan. At the national level, the Quality Project seeks to improve the systemic weaknesses and capacity deficits that prevent MARPs from accessing high-quality HIV prevention, care, and treatment services by increasing the technical knowledge of decision makers, and working with those individuals to improve practice standards at the national level. As a critical intervention for long-term HIV risk reduction for IDUs, medication-assisted therapy (MAT) remains a priority focus for the Quality Project. However, considering both political concerns and comparative advantages with other projects working in this area, the Quality Project is focusing primarily on addressing special topical and operational issues that affect MAT scale-up. The Quality Project is also focusing on supporting ongoing GFATM grants, and particularly on helping Kazakhstan to transition to a GFATM-free environment, where programs can be supported with state funding. With all levels of intervention, as the Quality Project matures, best practices that have been successful in localities will be transferred to the national level for scale-up and institutionalization.

Populations most at risk for HIV infection and transmission often have complex social needs. From an outreach worker's first contact to repeated clinic visits for treatment of on-going medical conditions, each encounter with a member of a MARP group provides the opportunity to link individuals in need with the social and psychosocial support that can help to limit unsafe behaviors that promote the expansion of the HIV epidemic. On the national level, the Quality Project is working to assure that a range of social support services are introduced and continually improving to meet the needs of the populations they serve. Types of social support include trained social workers for MARPs, services from NGOs and CBOs, and self-help groups.

MARPs are often marginalized based on society's perception of their actions as illegal or immoral. Access to even basic services, let alone complex medical and social support services, may be limited by lack of documentation, discrimination, and breaches of confidentiality. Furthermore, the policy frameworks that would help reduce the spread of HIV (e.g. harm reduction in prison) are often absent. The Quality Project is actively working to identify major legal and policy barriers, as well as respond to those brought up by local and development partners, to improve the environment for MARPs. Key issues include the re-documentation of MARPs; the expansion of the VCT system to focus not only on

MARPs but to reach them where they are most likely to access services; and the institutionalization of a professional social work position for providing comprehensive case management services to MARPs.

Currently, MARPs seek care almost exclusively from AIDS centers. This is both geographically limiting and problematic for MARPs who are HIV-negative, yet require other, non-HIV related health services. The crux of the Quality Project strategy for improving access for MARPs is to expand the number of facilities where MARPs can access basic care services and the range of services they can receive. These increase Entry Points into the health system and provide opportunities for medical and non-medical personnel to assess MARPs risks and encourage VCT. Additionally, for MARPs who test positive for HIV, access to high-quality, geographically feasible HIV care and treatment is critical for both their own care and for the sake of positive prevention efforts. The Quality Project is working in target localities with high concentrations of MARPs to address these challenges through training, mentoring, and other expert support.

NGOs remain the driving force behind social support services for MARPs in Kazakhstan. These organizations play a critical role and may offer a select number of high quality services to MARPs, but often fall short in addressing the more comprehensive social needs of the population. Within target localities, the Quality Project is working with NGO partners to increase the range of social support services available, as well as updating existing services with new methodologies and best practices. Through the provision of professional development opportunities for select personnel, as well as on-going mentoring of organizational staff, it is expected that the Quality Project will encounter lessons and models that can be scaled up and potentially institutionalized on the national level. Additionally, in order to demonstrate the success needed for national buy-in, the Quality Project will train the first cadre of professional MARPs social workers from these localities, where project evaluation efforts can focus on specific benefits that the population receives from the fledgling profession.

#### ***2.4.1 HIV/NATIONAL LEVEL/PREVENTION, CARE, AND TREATMENT***

During Year 1, the Quality Project worked to identify major weaknesses in technical knowledge and perspective at the national level, and address those through high-level trainings and workshops on special topical issues, including the management of effective HIV prevention programs for IDUs, MAT operational issues, and harm reduction practices for high-risk women. A complete review of HIV CPs was conducted, and the Quality Project installed anti-retroviral (ARV) forecasting software at the Republican AIDS Center. Key staff were trained to use this software, and on-going support is provided through a local consultant and weekly virtual consultations with Quality Project specialists. The Quality Project also conducted a regional meeting of PLHIV organization representatives, with the specific focus of discussing the current stakeholder engagement of PLHIV in health services, and how this can be improved and appropriate models can be institutionalized. Follow-up work on this topic will be ongoing in Year 2.

#### **2.4.2 HIV/NATIONAL LEVEL/SOCIAL SUPPORT**

In Year 1, the Quality Project focused primarily on the support services provided by the NGO sector, conducting baseline focus group discussions with MARPs to assess gaps in services, and providing training to outreach organizations to expand the package of services provided to MARPs. This included national coverage of NGOs with human resources management training, and the inclusion of NGOs in other high-level trainings that covered elements of social support for MARPs. However, it has become apparent throughout this work that significantly more effort is need to expand the range of sustainable, institutionalized support services, and that professional tracks need to be established for the individuals providing these services, whether in government or non-governmental facilities. This realization has guided the restructuring of the HIV sub-elements in this strategy and will become a sub-element of major focus in upcoming years, with significantly more attention than was devoted in Year 1.

#### **2.4.3 HIV/NATIONAL LEVEL/LEGAL AND POLICY**

During Year 1, the Quality Project engaged partners on the importance of harmonizing a unique identifier code (UIC) to be used across all outreach and care institutions to allow for proper assessment of coverage of MARPs, and worked to evaluate the overall legal and policy challenges within the framework of HIV in order to build a set of priority activities for Year 2 (see below).

#### **2.4.4 HIV/LOCALITY STRENGTHENING/PREVENTION, CARE, AND TREATMENT**

During Year 1, the Quality Project selected Entry Points to focus on within the chosen localities in Almaty and Temirtau. These facilities, which were already providing some basic level of access to services for MARPs, were chosen for further expansion and strengthening of services over the next five years. Staff from Entry Point facilities participated in an interactive roundtable discussion, meant to have the dual purpose of reaffirming best VCT practices, while identifying barriers and weakness in current VCT practice. From this experience, a training course was developed to address the difficulties that health care workers reported in interpersonal communications with MARPs, while initiating and providing VCT. This training was provided to an initial cadre of health care workers in Year 1, and will be continued until all relevant staff at Entry Points have been trained in Year 2. In addition, this model of interpersonal communications skills-based training will be expanded to other topics where needs have become apparent, including special topics in caring for patients with substance-use issues, introducing harm reduction services and brief interventions during regular care visits. Additionally, during Year 1, management and clinical staff of Entry Points were prioritized for participation in other Quality Project trainings and events.

#### **2.4.5 HIV/LOCALITY STRENGTHENING/SOCIAL SUPPORT**

In Year 1, the Quality Project built strong relationships with NGOs within localities, including them preferentially in all training and workshop events for civil society audiences. During the course of trainings, it became apparent that many NGOs would benefit from on-going mentoring to expand the range and quality of services available for MARPs; in response, the Quality Project has included this as a

major activity for Year 2. The Quality Project also engaged in efforts specifically directed at improving and systematizing the relationship between NGOs and government health facilities in assuring a continuum of care for MARPs. During an interactive meeting on NGO brokering (a term used to describe the ways in which NGOs negotiate access to health care services for MARPs) NGO leadership from localities worked with Quality Project staff to assess their successes, challenges, and hopes in working with government health facilities. Quality Project specialists, in turn, have shared some successful models that have been used in other countries. As Year 1 draws to a close, the Quality Project continues to work with NGO partners to develop a plan for Year 2 support of NGO brokering, which will include on-going mentoring and close collaboration with Entry Point facilities.

## **2.5 MCH/FP/RH**

### **2.5.1 MATERNAL HEALTH**

The quality of antenatal and perinatal care in Kazakhstan is still not in compliance with international scientific standards and WHO recommendations, and the capacity of medical staff to identify and manage OB complications is underdeveloped. There is also significant disparity by region in levels of access to quality care. However, the Government of Kazakhstan is committed to the improvement of MCH and has endorsed a long-term strategy and implementation plan for MCH based on WHO strategic approaches and tools, as part of the National Program on Health System Development, Salamatty Kazakhstan (2011-2015).

The Quality Project provided technical assistance in revising the ANC module and in developing instruments for assessing quality of services provided in maternities based on WHO recommendations. To develop capacity of clinical mentors, the Quality Project adapted a module on clinical mentoring and is working with MOH to obtain approval for national use.

Kyzylorda was selected as a pilot oblast for activities to improve quality of care for mothers and newborns. Activities included ANC training and monitoring, and assessment of service delivery quality at maternity hospitals and women's consultation clinics. To ensure ownership and sustainability, these activities were co-financed by oblast authorities.

### **2.5.2 CHILD HEALTH**

Kazakhstan was the first of the FSU countries to introduce IMCI in 1999. The program has gradually been scaled up to five of Kazakhstan's 14 oblasts. In 2008, MOH decided to adopt IMCI as an integrated national policy.

The Quality Project collaborated with WHO to develop a full package of IMCI materials, including a facility assessment checklist; patient survey; and medical worker and health manager interview instruments. These instruments, which have been adapted for use in Kazakhstan, are integral to facility-

level QI processes to monitor and assess implementation. The Quality Project is also providing technical support to incorporate neonatal IMCI into the EPC training program.

### ***2.5.3 FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)***

Although Kazakhstan has seen an increase in the use of modern contraceptive methods in recent years, abortion rates continue to be high compared to economically developed countries. With rising income levels, donor support for contraceptive security is minimal. However, not all oblast health departments procure contraceptives regularly as the State Guaranteed Benefits Package includes free consultation and FP services, but does not include contraceptive methods. Low levels of contraception literacy among the population, combined with relatively high prices for modern contraceptives such as combined oral contraceptive pills act as barriers to access.

Information and education materials on FP previously developed by USAID ZdravPlus were provided to MOH for dissemination in PHC facilities. A working group of national trainers and FP experts was formed to review and update CPs on FP.

## ***2.6 CVD/NCD***

CVD remains the leading cause of mortality among adults in Kazakhstan and has been prioritized in the State Health Care Development Program 2011-2015. Evidence-based approaches to hypertension at the PHC and hospital levels have been adopted through a CPG on AH developed collaboratively by the Cardiology Institute, KAFP, and USAID ZdravPlus Projects in 2009. The PHC P4P system introduced in 2010-2011 creates financial incentives for PHC providers to improve detection and control of arterial hypertension at the PHC level and decrease AH-associated hospitalization rates.

In Year 1, KAFP planned to support the AH CPG implementation through its branches. However, due to the late approval of the KAFP grant and reduction of OPHT funding, KAFP shifted focus to target TB. CVD activities were limited to developing the outline of the CVD/AH Package that would include the AH CPG, AH training module, AH patient club materials, and CQI tools for complete institutionalization.

## ***2.7 HSS/LEGAL AND POLICY***

The overall legal and policy framework is critical in Kazakhstan as growing funding and government capacity increase the probability that policies, laws, and regulations will be implemented. The State Health Care Development Program 2011-2015 will serve as the main mechanism for broad health policy dialogue including working groups, policy content, and further development of the legal and regulatory framework.

The Quality Project established working relationships and routinely engaged in discussion with MOH and all national agencies, including the National TB Institute, the Republican AIDS Center, and National MCH

Centers. In Year 1, the Quality Project implemented approximately 90 technical activities, including working group meetings, presentations, roundtable discussions, individual counseling, and technical papers. Throughout these activities, the Quality Project engaged MOH policy and technical staff, as well as staff from subordinating national agencies, to educate them on health reform conceptual and technical approaches with a focus on health financing; single payer and provider payment; and improving health policy processes and content. These activities were of particular importance as MOH leadership has changed in the reporting year. The Quality Project and its grantee, KAFP, collaborated with World Bank Project Component Twinning Partners on HSS, quality improvement, provider payment, and CPG development to ensure consistency in policy messages and technical methodologies.

## **2.8 HSS/HEALTH FINANCING**

Health financing activities in Kazakhstan are designed to maximize the link between the growing health budget and ensuring access, equity, and equal financial risk protection for vulnerable populations, while also continuing to make progress in increasing efficiency and allocating savings to PHC, direct patient care, and quality improvement for priority programs. The highest priority health financing activity will be contributing to the TB HSS strategy of creating linkages and synergies between roll-out of TB PHC CQI and including TB indicators in P4P or the second level of the PHC per capita payment system.

From 2010-2011, MOH and the Government of Kazakhstan made a critically important decision to move away from hospital provider payment based on medical economic tariffs to clinical statistical groups (diagnosis-related groups). This shift will have strategic implications for further restructuring of the health care system. During the shift, the Quality Project provided intensive political and technical support, including leading technical presentations and discussions within the national working group to create informed support for the new PPS, and revising clinical statistical group classifications and relative weights.

The Quality Project supported further improvement of the State Guaranteed Benefit Package funding and the health provider reward system by contributing to the key regulatory documents approved by MOH in 2011. These key regulatory documents include MOH Prikaz #180 which approves the revised tariff setting and expenditure planning for health services provided within the State Guaranteed Benefit Package; and MOH Prikaz #310 which regulates differentiated reward of health workers based on the P4P methodology.

Through dialogue with NCTP and participation in national working group meetings, the Quality Project provided technical recommendations on the menu of TB indicators for PHC P4P payment, and helped envision the relationship between PHC P4P payment and TB PHC QI sites in driving improvement in TB outcomes in Kazakhstan. The Quality Project discussed a master plan for health care system restructuring and investment prioritizing TB system restructuring and financing with the World Bank Project Twinning Partner, Sangiest Company.

## **2.9 HSS/PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES**

Over the last few years, quality improvement and strengthening of health management have become more visible as Government and MOH priorities. Taken together, State Health Care Development Program 2011-2105 and World Bank Technology Transfer and Institutional Reform Project priorities, a relatively open society, an acceptance of CQI processes and improved health management techniques, and blossoming examples in CVD and MCH all argue that the time is ripe to increase awareness of QI, improve health management, and expand improvements in health systems functions across all priority programs.

As the new P4P system strongly incentivizes health providers to achieve quality targets, the appropriate selection of indicators is critical for the overall success of the PHC P4P system. In Year 1, the Quality Project engaged in dialogue with MOH, HCDI, and NTBI to review and revise PHC-level P4P indicators on TB, recommending inclusion of both process and outcome indicators that would be explicitly linked to facility-level CQI processes.

In conjunction with STLI consultants, Quality Project helped to build capacity of National Medical University trainers, its EBM Center, and School of Public Health, providing a series of interactive workshops and lectures discussing overall quality improvement, health system barriers to quality, and health system contributors to quality, and providing practical examples of applied EBM and OR. In collaboration with World Bank Project twinning partners, KAFP contributed to the creation of a list of PHC and hospital CPGs prioritized for development/revision under the World Bank Project, including CPGs on Practical Approach to Lung Health (PAL), IMCI, arterial hypertension, and EPC, and non-genital pathology which is currently prioritized by MOH. The Quality Project provided Guidelines International Network (GIN) subscriptions to over 20 key national and research institutions and NGOs.

## **2.10 HSS/INSTITUTIONALIZATION FOR SUSTAINABILITY**

Institutionalization for sustainability is a very high priority in Kazakhstan as the growing health budget means that new methodologies and tools can be incorporated into operational processes and routine work. Institutional roles and relationships of entities including MOH, MOF, the Ministry of Economic and Budget Planning, Health Purchasing Committee, Health Development Institute, educational institutions, providers, and PAs are important to avoid overlapping or duplicating roles, competition, or lack of clarity on long-term roles of institutions and what interventions and improvements will be institutionalized where.

In Year 1, the Quality Project engaged in several capacity-building exercises to help improve and institutionalize the processes of CPG development and implementation. Trainings on CPG development methodology and on development of CPG implementation indicators were conducted for HCDI, MCH centers, and NTBI. KAFP continued to support FM CME departments and residencies.

## **2.11 HSS/COUNTRY M&E, OR, AND HIS**

OR is intended to identify best practices and document successful innovation for replication within the framework of the Quality Project. The results of OR studies will be used to inform policy makers and stakeholders about important issues in the health system and serve as a basis for further development of health policy in the county. Results will also be used to inform Quality Project activities and interventions. The nature of OR is not bound by project or calendar year; as such, some projects begin in one year and finish in another.

After internal deliberation, the Quality Project prioritized an HIV/AIDS OR study for Year 1, entitled “Legal barriers to public funding for NGOs providing HIV/AIDS prevention activities”. The aim of the OR study is to analyze whether there are legal barriers or other barriers to funding HIV/AIDS prevention NGOs from the state budget through a State-Social Request (“Gosudarstvennyi-socialnyi zakaz”). This topic is timely and important because GFATM has reduced funding to Kazakhstan.

In collaboration with experts from Health Policy Analysis Center (HPAC) Kyrgyzstan, the Quality Project developed a proposal, concrete research questions, and methodology, including sampling and research tools. In line with the OR study methodology, the Quality Project reviewed the existing legislative base and funds flow of the State-Social Request, and conducted semi-structured interviews with HIV prevention NGOs, the Republican AIDS Center, and oblast and city AIDS centers. In September 2011, the Quality Project will present the final report, produce short policy briefs based on the findings, and hold a workshop to present results to key stakeholders.

## **3. KYRGYZSTAN**

### **3.1 COUNTRY SUMMARY**

The overall Kyrgyzstan implementation strategy is to support the Government of Kyrgyzstan in implementing the Manas Taalimi National Health Sector Reform Strategy and sector-wide approach (SWAp) particularly health systems strengthening and priority program quality improvement activities contributing to improving health outcomes in TB, HIV, MCH/FP/RH, and CVD/NCD. Collaborations with other projects and donors include the USAID Dialogue Project on HIV and TB; USAID TB CARE Project on TB; CDC Support Project on HIV; GFATM on TB, HIV, and health systems strengthening; European Commission CADAP Project on HIV; DFID Central Asian Republics HIV/AIDS Program (CARHAP) on HIV; and all SWAp joint and parallel financiers on implementing Manas Taalimi/SWAp including World Bank, DFID, KFW, SDC, WHO, UNICEF, and UNFPA

### **3.2 TB**

Kyrgyzstan continues to battle a high prevalence of TB and MDR-TB. Despite small reductions in incidence and mortality reflected in official statistics, the situation remains concerning. Efforts put forth

by local leaders and international development partners to improve quality of TB care are often beset or hindered by real but difficult-to-measure issues such as corruption, poverty, emigration of medical workers and patients, frequent internal migration, stigma, and a host of health system issues which have yet to be adequately analyzed or addressed. Despite the barriers, change is possible and the Quality Project is beginning to see signs of meaningful health system reform to create an environment for rapid improvement of TB service delivery that should contribute not only to improved detection and treatment of drug-sensitive TB, but also to reduced rates of MDR-TB.

During the consultancy visit of Quality Project consultant Dr. Fabio Luelmo, Dr. Luelmo reviewed the organization and finance, case detection, treatment of TB, prevention of MDR-TB, and treatment of MDR-TB. Details of his visit are included in the consultancy report provided to USAID. Key priorities identified which will be implanted in Kyrgyzstan include:

- Coordination of external assistance, mainly in ACSM to obtain a political decision and support to implement building of the new central laboratory;
- Implementation of GeneXpert; definition of the priority groups and revision of clinical algorithms;
- Increased funding for SLD from national or external sources;
- Systematic screening of suspects by microscopy, ensuring registration of the smear positive cases detected; and using the number examined by PHC microscopy as an indicator of detection; and
- Improve data analysis and promote operational research for action.

### ***3.2.1 TB/NATIONAL LEVEL/LEGAL AND POLICY***

The primary focus was on contributing to the development of the new five-year national TB strategy and development of the next five-year health sector strategy, Den Sooluk, which will set the stage for meaningful health system reform to address numerous system barriers to quality TB care. Harmonization of these strategies and inclusion of key activities to improve service delivery was a primary goal of the intense work with the teams contributing to the writing of Den Sooluk.

### ***3.2.2 TB/NATIONAL LEVEL/DRUG MANAGEMENT***

The Quality Project provided intense technical support to develop NTBC's capacity in TB drug management, which was desperately needed due to frequent staff turnover. In addition, the Quality Project supported a situational analysis on use and management of second line drugs which showed a number of system barriers, primarily at the PHC level, including lack of proper storage conditions and reporting forms, and started work on development of LMIS for second line drugs. The Quality Project also supported NTBC to prepare a GTAFM grant proposal for procurement of pediatric anti-TB drugs to prevent stock-outs.

### ***3.2.3 TB/SERVICE DELIVERY/PHC LEVEL***

Phase I implementation of TB PHC QI sites started in Year 1 to increase coordination between the TB system and PHC, and to improve quality of PHC-delivered care. Using QI methodologies, the Quality Project worked intensely with PHC facilities in three pilot rayons: Issyk-Ata (Chui Oblast), Ton (Issyk-Kul Oblast), and Bazarkurgon (Jalal-Abad Oblast) to identify key barriers to quality service delivery and to address those barriers through the formulation of concrete improvement plans implemented and tested through CQI cycles. Common problems include inadequate patient education, divergence from standard diagnostic algorithms, and lack of funding to transport sputum and patients to centers with diagnostic capabilities.

### ***3.2.4 TB/SERVICE DELIVERY/HOSPITAL LEVEL***

While attention in Year 1 was mostly focused on strengthening PHC TB service delivery, the Hospital Association (HA) did conduct an assessment of TB facility infrastructure and IC measures currently practiced in Issyk-Kul Oblast.

### ***3.2.5 TB/SERVICE DELIVERY/LAB***

An assessment of EQA was conducted in Bishkek and Chui Oblast, revealing a system that functions properly in Bishkek but only sporadically works outside the capital. By the end of Year 1, a second EQA assessment was completed in Issyk-Kul and Jalal-Abad Oblasts, allowing the project to make concrete recommendations to MOH on policies related to EQA. Based on EQA assessment findings in Issyk-Kul and Jalal-Abad Oblasts, the Quality Project prepared a plan for expansion of EQA activities in these two oblasts to be implemented in Year 2.

### ***3.2.6 TB/COMMUNITY ACTION FOR HEALTH***

The Quality Project took a leading role in bringing partners together to write a national ACSM strategy that will be incorporated into the national TB strategy. Additionally, the Quality Project worked closely with the Swiss Red Cross and Republican Health Promotion Center to develop a TB community involvement/education curriculum, which will be rolled out through VHCs in Year 2. IPCC training with a focus on TB was conducted in TB QI sites to improve the quality of patient education, improve patient-doctor relationships, and improve patient satisfaction which is correlated with improved patient adherence to prescribed therapy. Journalists and media representatives were trained on TB prevention and control to promote high-quality media coverage of key TB messages which should lead to improved self-referral of symptomatic patients and reduced TB-related stigma, a barrier to care which is particularly relevant in small towns.

### **3.3 TB/HIV**

With the high prevalence of TB in Kyrgyzstan, and the fact that MARPs are at high risk of both HIV and TB, the Quality Project seeks to create an integrated TB/HIV strategy to improve IC, detection, and treatment in cases of co-infection.

During Year 1, the primary focus was on separate activities in HIV and TB and studying the TB/HIV co-infection situation in the country through work with providers and participation in the national TB/HIV working group.

### **3.4 HIV**

While HIV epidemics are driven by individuals in complex, unique settings, the protocols and individuals that drive national responses are key to stabilizing HIV in Kyrgyzstan. At the national level, the Quality Project seeks to improve the systemic weaknesses and capacity deficits that prevent MARPs from accessing high-quality HIV prevention, care, and treatment services. By increasing the technical knowledge of decision makers within MOH, the Quality Project is laying the foundations for working with those individuals to improve practice standards at the national level. As a critical intervention for long-term HIV risk reduction for IDUs, the expansion of low-threshold MAT remains a priority focus for the Quality Project. However, considering comparative advantages with other projects working in this area, the Quality Project is focusing primarily on addressing special topical and operational issues that affect MAT scale-up. The Quality Project will also focus on supporting ongoing GFATM grants, and with a particular focus on technical assistance to the GFATM PR, the Quality Project will support improving CCM capacity and capacity-building for NGO sub-recipients. At all levels of intervention, as the Quality Project matures, best practices that have been successful in localities will be transferred to the national level for scale-up and institutionalization.

Populations most at risk for HIV infection and transmission often have complex social needs. From an outreach worker's first contact, to repeated clinic visits for treatment of on-going medical conditions, each encounter with a member of a MARP group provides the opportunity to link individuals in need with the social and psychosocial support that can help to limit unsafe behaviors that promote the expansion of the HIV epidemic. At the national level, the Quality Project is working to assure that a range of social support services are introduced and continually improving to meet the needs of the populations they serve. Types of social support include trained social workers for MARPs, services from NGOs and CBOs, and self-help groups.

MARPs are often marginalized based on society's perception of their actions as illegal or immoral. Access to even basic services, let alone complex medical and social support services, may be limited by lack of documentation, discrimination, and breaches of confidentiality. Furthermore, the policy frameworks that would help reduce the spread of HIV are often absent. The Quality Project is actively working to identify major legal and policy barriers, as well as respond to those brought up by local and development partners, to improve the environment for MARPs. Key issues include the re-

documentation of MARPs; the expansion of the VCT system to allow rapid testing for MARPs (not just pregnant women) and also to reach MARPs where they are most likely to access services; and the institutionalization of a professional social work position for providing comprehensive case management services to MARPs.

Currently, most MARPs seek care from a small network of friendly clinics. Many of these clinics are friendly to MARPs based on incentives provided from donors, including GFATM. Recent interruptions in GFATM funding have shown that the MARPs-friendly environment of these clinics is not sustainable without monetary incentives. The crux of the Quality Project strategy for improving access for MARPs is to expand the number of facilities where MARPs can access basic care services and the range of services they can receive. In Kyrgyzstan, this is particularly important to address in a sustainable manner. Doing so increases the long-term, sustainable number of Entry Points into the health system, and increases the number of opportunities for medical and non-medical personnel to assess MARPs risks and encourage VCT. Additionally, for MARPs who test positive for HIV, access to high-quality, geographically feasible HIV care and treatment is critical for both their own care and for the sake of positive prevention efforts. The Quality Project is working in target localities with high concentrations of MARPs to address these challenges through training, mentoring, and other expert support.

NGOs remain the driving force behind social support services for MARPs in Kyrgyzstan. A relatively well-developed cadre of organizations plays a critical role in reaching MARPs, and many offer a select number of high-quality services. However, the range of services remains limited, and some organizations remain weak in addressing the more challenging social needs of their clients. Within target localities, the Quality Project is working with NGO partners to increase the range of social support services available, as well as update existing services with new methodologies and best practices. Through the provision of professional development opportunities for select personnel, as well as ongoing mentoring of organizational staff, it is expected that the Quality Project will encounter lessons and models that can create more unified standards for NGOs providing MARPs care across the country. Additionally, in order to demonstrate the success needed for national and donor (e.g. GFATM) buy-in, the Quality Project will train the first cadre of professional MARPs social workers from these localities, where project evaluation efforts can focus on specific benefits that the population receives from the fledgling profession.

### ***3.4.1 HIV/NATIONAL LEVEL/PREVENTION, CARE, AND TREATMENT***

During Year 1, the Quality Project worked to identify major weaknesses in technical knowledge and perspective at the national level, and address those through high-level trainings and workshops on special topical issues, including the management of effective HIV prevention programs for IDUs, MAT operational issues, and harm reduction practices for high-risk women. A complete review of HIV CPs was conducted, and the Quality Project installed ARV forecasting software at the Republican AIDS Center. Key staff were trained to use this software, and on-going support is provided through a local consultant and weekly virtual consultations with Quality Project specialists. At the request of the Republican Narcology Center, and in close collaboration with the Dialogue Project, the Quality Project prepared

national-level trainers and a cadre of pharmacists on naloxone use to pilot the Dialogue Project's pharmacy-based naloxone initiative.

### ***3.4.2 HIV/NATIONAL LEVEL/SOCIAL SUPPORT***

In Year 1, the Quality Project focused primarily on the support services provided by the NGO sector, conducting baseline focus group discussions with MARPs to assess gaps in services, and providing training to outreach organizations to expand the package of services provided to MARPs. This included national coverage of NGOs with human resources management training, and the inclusion of NGOs in other high-level trainings that covered elements of social support for MARPs. However, it has become apparent throughout this work that significantly more effort is needed to expand the range of sustainable, institutionalized support services, and that professional tracks need to be established for the individuals providing these services, whether in government or non-governmental facilities. This realization has guided the restructuring of the HIV sub-elements in this strategy, and will become a sub-element of major focus in upcoming years, with significantly more attention than was devoted in Year 1.

### ***3.4.3 HIV/NATIONAL LEVEL/LEGAL AND POLICY***

During Year 1, the Quality Project actively participated in the development of the next health sector strategy, Den Sooluk, as well as in the development of the next State Program on HIV. In both settings, the Quality Project advocated strongly for an increased focus on MARPs, and engaged partners on the importance of harmonizing a UIC to be used across all outreach and care institutions to allow for proper assessment of coverage of MARPs. Additionally, the Quality Project worked to evaluate the overall legal and policy challenges within the framework of HIV in order to build a set of priority activities for Year 2 (see below).

### ***3.4.4 HIV/LOCALITY STRENGTHENING/PREVENTION, CARE, AND TREATMENT***

During Year 1, the Quality Project selected Entry Points to focus on within the chosen localities in Bishkek City, Jalal-Abad City, and Kara-Suu Town. These facilities, which were already providing some basic level of access to services for MARPs, were chosen for further expansion and strengthening of services over the next five years. Staff from Entry Point facilities participated in an interactive roundtable discussion, meant to have the dual purpose of reaffirming best VCT practices while identifying barriers and weakness in current VCT practice. From this experience, a training course was developed to address the difficulties that health care workers reported in interpersonal communications with MARPs while initiating and providing VCT. This training was provided to an initial cadre of health care workers in Year 1 and will be continued until all relevant staff at Entry Points have been trained in Year 2. In addition, this model of interpersonal communications skills-based training will be expanded to other topics where needs have become apparent, including special topics in caring for patients with substance-use issues, introducing harm reduction services, and brief interventions during regular care visits. Additionally, during Year 1, management and clinical staff of Entry Points were prioritized for participation in other Quality Project trainings and events, including the regional PEPFAR meeting in Kiev on HIV and drug use.

### **3.4.5 HIV/LOCALITY STRENGTHENING/SOCIAL SUPPORT**

In Year 1, the Quality Project built strong relationships with NGOs within selected localities of Bishkek City, Jalal-Abad City, and Kara-Suu Town. NGOs from these areas were then preferentially included in all training and workshop events for civil society audiences. During the course of trainings, it became apparent that many NGOs would benefit from ongoing mentoring to expand the range of services available for MARPs, and increase collaboration with other partners (including other NGOs). In response, the Quality Project has included this as a major activity for Year 2. The Quality Project also engaged in efforts specifically directed at improving and systematizing the relationship between NGOs and government health facilities in assuring a continuum of care for MARPs. During an interactive meeting on NGO brokering (a term used to describe the ways in which NGOs negotiate access to health care services for MARPs) NGO leadership from localities worked with Quality Project staff to assess their successes, challenges, and hopes in working with government health facilities. Quality Project specialists, in turn, have shared some successful models that have been used in other countries. As Year 1 draws to a close, the Quality Project continues to work with NGO partners to develop a plan for Year 2 support of NGO brokering, which will include ongoing mentoring and close collaboration with Entry Point facilities.

## **3.5 MCH/FP/RH**

### **3.5.1 MATERNAL HEALTH**

In spite of high-level commitment and strong collaboration between MOH and development partners to implement key MCH programs, Kyrgyzstan continues to struggle with high maternal and infant mortality. Although socio-economic factors contribute to high mortality rates, there remain significant quality gaps in service delivery. The quality of ANC pregnant women receive is often unsatisfactory despite the high percentage of pregnant women (97%) receiving ANC at least once during pregnancy.

In close collaboration with UNICEF, GIZ, and UNFPA, the Quality Project supported scale-up of EPC in seven maternities in Jalal-Abad Oblast. EPC follow-up training and mentoring visits were conducted in former ZdravPlus II pilots in all five rayons of Naryn Oblast and three maternities in Bishkek.

### **3.5.2 CHILD HEALTH**

Despite steady reductions in infant mortality rates over the past few years, in-hospital infant and child mortality remains high in Kyrgyzstan, with most deaths caused by respiratory and diarrheal diseases.

Effective practices for managing common childhood conditions have been nationally implemented at the primary care level. The Quality Project has expanded IMCI training to hospital-level providers by supporting national trainers to develop and conduct a training of trainers under the leadership of a WHO-certified international consultant.

### **3.5.3 FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)**

Access to quality FP services and modern contraceptives is limited in Kyrgyzstan, especially in rural areas. Women often resort to abortion as a means of fertility control or have more children than they intend to.

The Quality Project trained PHC providers in Jalal-Abad in FP methods and intrauterine device (IUD) insertion. In September 2011, the Quality Project will conduct two training courses in Jalal-Abad Oblast on postpartum/post abortion FP, including immediate postpartum insertion of IUD.

### **3.6 CVD/NCD**

As the leading cause of mortality among adults, CVD remains a serious public health in Kyrgyzstan. Considering evidence of huge gaps in detection and treatment of AH and its complications, improving the quality of CVD services will continue to garner the attention it deserves. CVD was identified as one of four priority programs in Manas Taalimi and in the next national health sector strategy, Den Sooluk.

The Quality Project provided substantial input to the working group responsible for developing the CVD priority program section of Den Sooluk to identify expected outcomes, system barriers to quality, and key activities required to achieve desired outcomes, including the scale-up of quality improvement activities.

The Quality Project also closely collaborated with the National Institute of Cardiology and Therapy (NICT) in preparation for hospital-level CVD QI activities, a key component of the national health strategy. New national CVD guidelines were completed and approved after a technical review and feedback from STLI consultants. Joint meetings were held with HA and NICT to identify key quality gaps in the provision of services to patients with myocardial infarction and unstable angina; develop quality indicators and CQI instruments; and create QI implementation plans, including plans for in-service education of those providing CVD services at the hospital level. The Quality Project collected and presented baseline data to hospital providers; provided trainings in quality improvement; and facilitated the development of concrete improvement plans.

In addition, FGPNA monitored the quality of detection and management of hypertension at the PHC level in Naryn and Talas Oblasts, while reinforcing standards of care and assessing the retention of quality gains achieved during previous CQI cycles. In parallel, FGPNA has started work on second-generation quality indicators for hypertension that will focus on chronic care of patients at high risk of developing CVD and continuity of care between CAH-PHC and PHC-hospital levels.

STLI consultants reviewed a number of other national CPs and guidelines, including those for pre-hospital management of stroke, GI bleeding, shock, headache, and obstetrics-gynecology. After review, protocols and guidelines were subsequently revised based on feedback.

### **3.7 HSS/LEGAL AND POLICY**

The vast majority of Quality Project legal and policy activities in Kyrgyzstan will be performed through the current national health sector strategy, Manas Taalimi/SWAp, and the next national health sector strategy, Den Sooluk/SWAp II. Legal and policy activities will focus on strengthening the overall legal and regulatory base for long-term sustainability and specific legal and policy improvements for the priority programs of TB, HIV, MCH/FP/RH and CVD/NCD.

Quality Project Year 1 activities focused on promoting legal and policy improvements through Manas Taalimi/SWAp and engaging in extensive policy dialogue in development of Den Sooluk/SWAp II. The Quality Project participated in health policy development through a variety of dialogue mechanisms, including working groups and increased engagement with parliamentary committees.

### **3.8 HSS/HEALTH FINANCING**

The MHIF/single-payer system for the State Guaranteed Benefit Package; RBF for MCH services; and the introduction of the new TB financing mechanism are health financing priorities in Kyrgyzstan. Continued strengthening of the MHIF/single-payer system is critical for both sustainability and implementation of TB financing reform, including incorporation of TB services into State Guaranteed Benefits Package pooling and purchasing arrangements.

In Year 1, the Quality Project supported strengthening of the MHIF/single-payer system; contributed to the design of the World Bank RBF Project for MCH services; and initiated design of new TB financing mechanisms, including a new TB hospital payment system. In designing and developing the new TB hospital payment system, the Quality Project collected and analyzed data from all 25 TB hospitals and departments; determined parameters and simulations of a new TB hospital payment system; and performed an initial analysis of TB hospital restructuring options. An MOH prikaz was issued enabling implementation of the new TB hospital payment system in 2012. The prikaz outlines a global budget based on relative weights of groups, differentiating by type of TB case through a new TB case classification system tied to the WHO classification of TB cases.

### **3.9 HSS/PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES**

Although facility-level CQI was introduced in Kyrgyzstan in 2001, general awareness of QI and the use of quality management approaches among health care managers are very limited. This has been identified as a key system barrier to realization of expected outcomes of the next health sector strategy.

As described in the priority program sections, QI training was conducted for providers from facilities focusing on improving TB, MCH, and CVD care. During these trainings, facility directors and deputy directors were included to ensure understanding of QI methodologies and to secure their leadership of and critical support for QI.

In collaboration with World Bank consultants on the planned RBF project, the Quality Project provided technical input into development of a Balanced Score Card, which will be used to assess the quality of management, internal processes, and key clinical outputs at the rayon hospital level. In addition to introducing a new health financing scheme, this RBF project should do much to define and reinforce standards of hospital management and advance overall awareness of quality improvement, including introduction of performance assessments by peer groups.

### ***3.10 HSS/INSTITUTIONALIZATION FOR SUSTAINABILITY***

Health systems strengthening is essential to both achieve and sustain gains in quality of health services delivered. Although challenging, such work in Kyrgyzstan is easier than in most CAR countries because of the SWAp and well-coordinated joint annual reviews of the national health sector reform program. In addition, Quality Project has very strong partners such as the EBM unit, MHIF, Republican Health Information Center, Medical Accreditation Commission (MAC), HA, and FGPNA, all of which are key stakeholders in improving quality of service delivery.

Having the “right” institutions doing the “right” things and working collaboratively to achieve nationally prioritized goals is a key aspect of our strategy for sustainability. Kyrgyzstan is exemplary in having established key institutes and organizations, including MHIF, MAC, and the EBM center, with defined key roles and relationships. However, much can be gained by improving coordination and in ensuring that these organizations are working toward common quality health goals.

Continuous support was provided to the EBM center to strengthen their role in managing the CP/CPG development and approval process. This support included planned updating of the CPG development calendar based on improved coordination with the MHIF; development of appropriate responses to guideline developers who resist making changes to draft guidelines despite the provision of high-grade evidence; implementation of online publishing of approved CP/CPGs to make them accessible at no cost to all providers with internet access; and acceptance of a process to develop performance measures or “implementation indicators” with each new CP/CPG to improve coordination between MHIF QA processes and facility-directed QI. To improve use of evidence-based information, the Quality Project provided free subscriptions to key stakeholders, including educational institutes, republican institutes, and PAs, to the GIN online database of CP/CPGs. In addition, the Quality Project financed production and distribution of 1,000 copies of a CD with all CPs and guidelines developed and approved over the past five years.

STLI and FMSA engaged in further planning and capacity development for scale-up of e-learning as a CME delivery mechanism. Doctor, nurse, and feldsher trainers from KSMIRCE participated in a blended learning course (e-learning and face-to-face) on development of e-learning courses. A web hosting company was selected, and all finalized e-learning courses were made available online.

A number of meetings were held with key local leaders of medical education reform and international consultants on undergraduate medical education to help support the process of curriculum revision with a goal to eventually unify the pediatric and adult medicine education tracks to produce medical school graduates who are broadly trained and competent to enter a general medicine internship. Assistance was provided to MOH to produce the necessary curriculum reform policy documents which were submitted to the Government of Kyrgyzstan for approval. Written recommendations to improve the quality of clinical training for medical residents were also provided to MOH and the deputy rector of KSMA.

HA consultants were trained in QI processes and mentored through the process of developing CQI indicators, instruments, and an implementation plan. New FGPNA staff was similarly mentored to develop CQI indicators.

### ***3.11 HSS/COUNTRY M&E, OR, AND HIS***

As in the other countries, a list of potential studies in different areas was proposed by technical leaders and the county manager. The topic selected was “Results of TB restructuring and baseline for the new TB financing system”. It sought to assess the effects of restructuring of TB hospitals and departments in Kyrgyzstan, in light of the planned introduction of new financing mechanisms. The M&E/OR team, including individual experts from HPAC Kyrgyzstan, developed a proposal, research questions, and methodology, including sampling and research tools. Research tools were piloted, revised, and finalized. The following methodology was applied: 1) revision of existing material on restructuring including strategy, financial tables, and other guidance; 2) collecting performance and financial data from the facility level; and 3) conducting semi-structured Interviews with heads of oblast TB centers and TB hospitals where restructuring took place, and heads of TB departments in FM centers and heads of territorial hospitals that had TB departments.

The field work was completed, and a final report is currently being drafted. The final reports will be presented to main stakeholders in September 2011. When the reports are ready, short policy reports will be produced based on the report, and a workshop will be held to present findings to key stakeholders.

## **4. TAJIKISTAN**

### ***4.1 COUNTRY SUMMARY***

The overall Tajikistan implementation strategy is to support the Government of Tajikistan in implementing the National Health Sector Strategy and accelerate health systems strengthening including PHC development and health financing reform to enable priority program quality improvement activities contributing to improving health outcomes in TB, HIV, MCH/FP/RH, and CVD/NCD. Collaborations with other projects and donors include the USAID Dialogue Project on HIV and

TB; GFATM on TB and HIV; European Commission CADAP Project on HIV; DFID Central Asian Republics HIV/AIDS Program (CARHAP) on HIV; European Union, SDC, World Bank and WHO on health systems strengthening and health financing; WHO on MCH/FP/RH; and SDC on medical education.

## **4.2 TB**

The epidemiological situation in the country is complicated and alarming due to high rates of general TB morbidity as well as high prevalence of drug resistant cases. Tajikistan has the poorest case detection rate (44%) among the countries in the region. No major further declines in prevalence or mortality can be expected until improved case finding is in place. Tajikistan also has the highest TB mortality rate (48 per 100,000) and is the poorest country in the region.

In Tajikistan, the Quality Project has sought to catalyze change within the TB system by linking activities such as HSS and health/finance reform to the traditional focus areas covered by the Stop TB Strategy, while also responding to emerging issues in the country. For example, in January 2011, MOH issued a prikaz expanding MDR-TB patient treatment to 11 additional rayons of the country. However, as the prikaz was issued without adequate advance planning for implementation, the Quality Project sought to mitigate potential negative consequences of the prikaz by strengthening programmatic management of drug-resistant TB in the country. Project activities focus on preparing the system and community for the upcoming shift toward increased outpatient TB treatment.

During the consultancy visit of Quality Project consultant, Dr. Fabio Luelmo reviewed the organization and finance, case detection, treatment of TB, prevention of MDR-TB, and treatment of MDR-TB. Details of his visit are included in the consultancy report provided to USAID. Key priorities identified which will be implemented in Tajikistan starting next year include:

- Supporting NTP staff to develop a public health approach to TB control, including training in interpretation of the information, supervision, and operational research for action.
- Defining the functions of the central and Macheton hospital laboratories and the rational use of diagnostic equipment and technology to limit the costs in staff, training, and reagents.
- Introduction of the GeneXpert technology, accompanied by revision of the diagnostic algorithms and development of SOP, including full treatment of all susceptible smear positive cases by PHC.
- Improving coordination of external support through regular monthly meetings on fixed dates (including NTP staff), with agenda including at least one or two points for decision and action.

### **4.2.1 TB/NATIONAL LEVEL/LEGAL AND POLICY**

During Year 1, the Quality Project worked to address policies related to the availability of anti-TB drugs on the open market; adjusting MDR-TB case management practices and reporting forms; and strengthening the CCM policy framework. Efforts were made to strengthen prescription practices so that anti-TB drugs would be available only via prescription; an assessment was prepared on MDR-TB case

management; and strategies were developed in cooperation with partners and donors on support and capacity improvement for CCM.

#### ***4.2.2 TB/NATIONAL LEVEL/DRUG MANAGEMENT***

To strengthen NTP capacity in drug management with a focus on the use of TB drug information systems, the Quality Project, responding to a GFATM request for technical assistance, provided technical assistance to further institutionalize LMIS. The Quality Project designed and piloted LMIS for second line drugs and worked to develop local capacity in the NTP on drug forecasting.

#### ***4.2.3 TB/SERVICE DELIVERY/PHC LEVEL***

CQI teams were formed at PHC facilities in Dushanbe and Vakhdat Rayon to begin Phase 1 of our strategy to strengthen integration and quality of TB service at the PHC level. Quality gaps were identified and improvement plans implemented to address prioritized problems such as poor quality of patient education, poor adherence to approved diagnostic algorithms, and inconsistent DOTS. Interventions included training of PHC staff to improve interpersonal communications skills, introduction of a Tajik-language TB diagnostic algorithm as a job aid, and introduction of a form to assist in better recording of DOTS performance. In addition, small renovations were supported in facilities participating in CQI in order to improve IPC and an assessment of TB patients' knowledge about the disease and treatment was carried out at CQI sites in Dushanbe.

#### ***4.2.4 TB/SERVICE DELIVERY/HOSPITAL LEVEL***

The Quality Project carried out a situational analysis of MDR-TB case management in Dushanbe City and Vakhdat Rayon in April 2011. The analysis has been used to help NTP improve their staff capacity in identifying weaknesses in their program. A subsequent TOT on national MDR-TB guidelines prepared 15 national trainers, who then carried out cascade trainings for TB doctors and PHC health providers.

#### ***4.2.5 TB/SERVICE DELIVERY/LAB***

In Year 1, the Quality Project conducted a Laboratory QMS assessment and an assessment of laboratory needs at CQI sites in Dushanbe and Vakhdat to help improve case finding by microscopy. Discussion with the WHO country office on collaboration for implementation of QMS in laboratory services in Tajikistan and coordination of activities resulted in an agreement to have Quality project support WHO implementation of QMS in the TB laboratory network. In addition, the Quality Project participated in TWG meetings on SOP development and collaborated with development partners, including UNDP, KfW, and Project HOPE, on various aspects of laboratory work.

#### ***4.2.6 TB/COMMUNITY ACTION FOR HEALTH***

Year 1 CAH focused on working with partners, including the Red Crescent Society, healthy lifestyle centers, and youth committees to improve patient adherence in CQI sites in Dushanbe City and Vakhdat

Rayon. A TOT on TB community involvement was conducted for representatives of governmental and non-governmental organizations followed by facilitation of a PRA focused on TB in CQI sites in Dushanbe City and Vakhdat Rayon. This resulted in the development of a participatory action plan for implementation in Year 2. The Quality Project also worked to raise general TB awareness among the population and decrease stigma through World TB Day activities and a TOT for journalists, which was held in collaboration with the Dialogue Project.

### **4.3 TB/HIV**

At present, both the HIV and TB care systems in Tajikistan are severely vertical and disconnected from primary care. It is important that co-infection be addressed by bringing the two systems closer to the PHC level rather than allowing the creation of a vertical TB/HIV system with attendant stakeholders.

During Year 1, the Quality Project focused on examining the TB and HIV epidemics separately and identifying ways that HIV and TB infections could be addressed separately and concurrently at the PHC level. This included establishing CQI teams on TB and attending working group meetings on TB/HIV co-infection.

### **4.4 HIV**

While HIV epidemics are driven by individuals in complex, unique settings, the protocols and individuals that drive national responses are key to stabilizing HIV in Tajikistan. At the national level, the Quality Project is seeking to improve the systemic weaknesses and capacity deficits that prevent MARPs from accessing high-quality HIV prevention, care, and treatment services. By increasing the technical knowledge of decision makers within MOH, the Quality Project is laying the foundations for working with those individuals to improve practice standards at the national level. As a critical intervention for long-term HIV risk reduction for IDUs, the expansion of MAT beyond the pilot stage remains a priority focus for the Quality Project. Considering comparative advantages with other projects working in this area, the Quality Project is focusing primarily on addressing special topical and operational issues that affect MAT scale-up, and is working closely with the National Narcology Center, at their request, to explore opportunities for integrating MAT with other critical MARPs services. The Quality Project is also focusing on supporting ongoing GFATM grants, as well as preparation of new proposals, as needed. Foci of GFATM support will include technical assistance to the GFATM PR, support for improved CCM (NCC) capacity, and capacity-building for NGO sub-recipients. At all levels of intervention, as the Quality Project matures, best practices that have been successful in localities will be transferred to the national level for scale-up and institutionalization.

Populations most at risk for HIV infection and transmission often have complex social needs. From an outreach worker's first contact, to repeated clinic visits for treatment of on-going medical conditions, each encounter with a member of a MARP group provides the opportunity to link individuals in need with the social and psychosocial support that can help to limit unsafe behaviors that promote the

expansion of the HIV epidemic. On the national level, the Quality Project is working to assure that a range of social support services are introduced and continually improving to meet the needs of the populations they serve. Types of social support include trained social workers for MARPs, services from NGOs and CBOs, and self-help groups.

MARPs are often marginalized based on society's perception of their actions as illegal or immoral. Access to even basic services, let alone complex medical and social support services, may be limited by lack of documentation, discrimination, and breaches of confidentiality. Furthermore, the policy frameworks that would help reduce the spread of HIV are often absent. The Quality Project is actively working to identify major legal and policy barriers, as well as responding to those brought up by local and development partners, to improve the environment for MARPs. Key issues include the re-documentation of MARPs and the institutionalization of a professional social work position for providing comprehensive case management services to MARPs.

Currently, most MARPs seek care from a small network of friendly clinics. Many of these clinics are friendly to MARPs based on incentives provided from donors, including GFATM. However, experience in other countries has shown that these clinics are often not sustainable for providing MARP-friendly services without monetary incentives. The crux of the Quality Project strategy for improving access for MARPs is to expand the number of facilities in Tajikistan where MARPs can access basic care services and the range of services they can receive. Doing so increases the long-term, sustainable number of Entry Points into the health system, and increases the number of opportunities for medical and non-medical personnel to assess MARPs risks and encourage VCT. Additionally, for MARPs who test positive for HIV, access to high-quality, geographically feasible HIV care and treatment is critical for both their own care and for the sake of positive prevention efforts. The Quality Project is working in target localities, with high concentrations of MARPs, to address these challenges through training, mentoring, and other expert support.

NGOs remain the driving force behind social support services for MARPs in Tajikistan. A relatively small, under-developed cadre of organizations plays a critical role in reaching MARPs. A few of these organizations offer a select number of high-quality services. However, the range of services remains limited, and some organizations remain weak in addressing the more challenging social needs of their clients. Within target localities, the Quality Project is working with NGO partners to increase the range of social support services available and update existing services with new methodologies and best practices. Through the provision of professional development opportunities for select personnel, as well as ongoing mentoring of organizational staff, it is expected that the Quality Project will encounter lessons and models that can be scaled up and encouraged throughout Tajikistan. Additionally, in order to demonstrate the success needed for national and donor (e.g. GFATM) buy-in, the Quality Project will train the first cadre of professional MARPs social workers from these localities where project evaluation efforts can focus on specific benefits that the population receives from the fledgling profession.

#### ***4.4.1 HIV/NATIONAL LEVEL/PREVENTION, CARE, AND TREATMENT***

During Year 1, the Quality Project worked to identify major weaknesses in technical knowledge and perspective at the national level, and address those through high-level trainings and workshops on special topical issues, including the management of effective HIV prevention programs for IDUs, MAT operational issues, and harm reduction practices for high-risk women. A complete review of HIV CPs was conducted, and the Quality Project installed ARV forecasting software at the Republican and Dushanbe City AIDS Centers. Key staff were trained to use this software, and ongoing support is provided through a local consultant and weekly virtual consultations with Quality Project specialists. At the request of the Republican Narcology Center, the Quality Project prepared a large cadre of national-level trainers on naloxone use, and worked with both NGO and government partners to begin the development of a comprehensive strategy for naloxone use in HIV prevention.

#### ***4.4.2 HIV/NATIONAL LEVEL/SOCIAL SUPPORT***

In Year 1, the Quality Project focused primarily on the support services provided by the NGO sector, conducting baseline focus group discussions with MARPs to assess gaps in services, and providing training to outreach organizations to expand the package of services provided to MARPs. This included national coverage of NGOs with human resources management training, and the inclusion of NGOs in other high-level trainings that covered elements of social support for MARPs. However, it has become apparent throughout this work that significantly more effort is needed to expand the range of sustainable, institutionalized support services, and professional tracks need to be established for the individuals providing these services, whether in government or non-governmental facilities. This realization has guided the restructuring of the HIV sub-elements in this strategy and will become a sub-element of major focus in upcoming years, with significantly more attention devoted to it than was done in Year 1.

#### ***4.4.3 HIV/LOCALITY STRENGTHENING/NATIONAL LEVEL/LEGAL AND POLICY***

During Year 1, the Quality Project provided technical support to reform the anti-discrimination law in Tajikistan to protect people living with HIV, and engaged partners in a roundtable discussion on the importance of harmonizing a UIC to be used across all outreach and care institutions to allow for proper assessment of coverage of MARPs. Additionally, the Quality Project worked to evaluate the overall legal and policy challenges within the framework of HIV in order to build a set of priority activities for Year 2 (see below).

#### ***4.4.4 HIV/LOCALITY STRENGTHENING/PREVENTION, CARE, AND TREATMENT***

During Year 1, the Quality Project selected Entry Points to focus on within the chosen localities in Dushanbe and Vakhdat. These facilities, which were already providing some basic level of access to services for MARPs, were chosen for further expansion and strengthening of services over the next five years. Staff from Entry Point facilities participated in an interactive roundtable discussion meant to have the dual purpose of reaffirming best VCT practices while identifying barriers and weakness in current

VCT practice. From this experience, a training course was developed to address the difficulties that health care workers reported in interpersonal communications with MARPs while initiating and providing VCT. This training was provided to an initial cadre of health care workers in Year 1 and will be continued until all relevant staff at Entry Points have been trained in Year 2. In addition, this model of interpersonal communications skills-based training will be expanded to other topics where needs have become apparent, including special topics in caring for patients with substance-use issues; and introducing harm reduction services and brief interventions during regular care visits. Additionally, during Year 1, management and clinical staff of Entry Points were prioritized for participation in other Quality Project trainings and events.

#### ***4.4.5 HIV/LOCALITY STRENGTHENING/SOCIAL SUPPORT***

In Year 1, the Quality Project built strong relationships with NGOs within selected localities of Dushanbe and Vakhdat. NGOs from these areas were then preferentially included in all training and workshop events for civil society audiences. During the course of trainings, it became apparent that many NGOs would benefit from ongoing mentoring to build capacity of staff and expand the range and quality of services available for MARPs. In response, the Quality Project has included this as a major activity for Year 2. The Quality Project also engaged in efforts specifically directed at improving and systematizing the relationship between NGOs and government health facilities in assuring a continuum of care for MARPs. During an interactive meeting on NGO brokering (a term used to describe the ways in which NGOs negotiate access to health care services for MARPs), NGO leadership from localities worked with Quality Project staff to assess their successes, challenges, and hopes in working with government health facilities. Quality Project specialists, in turn, have shared successful models that have been used in other countries. As Year 1 draws to a close, the Quality Project continues to work with NGO partners to develop a plan for Year 2 support of NGO brokering, which will include ongoing mentoring and close collaboration with Entry Point facilities.

### ***4.5 MCH/FP/RH***

#### ***4.5.1 MATERNAL HEALTH***

Tajikistan has a high rate of home births not attended by skilled health staff. Although Tajikistan has made significant progress in reducing maternal mortality, much remains to be done in ensuring greater access to care. The formation of a national-level MCH advisory council has helped MOH to better coordinate efforts among development partners. The Tajik MOH has also taken steps to scale up and institutionalize the SM program by approving national standards and protocols based on EPC guidelines. However, the successful implementation of national standards requires building EPC mentoring capacity among supervisors and reinforcement of health workers' skills in providing EMOC.

Through joint efforts, the Quality Project, WHO, and MOH conducted a national assessment of hospital-level perinatal care, the results of which will shape policy decisions on MCH. The Quality Project also conducted EPC and ANC training courses in Vakhdat and Tursunzade, and follow-up mentoring is

currently underway at new EPC sites. Provider teams were trained in newborn resuscitation and provided with newborn manikins to practice resuscitation skills on an ongoing basis. To strengthen national training capacity, the Quality Project conducted a national-level training of trainers in ANC, with a strong focus on developing counseling skills.

#### **4.5.2 CHILD HEALTH**

Tajikistan has one of the highest child mortality rates in the region, with mortality largely attributable to preventable causes. Premature delivery and low birth weight rank among the major causes of death in the neonatal period, while diarrhea and meningitis account for the majority of deaths in the post-neonatal period.

The Quality Project trained FM doctors, pediatricians, and nurses in PHC-level IMCI. In addition, the Quality Project will also train and support community nurses in September 2011 on the third component of IMCI: community-based health education.

#### **4.5.3 FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)**

Women's health in Tajikistan is negatively impacted by a lack of access to modern contraceptives and quality FP services. Inappropriate method choice, out-of-pocket payments, providers' lack of knowledge about modern methods and counseling skills, and a lack of government commitment to securing contraceptive supplies are all barriers to access.

The Quality Project conducted a national-level training of trainers in FP methods and counseling to build the capacity of national cadres. National trainers, under the supervision of Quality Project consultants, will conduct further roll-out trainings.

#### **4.6 CVD/NCD**

The Quality Project supported CME on hypertension for PHC providers in Dushanbe and Vakhdat and introduced CQI focused on CVD. Three Dushanbe health facilities were chosen as QI pilots. Each facility has a monitoring team trained in QI and an assigned QI facilitator, but results to date indicate that additional training and support are needed for the facilities to fully engage in CQI.

#### **4.7 HSS/LEGAL AND POLICY**

Quality Project legal and policy activities in Tajikistan are based upon the current national health sector strategy. Legal and policy activities will focus on strengthening the overall legal and regulatory base for long-term sustainability and specific legal and policy improvements for the priority programs of TB, HIV, MCH/FP/RH and CVD/NCD.

The Quality Project assisted MOH in a comprehensive review of the medical codex, the body of laws relating to health care. At present, the codex features a number of contradictory and redundant laws. The review will identify those laws which require revision or removal for consistency. The Quality Project also provided technical support to the draft of an anti-discrimination law and legislation for the introduction of funds pooling.

#### **4.8 HSS/HEALTH FINANCING**

Health financing reform is required to improve equity, financial risk protection, and access to BBP benefits for vulnerable populations; improve efficiency to extend the very limited Tajikistan health budget; and improve quality in TB, HIV, MCH/FP/RH and CVD/NCD priority programs. Opportunities exist now to expand health financing reform, and the Quality Project will provide extensive technical assistance and operational support to take advantage of these opportunities.

Extensive dialogue and technical assistance in collaboration with WHO, EU, World Bank, and SDC resulted in agreement in principle on pooling of funds at the oblast level (a condition of EU budget support) and a phased health financing reform implementation plan starting in 2012, which includes expansion of the PHC per capita payment system and introduction of a new hospital payment system. Notwithstanding the agreement in principle, MOF balked at approval of detailed implementation plans specifying the steps required. However, during an MOH and MOF study tour to Kyrgyzstan to observe the health system reforms, MOF agreed to support step-by-step implementation of health financing reform in Tajikistan and to be active in every step of the process. In addition to policy dialogue, the Quality Project also initiated development of products and methodologies required to expand health financing reform including draft legal and regulatory documents; detailed funds flow analyses; collection and analysis of budget data required to calculate payment rates; and collection and analysis of clinical data required for the design of a new hospital payment system.

#### **4.9 HSS/PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES**

Given the comprehensiveness of the national health sector strategy, Tajikistan reforms, and Quality Project activities, significant opportunities exist for cross-cutting activities in QI awareness, health management, and leveraging improvements in health systems functions across the entire health system. In addition, the very low health budget in Tajikistan makes cross-cutting activities critical to the ability of the Tajikistan health system to deliver high-quality health services to the population.

To build health management capacity, the Quality Project brought health managers from Vakhdat to Dushanbe to learn how FM principles work in practice. They visited Medical Center #1 to learn about how care is organized, referrals, and documentation; how to structure a FM facility; and the most effective way for family doctors and narrow specialists to interact. The Quality Project also conducted roundtable discussions which featured examples of how FM providers and specialists can work together

effectively. Geographic Information Systems (GIS) software was purchased for the purpose of mapping health facilities.

#### **4.10 HSS/INSTITUTIONALIZATION FOR SUSTAINABILITY**

Tajikistan is at an early phase of institutionalization for sustainability as many of the methodologies and tools are still being developed, and roles and relationships among a number of health sector entities are either not clear or not well developed. The Quality Project will work in parallel to develop and implement new methodologies and tools and also institutionalize them for sustainability.

The Quality Project supported the EBM Center and Drug Information Center to promote EBM and begin to establish a CPG development methodology and process. Support was provided for PGMI FM trainers to continue to improve the FM training and develop a concept paper on CME. Dialogue was initiated with Tajik State Medical University (TSMU) on strengthening the content of undergraduate medical curriculum. Regarding institutional structure, roles, and relationships, the Quality Project engaged in dialogue on the revision of Governmental Decree #525 which governs organization of health care structures; developed plans for establishment of the oblast health department (OHD) as health purchaser; and further supported development of the EBM Center, Drug Information Center, and PGMI.

In September 2011, the Quality Project will begin piloting a one-year general internship model in cooperation with TSMU and PGMI. A general internship has been a mandatory part of medical education for several years, but little attention has been given to developing appropriate models of clinical mentoring of interns or assessment of training quality. Our long-term aim will be to improve the overall quality of intern training by developing these methodologies while simultaneously promoting FM as a career in our pilots, which will start in Dushanbe.

#### **4.11 HSS/COUNTRY M&E, OR, AND HIS**

As in other countries, a list of potential studies in different areas was proposed by technical leaders and the county manager. The topic selected was the impact of new financing mechanism on hospital efficiency of services. It investigated how hospitals in Tajikistan distribute their expenditures, looking in particular at financial and performance indicators. This study provides a baseline analysis of current hospital expenditures and will be presented to stakeholders in September 2011 along with short policy briefs and a full written report. A follow-up study will take place in Year 2 after the introduction of new financing mechanisms, allowing health policy makers to make informed decisions about broader implementation of the piloted health financing reforms.

## **5. TURKMENISTAN**

### **5.1 COUNTRY SUMMARY**

In Year 1, the environment in Turkmenistan remained difficult, and forward progress was hampered by a lengthy delay in Government of Turkmenistan and USAID Memorandum of Understanding (MOU) approval and the sudden dismissal of key Ministry of Health and Medical Industry of Turkmenistan (MOHMIT) senior specialists and health facility managers in April and May 2011. However, despite the challenging work environment, the Quality Project completed start-up of the Turkmenistan program and was able to perform a significant number of project activities contributing to improving health outcomes for TB, MCH, and HIV in Turkmenistan. The Quality Project expects growth in activities in all program areas to continue in Year 2.

The Quality Project team in Turkmenistan is committed to building productive and meaningful collaborative partnerships with other donors/projects. The Quality Project has achieved impressive results implementing key TB, MCH, and HIV activities through cost-share agreements with international partners, including WHO, GFATM, UNFPA, UNICEF, UNODC, and Youth Centers.

### **5.2 TB**

Conflicting data trends make it difficult to evaluate the general TB situation in Turkmenistan which is complicated by tight governmental control of available data. Despite reported stabilization in prevalence, a modest increase in notification rate, and high treatment success rates, the situation remains concerning. Officially, no HIV cases are reported. Since the project has no direct access to the country data on all levels, the only available source for TB epidemiological data for Turkmenistan is the WHO Global TB report.

While the data situation creates difficulties in assessing the overall situation, it does not affect the need for the Quality Project to continue to focus on key TB control activities, including strengthening case finding, especially of infectious cases; treatment adherence; and the control of MDR-TB. The Quality Project is also working to increase the role of PHC in TB control.

#### **5.2.1 TB/NATIONAL LEVEL/LEGAL AND POLICY**

During Year 1, the Quality Project actively participated in a number of TB TWGs (IC, Health System Strengthening, Laboratory Diagnosis, Drug Management, MDR-TB, TB/HIV) to provide technical support to revise and develop national-level technical and regulatory documents. In order to support these revisions, the Quality Project conducted a number of workshops, roundtable discussions, and assessments, including an assessment of PHC and TB service integration gaps and weaknesses; a TB-IC assessment; a smear microscopy EQA system assessment; and an assessment of the TB regional bacteriology laboratory in Balkanabat. In addition, the Quality Project prepared and presented

informational materials on best international TB practices to influence policy makers to develop policy in line with international standards. The Quality Project co-facilitated the HSS and MDR-TB TWG meetings at which consensus was achieved on principle aspects of the national MDR-TB guidelines.

The Quality Project also made major contributions to the development of national TB infection control guidelines. The document is currently being reviewed by the government.

### ***5.2.2 TB/NATIONAL LEVEL/DRUG MANAGEMENT***

At the start of the Quality Project, there was not a clear system in place for TB drug supply management, LMIS had been implemented in only one velayat, and quality-assured TB first line drugs were, and continue to be, supplied by international donors (e.g. GDF grants, pediatric WHO grants, and the GFATM R9 grant). As regulatory and managerial aspects of TB drug management are critical for ensuring uninterrupted TB drug supply, the Quality Project is focused on improving the drug management system in Turkmenistan.

A joint situational analysis of the TB drug regulatory base and management system was conducted with WHO, resulting in a recommendation to prohibit the sale of TB first line drugs on the open market; this recommendation was accepted by principle national stakeholders. In addition, a roundtable discussion was held involving regional drug management coordinators and representatives from other organizations; the discussion focused on 1) improving TB drug management; 2) the availability of TB first line drugs on the open market; and 3) the analysis of existing regulatory documents on drug management. A key decision was made to implement a unified system for TB drug management including recording and reporting forms. As a result, LMIS training for national and regional level drug management coordinators was conducted, and a draft of the national LMIS manual was revised and adopted.

### ***5.2.3 TB/SERVICE DELIVERY/PHC LEVEL***

Activities at the PHC level were limited by the absence of an MOU as the Quality Project did not have the legal authority to directly communicate or collaborate with PHC providers. Quality Project activities were targeted at establishing and strengthening the continuum of care between the TB and PHC systems. The preparatory phase of activities included finalizing criteria for CQI site selection, mapping potential sites, and developing a log frame of activities to coordinate with partners. In collaboration with WHO, an assessment of PHC services was conducted and potential system barriers identified. The assessment identified a lack of collaboration between the TB and PHC services and serious gaps in the performance of PHC providers when judged against existing standards.

### ***5.2.4 TB/SERVICE DELIVERY/HOSPITAL LEVEL***

The primary aims of the Quality Project are to improve case finding; standardize treatment and strengthen treatment adherence; and reduce the risk of MDR-TB. To this end, a joint training with WHO on MDR- and XDR-TB diagnosis and treatment was conducted in Mary Velayat, and a training on

pediatric TB was conducted in Turkmenbashy, Ashgabat, and Mary. Up-to-date information on the diagnosis and treatment of MDR- and XDR-TB, as well as pediatric TB, was provided, and international experiences were shared.

An assessment of TB services was conducted in Balkan Velayat, which is a former pilot site from a past USAID-Project HOPE project. The assessment indicated that DOTS, TB microscopy, sputum transportation, and TB reporting and documentation were generally well-organized. In addition, a TB-IC assessment was conducted in the Balkanabat TB regional hospital, and an activity plan was subsequently developed, in cooperation with WHO and NTP, to address identified TB-IC issues. The IC plan for the regional TB hospital in Balkanabat was developed and adopted at the facility level.

### ***5.2.5 TB/SERVICE DELIVERY/LAB***

A joint assessment with WHO of the EQA system and the regional TB bacteriology lab in Balkan Velayat was conducted, with major findings and recommendations reported to NTP and other partners. The Quality Project actively participated in the working group on TB laboratory diagnosis where principle approaches to EQA were agreed upon and a decision was made to develop a national guideline on EQA. Four trainings were conducted on EQA implementation, including a national-level TOT and three regional trainings. The Quality Project was invited to participate in an international conference on “New Technologies in Medical Science” and present new methods for TB laboratory diagnosis. The conference was organized by Turkmen State Medical University in honor of the twentieth anniversary of Turkmenistan’s independence.

### ***5.2.6 TB/COMMUNITY ACTION FOR HEALTH***

Due to conditions in Turkmenistan, there are strong barriers to working at the community level. Improving the quality of disease counseling received by TB patients and increasing public awareness of key TB issues were primary Quality Project focus areas in Year 1. In collaboration with GFATM, UNDP, and the MOH Press Center, a TOT on “Social Mobilization for TB Control” was conducted for 19 TB specialists. The Quality Project also collaborated with national and international development partners to support World TB Day activities, including a national TB conference and student conferences. A leaflet on cough etiquette was developed in partnership with the MOH Press Center.

## ***5.3 TB/HIV***

While the risks of TB/HIV co-infection are well established in international literature, Turkmenistan still does not regularly register HIV cases, and therefore is not currently engaged in actively addressing co-infection prevention or treatment. However, the Government of Turkmenistan is open to the development of plans for addressing such co-infections should the need arise. The Quality Project will continue to provide technical assistance to assure that a system is in place to manage co-infected patients and, as necessary, to support implementation of co-infection prevention and treatment measures.

Due to ongoing issues with the Quality Project MOU and the politically sensitive nature of HIV activities, the Quality Project did not engage significantly on the issue of TB/HIV co-infection in Year 1.

## **5.4 HIV**

HIV remains the most ‘invisible’ of diseases in the overall process of improving public health in Turkmenistan. The core message from the health authorities remains that there are no cases of HIV in Turkmenistan despite the fact that the health authorities have been engaged in HIV testing for several years. Stigma and discrimination related to HIV is pervasive and hinders access and acceptance of services.

Reports of actual HIV positive cases in Turkmenistan have decreased from 16 cases in 1996 to two cases in 2002, while no cases were reported from 2006 to 2008.<sup>2</sup> Nevertheless, Turkmenistan’s health authorities are collaborating with international organizations in HIV prevention. The first drop-in center in Ashgabat was opened by the USAID Capacity Project in collaboration with UNODC in 2009, and there is an HIV prevention center in each velayat and a national center in Ashgabat. Encouragingly, the government developed and implemented the National HIV/AIDS Prevention Strategy for 2005-2010.

Since all donor organizations’ HIV activities are restricted by MOHMIT, the Quality Project is working with USAID Turkmenistan, UNODC, and other key stakeholders of the UN HIV Technical Group to strengthen the response to HIV. Key sites for the improvement of HIV prevention include USAID-funded Youth Centers and drop-in centers. Special attention will be paid to efforts to introduce MAT for HIV prevention purposes.

HIV prevention and social support for MARPS are very sensitive issues for Turkmenistan's health authorities. These activities are under strict control by national- and velayat-level HIV/AIDS centers. The management teams of these centers are open to collaboration with international organizations in cases where HIV/AIDS centers need repair, office furniture, and equipment. The centers are also willing to collaborate with donor partners for workshops to engage MARPS in social and professional orientation activities, and to accept educational and training materials. Local authorities (hyakimliks and police) support HIV/AIDS centers by providing information on the number of MARPS and by mobilizing communities, outreach, and health workers for HIV/AIDS prevention and implementation of CAH activities.

### **5.4.1 HIV/NATIONAL LEVEL/LEGAL AND POLICY**

The Quality Project participated in policy dialogue on the development of the legal basis for HIV prevention issues and in the development of the National HIV Strategy for 2011-2016.

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<sup>2</sup> *UNGASS, 2008 Turkmenistan Update*

As a member of the National HIV/AIDS Working Group, the Quality Project participated in HIV/AIDS CCM meetings, which were led by the Director of the National Center of Infectious Diseases. Representatives from the Ministry of Interior Affairs and MOHMIT SES Department, as well as key stakeholders from the UN HIV Technical Group, became members of the National HIV/AIDS Working Group. The HIV/AIDS Working Group agreed upon on the development stages of the new National HIV/AIDS Strategy for 2011-2016. Beginning in August 2011, the working group is preparing a situational analysis. In September 2011, the Working Group will deliver a preliminary report on the results of the situational analysis to MOHMIT. From October to November 2011, the Working Group will prepare a draft of the National HIV/AIDS Strategy for submission to MOHMIT. By December 2011, it is expected that the National HIV/AIDS Strategy for 2011-2016 will be approved.

#### ***5.4.2 HIV/LOCALITY STRENGTHENING/PREVENTION, CARE, AND TREATMENT***

In collaboration with UNODC and the USAID Youth Centers, the Quality Project focused on strengthening multi-sectoral coordination and by providing technical assistance to Ashgabat, Akhal, and Turkmenabat Drop-in Centers to facilitate the establishment of MAT rooms. The Quality Project worked towards improving continuum of care for HIV prevention, care, and support, and focused efforts on the implementation of community prevention services to reach MARPS through outreach and health workers. To ensure effective operation of AIDS centers, the Quality Project promoted the concept of coordination rather than control and supported evolution towards a more patient-centered and less-discriminating atmosphere to attract vulnerable populations.

Per the request of the Abadan AIDS Center, the Quality Project purchased 6,000 syringes to distribute to IDUs.

#### ***5.4.3 HIV/LOCALITY STRENGTHENING/SOCIAL SUPPORT***

During Year 1, the Quality Project organized two training courses for outreach workers in Ashgabat and one course for IDUs in Turkmenabat, and printed and distributed educational materials provided by UNODC to AIDS centers in Ashgabat, Abadan, and Turkmenabat. With the support of UNODC, the Quality Project organized a roundtable discussion in Abadan on “The Role of Drop-In Centers and MAT Rooms.”

### ***5.5 MCH/FP/RH***

#### ***5.5.1 MATERNAL HEALTH***

Quality Project MCH activities in Turkmenistan are designed to both improve the quality of services included in the SM package and to improve the continuum of care for infants and children by continuing to institutionalize EPC, ANC, and IMCI. To support MOHMIT in their efforts to expand the adoption of evidence-based MCH standards throughout the country, the Quality Project is working to build the

capacity of national EPC and IMCI trainers to effectively conduct mentoring and supportive supervision after training.

The Quality Project assisted in numerous activities to support the final year of National SM Program (2007-2011) implementation. Through joint efforts with MOHMIT, MCHI, and UNFPA, the Quality Project supported the training of 71 obstetrician-gynecologists, neonatologists, midwives, and neonatal nurses through two ten-day EPC training courses in Akhal and Balkan Velayats. Each EPC training course was followed by a one-day EPC roundtable discussion at which health facility managers, senior health department officials, and SES specialists learned about WHO EPC/ANC standards and discussed plans of action for introducing EPC technologies in their respective etrap maternities. The Quality Project also collaborated with UNFPA to support both a fifteen-day EPC monitoring and mentoring activity in Akhal and Balkan Velayats and MOHMIT-sponsored ANC trainings for 40 obstetrician-gynecologists and family practitioners from Akhal and Balkan Velayats.

In collaboration with WHO, UNFPA, and UNICEF, the Quality Project is involved in preparations for the National SM Program assessment at the PHC level which is planned for December 2011. UNICEF, WHO, and the Quality Project are developing assessment tools, which will be completed by September 2011. The assessment's outcomes and conclusions will inform the development of the new National SM Strategy for 2012- 2016.

### **5.5.1 CHILD HEALTH**

Working together, ZdravPlus, WHO, UNICEF, and UNFPA achieved significant success in introducing IMCI at both the PHC and hospital levels in 14 pilot etraps, while also promoting the use of IMCI approaches throughout the county. Significant steps were taken toward institutionalization of IMCI when MOHMIT mandated inclusion of IMCI into the curriculum of TSMU and five other medical schools, and promoted national-level IMCI guideline development. The IMCI Strategy was included in the MOHMIT MCH Strategy for 2008-2010 and 2011-2013.

The Quality Project provided financial support to MCHI to strengthen, scale up, and institutionalize the IMCI program through the use of refined mentoring and monitoring tools, thus enabling family doctors and hospital pediatricians to improve the continuum of care and ensure the strengthening of child health services in 14 IMCI pilot sites. Jointly with WHO, the Quality Project organized a meeting on scaling up IMCI Strategy implementation and strengthening the health system. The Quality Project also supported implementation of the new WHO IMCI "0 to 2 months" Training Program, using national trainers. The Quality Project participated in the Child and Adolescent Health Strategy Development Working Group; organized two KCH campaigns in Dashoguz and Balkan Velayats; and developed a schedule for KCH campaigns in Year 2.

### **5.5.2 FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)**

Despite the challenges of the current environment, the Quality Project continues to provide technical assistance to the MCHI FP Center through 1) participation in WHO-led MCH Coordination Group

activities; 2) promotion of sustainable FP monitoring and mentoring system; and 3) provision of FP/RH training as part of ANC training and KCH educational materials.

The ANC training in Akhal and Balkan Velayats covered FP/RH topics. Follow-up monitoring will include the collection of indicators on FP. The Quality Project also developed plans for upgrading the knowledge of etrap RH specialists, and continued discussions with WHO, UNICEF, and UNFPA on the development of clinical guidelines on FP/RH.

## **5.6 CVD/NCD**

The Quality Project engaged in coordination and planning meetings with TSMU and the National Cardiology Center, which expressed great interest in collaborating to develop CME modules on hypertension for family physicians and creating a CVD/NCD working group to develop a national CVD strategy to improve quality of CVD care.

## **5.7 HSS/LEGAL AND POLICY**

Although no national health sector strategy exists in Turkmenistan, the Quality Project supports implementation of activities authorized by national programs including the State Presidential Health Program, the National SM Strategy for 2007-2011, and the Mother and Child Health Improvement Strategy for 2011-2013 developed by MCHI. In 2009, WHO initiated development of a Health Systems Strengthening Concept Note in collaboration with ZdravPlus II. MOHMIT preliminarily approved the document in 2010, but since then, the Government has taken no significant steps towards finalization and approval of the Health Systems Strengthening Concept Note although interest in the topic remains. The Quality Project will continue to simultaneously engage in policy dialogue in specific program areas while promoting development of a broad health systems strengthening concept or strategy.

The Quality Project engaged in policy dialogue on priority program areas and supported the passage of appropriate legal and regulatory documents. In collaboration with WHO and Global Fund, the Quality Project contributed to the development of a CQI concept and principles for the Turkmenistan TB Program; establishment of EQA for TB laboratory service in Turkmenistan; and formulation of national policies and regulations related to the drug management system, including registration issues, as well as policies contributing to strengthening the integration of TB control programs at the PHC level.

## **5.8 HSS/HEALTH FINANCING**

Health financing activities will remain relatively limited and were not started in Year 1. In Year 2, the Quality Project expects to gradually initiate health financing activities linked to health systems strengthening policy dialogue. The Government of Turkmenistan has requested technical assistance on converting voluntary health insurance to mandatory health insurance, and the Quality Project plans to engage in dialogue on this topic. In addition, the Quality Project hopes to initiate a small step in

improving health purchasing including provider payment systems possibly for TB health services as well as the general health system.

## **5.9 HSS/PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES**

The nature of targeted and specific health programs in Turkmenistan makes creating linkages across programs difficult. To the extent possible, the Quality Project will share experiences and lessons learned in introducing quality improvement processes in IMCI and SM with TB facilities initiating implementation of quality improvement processes. In addition, the severe lack of computer skills among PHC and TB Managers inhibits the ability of these managers to communicate through e-mail and complete reports. The Quality Project will organize training workshops for these managers in the use of computers in order to strengthen their management capacity and ability to better coordinate their work.

## **5.10 HSS/INSTITUTIONALIZATION FOR SUSTAINABILITY**

A strength of Turkmenistan is incorporating changes in clinical practice into medical education, and the Quality Project will continue to prioritize this activity. Promotion of EBM and development of new CPGs are two of the most important elements of long-term institutionalization of improvement in the content of clinical practice. Turkmenistan has expressed interest in EBM and CPG development methodologies which provides an opening to introduce concepts and methodologies.

The Quality Project engaged in dialogue with MOHMIT and educational institutions on medical education curriculum improvements and the promotion of EBM and CPG development methodologies to set the stage for more intensive activities in these areas.

## **5.11 HSS/COUNTRY M&E, OR, AND HIS**

While MOHMIT is working to create a unified M&E system, it is currently focused on the objective defined in the May 2010 Presidential Decrees of ensuring electronic circulation of reporting documents. This will hopefully provide opportunities for improving health system performance and allow data to be used for better decision-making. ZdravPlus implemented HIS activities in 14 pilot hospitals, including providing software that accelerated the reporting process. The value of accurate and timely information for strengthening policy development, service delivery, and management has motivated health authorities at all levels to improve the quality of the information they collect and report.

The Quality Project supported improvements to the M&E system in Turkmenistan by providing technical and financial support to MCHI and NTP through their respective M&E activities.

Due to the challenges inherent in Turkmenistan's policy environment, no OR was conducted during Year 1. OR topics focused on MCH were proposed, but discussions with main stakeholders, including MOHMIT, WHO, and UNICEF, to define the most urgent research needs are ongoing.

## **6. UZBEKISTAN**

### **6.1 COUNTRY SUMMARY**

In Year 1, the Quality Project priority was obtaining program operation approval from MOH and the Government of Uzbekistan. In close coordination with USAID, strategies to accomplish this task were developed and evolved as new information was received. Quality Project subcontractor Project HOPE is registered but bureaucratic procedures in this difficult environment required many steps, culminating in MOH approval of a workplan for the TB component. A variety of technical assistance activities were performed in the first nine months of the project and then broader program activities were initiated in July 2010 based on the approved workplan. It is expected that TB activities will proceed as planned in Year 2.

Abt Associates attempts to re-register with the Ministry of Foreign Economic Relations, Investment and Trade were not successful. At this point, the plan is to collaborate with the \$94 million World Bank Health 3 Project to provide international technical assistance in MCH and CVD quality improvement; health financing and hospital restructuring; and EBM/CPGs and medical education. The World Bank Health 3 Project was approved and is expected to become effective in late 2011 or early 2012. The Quality Project will join the November 2011 World Bank mission to work with MOH, World Bank, and USAID on the development of joint workplans for international technical assistance. It is likely that the Quality Project will pursue the same strategy for HIV program activities by linking with the Global Fund to provide international technical assistance. The Quality Project was able to provide some technical assistance in TB/HIV in Year 1 and will continue pursuing HIV technical assistance options. In addition, the Quality Project learned that all foreign donor projects in Uzbekistan that contain HIV/AIDS activities should receive approval from the Multisectoral Expert Council (MEC) prior to the start of activities. The Quality Project prepared an application to MEC and, together with other donor projects, submitted it in January 2011 with some dialogue occurring but no response received to date.

As described above, the Quality Project has planned and will continue to plan extensive collaborations with both USG and USAID projects, including the Dialogue Project, TB CARE, and CDC/Support Project, and other donor projects to both enable activities while leveraging and extending programs. Other donor/project collaborations will include Global Fund, World Bank, WHO, UNICEF, and other bilaterals as opportunities arise.

### **6.2 TB**

Uzbekistan has a poor case detection ratio (CDR=50%). This makes improved case finding and proper case classification top priorities of the national TB program. Improving case detection will require better management, improved diagnostic technologies, and practices. The reported treatment success rate for new smear-positive cases was 81% (2008 cohort of 5,117 patients). Overall, prevalence and mortality rates have been going up since 2005, and this suggests the need for data verification, especially with

14% of new TB cases reportedly having MDR-TB. The Quality Project is implementing a range of activities to address this situation.

During the consultancy visit of Quality Project consultant Dr. Fabio Luelmo, Dr. Luelmo reviewed the organization and finance, case detection, treatment of TB, prevention of MDR-TB, and treatment of MDR-TB. Details of his visit are included in the consultancy report provided to USAID. Key priorities identified which will be implemented in Uzbekistan include:

- Employ ACSM to promote a political decision at the ministerial level establishing a NTP managerial unit and structure; and adopting international guidelines. Expand the pilot projects in PHC and exchange and document the experiences for ACSM;
- Implement regular coordination meetings of the technical assistance partners, with agendas including decisions for action and follow-up of commitments;
- Support systematic detection of suspects for microscopy (OR to measure real prevalence of cough for more than two weeks in PHC, pilot non-medical screening for cough); expand microscopy EQA; implement rapid methods and revise the diagnostic algorithm;
- Support implementation of GeneXpert, including definition of priority groups and revision of clinical algorithms;
- Support PHC DOT for first line drugs and MDR-TB (analyze and document pilots of MSF, QI); and
- Use and teach practical indicators and promote OR to improve data quality and interpretation.

### **6.2.1 TB/NATIONAL LEVEL/LEGAL AND POLICY**

Several decrees issued by MOH in the 1990s are in conflict with current decrees and need to be invalidated. MOH is preparing a unified decree that will regulate TB control in the country and invalidate the previous decrees; the Quality Project is providing assistance to national partners to facilitate this process. The role of overseeing the National TB Program is shared between two state organizations: the Republican Center for Phthysiatry and Pulmonology, and the DOTS Center. Functions of the two organizations appear to overlap and conflict. The Quality Project works with both entities to create positive synergies between them. A medium-term national TB control plan does not exist.

While there were initial limitations in the project's approval to conduct activities, providing technical assistance for the preparation of TB-related legal documents was one area in which the Quality Project was able to assist national partners in Year 1. Assistance was provided to the TB/HIV Working Group in preparing and reviewing decrees on TB/HIV and in providing documentation on TB-IC standards.

MOH (Republican Center for Phthysiatry and Pulmonology) requested Quality Project assistance to organize a national TB workshop aimed at combining all TB regulations (prikazes) into one regulatory document. The date for this three-day workshop is pending MOH approval.

While Uzbekistan is another country in which the Quality Project does not expect to be able to fully realize its regional strategy, the project does see opportunities in the ongoing TB system rationalization process and the possibility of pilot sites fully integrating non-MDR-TB and MDR-TB treatment into PHC in

the near future as discussed in meetings with NGOs. The Quality Project will address legal and policy issues that are needed to expand the scope of TB services offered at the ambulatory level to reduce the inconvenience, costs, and infection risks inherent in lengthy hospital stays.

### ***6.2.2 TB/NATIONAL LEVEL/DRUG MANAGEMENT***

In Uzbekistan, LMIS for TB drugs was introduced and implemented throughout the country with the assistance of earlier USAID projects, and it provided a basis for managing TB drugs in the country.

In 2010-2011, Uzbekistan experienced interruptions in the TB drug supply chain. During a gap in development assistance, Uzbekistan ordered first line TB drugs without taking into account the need for buffer stocks which led to interruptions in the availability of TB drugs. Such interruptions in drug supply should not take place as the basic structure and reporting of LMIS are in place, providing the necessary information to avoid stock-outs. In order to help prevent recurrence of stock-outs, the Quality Project and the Director of the DOTS Center agreed to re-establish a working group on drug management that will operate through the DOTS Center.

LMIS training materials were reviewed and prepared in both Russian and Uzbek for TB and PHC providers. Training of these providers started during the fourth quarter of Year 1. The Quality Project met with GDF/GLC mission members to discuss the project's activities, drug management issues, procurement of second line TB drugs, pediatric TB drugs, quantification of drug needs, the quality assurance plan, and drug distribution plans. The Quality Project assisted the national team in preparing a grant request for pediatric TB drugs. This grant request was approved without conditions; when the drugs arrive, pediatric TB drugs will be available in Uzbekistan for the first time.

### ***6.2.3 TB/SERVICE DELIVERY/PHC LEVEL***

Improving integration of TB services into PHC, one of the key objectives of the Quality Project TB Strategy, will be achieved through piloting PHC-level CQI and roll-out of best practices. Phased implementation is planned to maximize coordination between the TB system and PHC level, and to minimize gaps in the continuum of care between systems.

The Quality Project organized a working group with the participation of the Director of the DOTS Center, representatives of Tashkent City and oblast TB dispensaries, and Chilanzar and Parkent Rayon ambulatory services. PHC-based TB QI sites were identified; candidates for on-site multidisciplinary QI teams were proposed; and preliminary plans for these QI teams were made. The Quality Project and national specialists agreed that they will support and coordinate all activities on CQI.

The Quality Project conducted a baseline assessment in Chilanzar Rayon to identify strengths and weaknesses of integration of TB services into PHC. The main findings of the assessment include the following:

- 1) Most TB patients are detected by TB facilities;

- 2) After the intensive phase of TB treatment, there are average delays of seven to ten days before patients continue treatment at PHC facilities;
- 3) Most PHC providers lack TB training and have only been recently hired; and
- 4) There is high staff turnover in PHC facilities.

The Quality Project will work to address these weaknesses through CQI activities in Year 2.

#### ***6.2.4 TB/SERVICE DELIVERY/HOSPITAL LEVEL***

A major reconstruction of TB hospitals was started by the Government of Uzbekistan in several oblasts. The leading TB facility in the country, the Republican Center for Phthisiatry and Pulmonology, was closed for reconstruction in January 2011 and may stay closed until 2012. Due to the closure, many patients are now being treated as outpatients.

During this process, the Quality Project provided technical assistance on TB-IC. The unexpected closure of the Republican TB Hospital, mentioned above, resulted in the relocation of patients, which presents a risk for increased transmission of MDR-TB. This situation provided the Quality Project with an opportunity to promote broad TB-IC implementation. Quality Project experts provided recommendations to key national partners on the planning and implementation of administrative TB-IC measures in TB facilities. These recommendations have contributed to the development of plans to separate patients in TB facilities according to their infectious status and drug resistance status.

The Quality Project assisted in planning, coordinating, and implementing a joint Quality Project-TB CARE TB-IC assessment mission. Meetings were held with representatives from the Global Fund PIU, the Republican Center of Phthisiatry and Pulmonology, Tashkent City TB Hospital #1, and the City TB Dispensary. TB-IC practices were assessed in several TB facilities, and a report on the assessment, including recommendations for TB IC improvement, will be provided to national partners. This is a politically sensitive issue as the TB-IC assessment did find weaknesses, such as poor ventilation and insufficient planned use of UV, in sites where national partners have made substantial investments. Depending on how these findings are presented, partners could face barriers to continuing work in Uzbekistan.

#### ***6.2.5 TB/SERVICE DELIVERY/LAB***

In Uzbekistan, new initiatives and resources to strengthen laboratory capacity and implement rapid and new diagnostic tests for TB will require recognition that laboratories are systems that require quality standards, appropriate human resources, and attention to safety in addition to supplies and equipment. Significant improvement of the TB laboratory network of Uzbekistan has been achieved during previous assistance programs implemented with USAID funding.

The Quality Project coordinated with a wide range of country and international partners on improving lab services in order to multiply the value and impact of interventions, avoid duplication of activities,

and enhance services for the benefit of the population. The Quality Project maintained close communication with international specialists responsible for the laboratory assistance being provided to Uzbekistan through KfW and the Stop TB Partnership-EXPAND TB project. This close coordination helped identify laboratory network needs and gaps in current funding. The Quality Project, together with partners, identified four areas in which laboratory staff need training but funding was not available. As a result, the Quality Project planned a training workshop in culture, DST, and advanced methods of TB diagnostics, including MGIT and Hain tests. The Quality Project also conducted preparatory work to implement the GeneXpert MTB/RIF.

The Director of the Uzbekistan NRL confirmed that Uzbekistan has selected the EQA method to be used nationally in Uzbekistan. This method was recommended and introduced by Project HOPE during earlier USAID projects. NRL welcomes Quality Project assistance to help strengthen the system throughout the country, and the Quality Project is implementing activities to ensure the national EQA system will be implemented effectively.

### **6.2.6 TB/COMMUNITY ACTION FOR HEALTH**

In Uzbekistan, TB control and assistance programs need to seek ways to achieve easier and wider access to communities and the general population in order to efficiently deliver health education messages. In an effort to improve TB prevention, early case detection, and successful treatment of patients, the Director of the Republican Institute of Health and Medical Statistics agreed with Quality Project to quickly expand CAH activities beyond the pilot sites by mobilizing the vast resources of the Institute. This collaboration utilizes the Institute's 159 branches to carry out community mobilization activities. The Quality Project conducted TOT workshops, on-the-job trainings, supportive supervision, and M&E of these activities with the Institute to increase the impact of collaboration.

The Quality Project conducted TWG meetings on the development of informational materials on TB, MDR-TB, and TB/HIV. Over the course of the meetings, participants defined the needs, requirements, and criteria for information, education, and communication (IEC) materials on TB, MDR-TB, and TB/HIV for target audiences. Three sub-groups were formed within the TWG to develop appropriate IEC materials for the general population, risk groups, and medical professionals. TWG participants decided to develop a poster for the general population and two different leaflets for youth and migrants. Draft versions of the poster and leaflets were developed jointly by the Institute of Health, the Ministry of Higher Educational Institutions, the Dialogue Project, and the Quality Project.

The Quality Project and the Dialogue Project worked with staff from the City TB Dispensary and the Republican AIDS Center to ensure key questions from MDR-TB and TB/HIV patients are incorporated into the patient counseling tool. The text for the tool was finalized and sent to MOH for approval.

The Quality Project identified the number of health providers in Tashkent pilot sites that need to pass IPCC and counseling skills trainings. The Quality Project is coordinating with the Institute of Health and Medical Statistics and Tashkent Institute of Postgraduate Medical Education to train these staff next

year. The involvement of the Tashkent Institute of Postgraduate Medical Education ensures these trainings will count towards the CME requirements for these medical workers.

### **6.3 TB/HIV**

Collaboration between TB and HIV systems is weak. Although the TB system conducts HIV testing of most TB patients, the provision of co-trimoxazole and ART to co-infected patients is suboptimal. A national working group on TB/HIV created in January 2011 stopped functioning in April 2011. Special approval from several governmental offices is required in order to collect epidemiological data on HIV/AIDS or TB/HIV, or to establish activities in either HIV or TB facilities.

Since January 2011, the Quality Project has been an active member of the TB/HIV Working Group. The Working Group concluded that an MOH decree is needed to streamline the coordination of services. It was decided that this MOH decree should define the coordination process and the position of a TB/HIV regional coordinator, including functional responsibilities. The Quality Project provided technical assistance to develop the draft MOH decree which was agreed upon by all TB and HIV services, the Institute of Health and Statistics, and international organizations such as the Global Fund and WHO. The draft has been submitted for MOH review and approval.

### **6.4 HIV**

#### **6.4.1 HIV/NATIONAL LEVEL/ALL SUB-ELEMENTS**

HIV activities were not initiated in Year 1 as they require additional approval from MEC under COM. Quality Project documents were submitted, and dialogue with the National AIDS Center was initiated.

### **6.5 MCH/FP/RH**

#### **6.5.1 MATERNAL HEALTH**

MCH activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in MCH quality improvement is desired, and will complement and enhance World Bank Health 3 investments in equipment and renovation.

#### **6.5.2 CHILD HEALTH**

MCH activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in MCH quality improvement is desired, and will complement and enhance World Bank Health 3 investments in equipment and renovation.

### **6.5.3 FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)**

FP/RH activities were not initiated in Year 1.

### **6.6 CVD/NCD**

CVD/NCD activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in CVD/NCD quality improvement is desired, and will complement and enhance World Bank Health 3 investments in equipment and renovation.

### **6.7 HSS/LEGAL AND POLICY**

Health policy dialogue occurred in Year 1 largely related to TB.

### **6.8 HSS/HEALTH FINANCING**

Health financing activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in health financing strategy, developing new hospital payment system, and hospital restructuring is desired to help ensure that health financing mechanisms contribute to equity, access, efficiency, and quality.

### **6.9 HSS/PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES**

Cross-cutting activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in further expansion of QI processes especially for health managers is desired, and will complement and enhance World Bank Health 3 investments in equipment and renovation.

### **6.10 HSS/INSTITUTIONALIZATION FOR SUSTAINABILITY**

EBM/CPG and medical education activities were not initiated in Year 1 other than limited dialogue and technical assistance. Discussions with the World Bank confirmed that international technical assistance and training in EBM/CPGs and medical education is desired, and will complement and enhance World Bank Health 3 investments in equipment and renovation as well as institutionalize improvements in the content of clinical practice.

### **6.11 HSS/COUNTRY M&E, OR, AND HIS**

Due to Uzbekistan's unique operating challenges, no OR took place in Year 1. Instead, Year 1 focused on dialogue and planning for OR. Two categories for research were selected: tuberculosis or health financing. The research options within each category will be narrowed down and a final choice selected after dialogue with MOH, based on the implementation needs of the Quality Project in Uzbekistan.

## **7. REGIONAL**

### **7.1 REGIONAL STRATEGY AND PLAN DEVELOPMENT**

Regional strategy and plan development was a priority in Year 1 and the Quality Project Regional Strategy is attached in Appendix B (separate file attached). Quality Project regional teams constantly communicated and held periodic regional meetings to further develop regional- and country-level strategies, plans, technical methodologies, and implementation processes.

### **7.2 REGIONAL PARTNER MEETINGS, TRAININGS, CONFERENCES, AND EXCHANGES**

To maximize regional project opportunities, the Quality Project supported and facilitated regional partner meetings, trainings, conferences, and exchanges to increase capacity, enhance dialogue, promote policies, observe reforms, or share experiences and lessons learned.

### **7.3 RESEARCH AND DEVELOPMENT OF REGIONAL PRODUCTS**

Research and Development (R&D) required for development of products that are relevant and applicable to all countries is a regional activity. The main purpose of this category is to explicitly recognize the Quality Project regional program management strategy and the importance and cost efficiency of regional R&D to develop products which can then be implemented in each country. Examples include, but are not limited to, policies, laws, or regulations (adapted to each country); NGO organizational development tools; performance or quality improvement processes in general and for specific priority programs; M&E frameworks and policy analysis or OR study design; provider payment systems; HIS; health management training; clinical training materials; CPGs; medical education including undergraduate curriculum; CME courses and distance education; lab or pharmaceutical methodologies; and health promotion and CAH materials.

### **7.4 M&E: OR**

One of the key aspects of the Quality Project M&E function is OR. OR findings will allow the Quality Project to identify best practices and document successful innovation for replication, as well as making

mid-course corrections as needed to current activities. The results of OR studies will be used to inform policy makers and stakeholders about current and urgent issues in the health system as a basis for good health policy making. OR studies will also generate demand for M&E of health reforms among policy makers and promote a culture of evidence-based policy making in country.

One OR study in each country (Kazakhstan, Kyrgyzstan and Tajikistan) was designed and carried out with reports to be presented to the main stakeholders early in Year 2. The results will be used as a basis for health policy making. When the reports are ready the following dissemination activities are planned:

- Policy briefs on each set of study results; and
- A roundtable discussion or working group meeting to present study results.

Also during Year 1, a regional TB study was planned for Year 2. It will assess patient satisfaction and quality of TB services at all health system levels. It is intended to be a baseline survey. The objective of this study is to understand how TB patients perceive the quality of services provided to them at all health service levels since they were first diagnosed with TB. The methodology is currently under development.

## **7.5 PROJECT PERFORMANCE MONITORING PLAN (PMP)**

In Year 1, the proposed project PMP was revised and submitted to USAID. It was then agreed that a further revision would be needed to ensure consistency with USAID priorities that had shifted during the procurement gap year and a revised draft version of PMP indicators was submitted in October 2011. The revised draft PMP indicators are also included in the Regional Strategy. Following USAID approval of the PMP indicators, next steps include developing detailed definition and measurement of PMP indicators, documentation of baselines and setting of targets.

The Quality Project PMP has been developed in tandem with the workplan and is tightly linked to project activities. The indicators selected for the PMP were chosen according to three criteria: validity, ease of collection, and data quality. Validity ensures that the selected indicators do accurately measure progress toward project objectives. Ease of collection ensures that all indicators can be collected as often as required. Data quality ensures that all indicators use accurate data and reflect the reality or project implementation. PMP data is collected on a regular basis, with the time frame dependent on the specific indicator and method of collection.

The selected indicators include process, intermediate, and impact indicators, as M&E efforts are intended to both guide the project and measure it. Process and intermediate indicators are frequently collected and provide day-to-day guidance on project progress. Impact indicators are collected quarterly or annually, and reflect the success or failure of Quality Project interventions.

Participant training information and Year 1 key outputs are included in Appendix C and D, respectively (separate files attached).

## **7.6 USAID PR/OUTREACH**

In Year 1, the Quality Project focused on promoting USAID, the project itself, and its achievements through success stories (see Appendix A for Year 1 success stories). Two of the project's stories were featured in USAID's *Frontlines* newsletter: one story focused on family physicians and the development of FM in Kyrgyzstan while the other profiled MDR-TB in the region and the upcoming introduction of GeneXpert. In addition to the *Frontlines* stories, the Quality Project submitted the following success stories in Year 1:

- "E-Learning Turns Barriers into Opportunities for Health Care Providers in Kyrgyzstan" (Kyrgyzstan)
- "Practitioner and Champion of Effective Perinatal Care" (Kyrgyzstan)
- "USAID Trains NGOs to Help Themselves" (Kazakhstan)
- "Sharing Health Reform Lessons and Successes in Central Asia" (Tajikistan)
- "Trust and Sympathy for Successful Care" (Uzbekistan)
- "Embracing Happy and Healthy Births in Turkmenistan" (Turkmenistan) (delayed release until Year 2)
- "Family Medicine Gains Momentum and Trust in Tajikistan" (Tajikistan)
- "Expanding Horizons for Quality Health Care" (Kazakhstan)

As the search continued for a public relations consultant, the Quality Project worked towards establishing a regional management process for press release production to ensure quality control; collected photos for the project's internal database; and created a six-month event calendar and provided monthly updates.

## **7.7 PROJECT TEAM BUILDING AND CULTURE**

The Quality Project presents enormous opportunities to raise the country health reforms to a new level by creating synergies between priority program service delivery improvements and health systems strengthening both inside the project and within the broader health sector environment. These synergies should result in substantial quality improvement and health systems strengthening in Central Asia particularly for TB and HIV programs. However, achieving these ambitious goals requires development and maintenance of a seamless project team and culture operating inside the project, with USAID, and with country partners. All technical teams (including teams incorporating USAID staff and country partners) will constantly search for opportunities to link and leverage program activities rather than implement vertical programs. All staff will engage in continuous and extensive communication, and substantial and effective program management will function at all levels of the Quality Project. In Year 2, team building and continuous development of a proactive and open culture will continue to be a priority.

To strengthen the team and provide opportunities for growth to both veteran staff members and those who have joined the new team, regional technical and management leadership and country managers

will continue to actively mentor and develop all staff. The Quality Project will selectively seek to involve local staff in international conferences, workshops, and trainings, believing it is critical that staff are exposed to recent, innovative, and international developments in the public health sector and encouraged to share their own work in such international forums. Staff capacity-building activities will be ongoing and are planned to include improvement in presentation skills (USAID local specialists will be invited to join the presentation skills training).

## **7.8 KNOWLEDGE MANAGEMENT**

Regional knowledge management is a Quality Project priority to maximize the inherent value of a regional project, enhance country level implementation, and take advantage of IT advances to increase efficiency and productivity. Two types of activities were initiated in Year 1 and will continue in Year 2.

- Regional administration – establish web-based databases to improve productivity and management efficiency and effectiveness. A regional travel approval database is already functioning and participant training, events calendar, and contact information databases will be added. A standardized finance and administration archive file structure has been developed and installed on all country networks.
- Program knowledge management – the Quality Project website has been established. A database or library will be added which will include USAID reports, success stories, press releases and technical reports. A standardized program archive file structure is being developed for installation on all country networks, and the Quality Project plans to make elements of it accessible through the internet.

## **7.9 PROJECT MANAGEMENT**

Abt Associates will follow the policies and procedures contained in the Abt Associates International Policies and Procedures and Financial Manual. In addition, the Quality Project has developed additional project-specific policies and procedures to further detail policies and procedures in the local environment; they will be refined and expanded in Year 2. Abt/CAR is working very closely with Abt/U.S. to ensure good and compliant regional- and country-level financial management systems and continuous improvement in internal controls including capacity building for local finance managers. Regional- and country-level administrative processes have been developed and will be solidified in Year 2. Subcontracts are in place for Project HOPE, APMG, STLI, and Socium Consult. Grants are in place for KAFP, FGPNA, HA, and FMSA. The Quality Project initiated and will strengthen our regional matrix management system and communication processes.

## **8. APPENDIX A: YEAR 1 SUCCESS STORIES**

### **“Wanted: Primary Care Docs in Kyrgyzstan”**

Dr. Cholpon Sadyrbaeva flipped through her photographs on a projector screen. When she got to one showing three generations of a family that she treated in rural Kyrgyzstan, she paused and smiled. There were photographs showing her examining an infant, listening to an old man’s lungs, and counseling a middle-aged woman about high blood pressure.

The Kyrgyz State Medical Institute for Retraining and Continuing Education, USAID, and the U.S. NGO Scientific Language and Technology Institute invited Sadyrbaeva to give her presentation to dozens of sixth-year medical students at a three-day family medicine symposium in Bishkek early last November. An annual event since 2006, the symposium provides information and hands-on training to encourage more medical students to consider a career as a primary care physician.

Sadyrbaeva returned to the symposium for a second time to present her photographs and experiences to her peers. She represents a new generation of Kyrgyz family physicians that came of age and began practicing after reforms radically transformed the health-care system of post-independence Kyrgyzstan.

### **Weaning Off Specialists**

Prior to independence, the Kyrgyz health-care system relied heavily on specialists to treat most illnesses. “Most people in Kyrgyzstan weren’t used to receiving care from a generalist and didn’t even understand the concept of family medicine, so they tended to trust specialists much more than family doctors.” Sadyrbaeva explained.

Typically, a patient would enter a health-care facility and almost immediately be referred to a specialist, even if the problem was minor. Pregnant women were required to visit three specialists. Children entering kindergarten were required to see at least five specialists and submit to numerous laboratory tests before starting school.

And most of these specialists were located in different clinics in different parts of town, adding to the time and bureaucratic hassle for patients.

When the Soviet Union dissolved and Kyrgyzstan achieved independence in 1991, the country’s health care system was financially unsustainable and unable to provide adequate health services to its citizens. Mounting financial pressures on the government resulted in drastically reduced health budgets over the years.

In 1996, the Kyrgyz Government, in partnership with USAID, launched an ambitious campaign to transform and streamline the country's health-care system to make it more financially sustainable and responsive. This campaign focused on broadening the scope of primary care, strengthening the capacity of providers, and establishing family medicine as the bedrock of the Kyrgyz health-care system.

"It was crucial to form a new primary health care system with a focus on family medicine in Kyrgyzstan in the 1990s. The old system was not responsive to the patient and was collapsing under its own weight," explained USAID health specialist Dr. Makhmudova. "This new system is better in two ways: it reduces the size of the health sector to make better use of limited resources and also creates space for primary health practices to expand services to more patients. A strong family medicine base is better for patients, the community, and costs less so it's better for all."

A major objective of the reforms was to move away from costly and often unnecessary hospital and specialist care toward more cost-efficient and patient-centered primary health care. With USAID support, the Government of Kyrgyzstan created a completely new primary health-care sector and pinpointed family practitioners—a new medical specialty that did not exist prior to reforms—as the linchpin to the new system.

### **Incentivizing a New Generation**

For Sadyrbaeva, the choice to become a family physician was not obvious. Originally from the southern Kyrgyz city of Osh, she had dreamed of becoming a cardiologist—a prestigious and lucrative career path. But her medical education began just as Kyrgyzstan started to implement plans to promote family medicine, including tuition assistance and monthly stipends for medical students that choose to study family medicine. The country needed to develop a new generation of family physicians—doctors who could treat a diverse array of ailments for all age groups. After carefully considering her options, Sadyrbaeva eventually decided to become a family physician.

"The first reason that I chose family medicine was that I needed a scholarship because I couldn't afford to pay for any more education after finishing the medical academy. The second reason was that I was really drawn to family medicine because I liked the idea of being able to get experience in many different areas of medicine and to treat both adults and children," says Sadyrbaeva.

After completing a family medicine residency in Bishkek, Sadyrbaeva served two years in a location chosen by the government in return for the financial aid that she received. Due to a shortage of doctors, the Kyrgyz Government sent Sadyrbaeva to remote and economically distressed Naryn province. In spite of the hardships of being a doctor in a rural area, Sadyrbaeva prospered and became a skilled clinician and trusted caregiver to her patients. Within months, she was promoted to deputy director of the city's family medicine center.

Once she finished her service in Naryn, Sadyrbaeva found work as a family physician in Bishkek. "I work part-time as a family physician in Bishkek now, but I don't really have a chance to practice family medicine," she explained. "When I work in the government family clinic, the patients are divided and the pediatricians get the pediatric patients, the gynecologists get the gynecology patients etc. I only get to

do real family medicine when my friends and relatives ask me for advice! I hope that family practice will truly develop more here as it has in rural areas.”

Despite Sadyrbaeva’s professional success and the success of the health-care reforms that created family practitioners, the prime barrier to expanding the field remains attracting medical students. At the symposium in Bishkek, many medical students admitted that although they were interested in family medicine, they ultimately planned to become specialists because of the higher wages they offer.

In the short term, USAID is working to improve the quality of family medicine. Today, USAID, through its Quality Health Care Project, is supporting improvements in family medicine education, including the introduction of evidence-based medical standards, to produce a new cadre of capable family physicians. Over the past 15 years, USAID-sponsored programs have re-trained over 2600 pediatricians, internists, and ob/gyns in evidence-based family medicine. These re-trained doctors, along with this new generation of family physicians, have positively impacted health outcomes in Kyrgyzstan over the past decade. In maternal and child health, Kyrgyzstan’s strengthened primary health care sector has contributed to a 30 percent drop in infant mortality rates and a 35 percent drop in mortality rates for children under five since the start of USAID-supported health reforms.

A longer-term goal is to ensure that family medicine becomes a respected and trusted first line of health-care provision and a more attractive and prestigious career path for young doctors, and, ultimately, to help the Kyrgyz government provide high quality and affordable health services to its people.

Through continued support from USAID and the Government of Kyrgyzstan, family medicine is steadily cementing its position in the Kyrgyz health care system as an affordable and effective system of quality health care provision. Ten years ago, people chose to visit a family physician for diagnosis and treatment only 15 percent of the time. Today, as the field of family medicine has matured, people choose family physicians, over specialists, more than 50 percent of the time. As more and more people choose to visit family physicians, the benefit for doctors will be getting to know their patients on a more personal level. For Sadyrbaeva, her presentation at the symposium is a way to promote the profession to aspiring doctors, but it’s her smile and photographs that show the audience the affection that a family physician can have for her patients.

### **“99-Minute Diagnosis: Will New Technology Turn Tide on TB War?”**

In his office in Kazakhstan’s National TB Institute, Dr. Shakimurat Ismoilov is quick to recall his latest encounter with multi-drug resistant tuberculosis (MDR-TB) – the country’s fastest growing and most dangerous epidemic. “Just this morning, I examined two patients who had MDR-TB for three years and didn’t know it! They infected their children and other relatives. MDR-TB is just not easy to diagnose, and the test isn’t fast. These patients didn’t have many symptoms, and initial TB tests were negative.” Unfortunately, Dr. Ismoilov, the chief MDR-TB physician in his facility, can easily think of many more such MDR-TB patient stories. “Another patient of mine first noticed symptoms in March 2010, but she

didn't go for diagnosis by a doctor until August. Then, it wasn't until November that we were able to diagnose her with MDR-TB, and she finally went on MDR-TB treatment in January. If she had been diagnosed earlier, she might not have developed these huge cavities in her lungs." Dr. Ismoilov holds up this patient's x-rays to show the ravages of tuberculosis: the large holes grow larger with each successive x-ray, taken in the months leading up to and after her MDR-TB diagnosis.

### **A Growing and Dangerous Epidemic**

Tuberculosis (TB) is a contagious disease that spreads through the air: when someone with an active TB infection coughs, sneezes, talks or spits, tiny TB bacteria, called bacilli, are launched into the air and can be inhaled by others. While anti-TB drugs have been successfully used to treat and cure TB for the past 50 years, roughly 1.8 million still die annually from TB, many of whom are between the ages of 15-45 years old.

Effective control of TB requires that patients who are infected with the disease take their medication regularly and finish their treatment. Treatment for TB takes between six to eight months, and if a patient does not take their medication or finish their treatment, TB can become resistant to anti-TB drugs. In the past few decades, drug-resistant strains of TB have emerged in different parts of the world, and these strains are more difficult to treat because they are resistant to the most common anti-TB drugs. Treating such cases takes up to two years.

Over the past decade, drug-resistant strains of TB have flourished in the former Soviet republics. In the 1990s, the breakdown of Central Asian health care systems after the collapse of the Soviet Union created gaps in TB screening and treatment, which led to growing numbers of TB and MDR-TB. The economic turmoil and social upheaval of the time further complicated efforts to adopt an effective strategy to tackle the growing TB and MDR-TB problem. Today, the highly infectious nature of MDR-TB, and the growing numbers of infected individuals in Central Asia, threaten to spread the disease far beyond the region.

### **Outdated and Decaying Detection Methods**

During the Soviet period, TB was primarily diagnosed through x-ray screening. This tool, while needed, should not be the primary method for TB diagnosis because it is not a reliable indicator of TB infection. In 1997, USAID and the Kazakhstan Ministry of Health provided new equipment to strengthen a diagnostic method called sputum microscopy. Around since the late 1800s, sputum microscopy works by using a microscope to look for TB bacilli in a patient's sputum. While preferable to x-ray screening as a priority screening method, sputum microscopy requires trained laboratory staff and proper guidelines, takes a day to produce results, and can sometimes generate false results. This simple method also does not identify drug-resistant strains of TB. For that, the patient's sputum must be further tested, and it can take between two weeks and three months to get those results back depending on the diagnostic method used.

The time lag between testing and diagnosis is extremely problematic and is a major contributor to the growing MDR-TB epidemic. In the spring of 2010, Zhenya M., an IT specialist in his early 20s, started to feel ill. He tried to treat himself at home before finally deciding to see a doctor. The doctor at his local primary health care clinic took an x-ray of Zhenya's chest and then referred him to the TB hospital for further testing. At the hospital, his sputum tested positive for TB, and he was sent to the section of the hospital for new TB patients. Over the following three months, further testing showed that the strain of TB that Zhenya had was not resistant to the main anti-TB drugs. But after nearly six months of treatment, he was still not feeling any better. At that time tests confirmed what everyone suspected: Zhenya's TB had become resistant to the treatment. Nearly nine months after he began to feel sick, Zhenya was finally placed on an effective drug regime.

While he is feeling better now, Zhenya was forced to quit his job because of his prolonged absence and is still in the TB hospital receiving treatment. During his time in the hospital, it is very likely that Zhenya contracted MDR-TB from a fellow patient who was waiting for his or her results. Unfortunately, this situation is all too common, says Dr. Alma Akbayeva, Deputy Chief Doctor of the Regional TB Hospital. "Twenty percent of all new cases in my hospital are MDR-TB, and the speed of MDR-TB diagnosis is a problem. If we could find MDR-TB sooner, we could assure that there would be less transmission of it in the hospital."

#### **A New Weapon in the War Against TB**

Globally, USAID has partnered with the World Health Organization, the World Bank, the STOP TB Partnership, the Global Fund and other global TB control initiatives to provide technical assistance, strengthen local capacity, and introduce innovative yet practical solutions to effectively prevent the spread of TB and MDR-TB.

In Central Asia, USAID and partner organizations are leveraging institutional knowledge, donor resources, and experience in the region to introduce one of the latest technological advances in TB diagnostics: GeneXpert. This new technology, which is compact and easy to use, is able to rapidly and accurately test for TB including strains of TB that are resistant to the most effective anti-TB drug, rifampicin. No advanced training or sophisticated laboratory infrastructure is required to use GeneXpert, and perhaps most importantly, it is able to deliver results in less than 99 minutes. Patients can be diagnosed while they wait, and proper treatment can begin almost immediately.

Quick diagnosis through GeneXpert also significantly lowers the chances that a patient will contract MDR-TB in the hospital, like Zhenya probably did. "USAID believes that hospital transmission is a prime mechanism for the spread of MDR-TB in the region. The use of GeneXpert will contribute to early detection of MDR-TB, as well as timely separation and appropriate treatment of MDR-TB patients. This is a key step in the successful control of MDR-TB," affirms USAID Health Specialist, Dr. Kairat Davletov.

In the past decade, USAID has worked to provide equipment and training for other needed laboratory diagnostic methods, to assist in introducing proper treatment regimens, and to ensure the availability of high quality anti-TB drugs. Combined with these efforts, GeneXpert has the ability to fulfill a dire need in

Central Asian health care systems for faster diagnosis of drug-resistant TB and promises to change the trajectory of TB and MDR-TB in the region and around the world.

### **No More Time Lost**

As the USAID Quality Health Care Project and USAID TB CARE work with local and international partners to prepare for the introduction of GeneXpert in Kazakhstan and potentially other Central Asian countries in the future, word is out that a new technology exists that can rapidly detect MDR-TB. For some patients already infected with MDR-TB, the arrival of this new technology is bittersweet. “My doctor recently told me that there is a new diagnostic method to identify drug-resistance in less than two hours! If this tool had existed in 2010, I wouldn’t have lost so much time because I would have started treatment much earlier,” says MDR-TB patient, Erik T., from east Kazakhstan.

As anticipation builds for GeneXpert, implementation of this new technology could not have come at a better time for patients and doctors alike. “We’re clinicians. We recognize the problem, and we see that there are more and more MDR-TB patients in our hospital every year. It would be invaluable to have GeneXpert here,” says Dr. Akbayeva.

USAID’s efforts to implement this cutting-edge technology for faster and more accurate diagnoses are part of a multi-pronged strategy to counter the growing swell of MDR-TB cases in Central Asia. In the future, with the help of GeneXpert, far more people will be diagnosed with MDR-TB in a shorter period of time. Prompt diagnosis and treatment will prevent transmission to neighbors and loved ones and over time will slow down this fast-moving epidemic. With GeneXpert, fewer individuals infected with MDR-TB will have to risk losing their health, time, and possibly their lives while waiting for a test result.

### **“E-Learning Turns Barriers into Opportunities for Health Care Providers in Kyrgyzstan”**

For doctors and nurses throughout the world, learning is far from over upon graduation from medical school. Aside from the importance of learning on the job, formal continuing medical education also plays a vital role in ensuring that patients are getting the best care possible. When health care providers are routinely provided with opportunities to update their knowledge of modern medical practice and skills, the impact on a population’s health can be tremendously positive. Since 2001, USAID and the Kyrgyzstan Ministry of Health have worked together to make the country’s continuing medical education program more accessible, relevant, and manageable for health care providers to improve the quality of care for everyone.

For health care professionals in Kyrgyzstan, like Dr. Natalya Karaseva, the continuing medical education system was fraught with difficulties in the past. As Dr. Karaseva recounts, “Courses were held in only two cities in the country, so I had to be away from my work and family for three months in order to attend them. I had to pay out of my own pocket to attend them, and the courses were traditionally-structured: lecturers dominated and learners were passive recipients of information.” Dr. Karaseva accepted these inconveniences though because the course improved her professional standing and pay

grade, and luckily for her and her colleagues, they only had to attend one course every five years. The geographic distance, burdensome absence from work and family, lecture-heavy course structure, and requirement to attend only one course every five years left health care providers underprepared and unmotivated. For many providers, these barriers kept them from attending courses for years at a time, and contributed to a system in which doctors and nurses were given little incentive and few chances to access modern medical advances and improved standards of practice.

To motivate health care providers to maintain and improve their knowledge and skills, USAID spearheaded a program in 2004 to bring the courses to the health care professionals as part of a two-pronged approach to build a modern continuing medical education system and introduce distance-learning alongside more traditionally structured learning. With the help of PACTEC, a US-based firm that specializes in communications technology, USAID developed computer-based courses to provide distance-learning opportunities to doctors and nurses. Through pilot testing in Kyrgyzstan, computer-based courses proved to be as effective as classroom-based courses in teaching new information and skills training to health care providers. Computer-based courses, once implemented throughout the country, promise to revolutionize continuing medical education in Kyrgyzstan by connecting health care professionals with standardized, up-to-date medical developments in an accessible and flexible format.

For Dr. Karaseva, who recently participated in one of the seven courses currently available, this new program has been a revelation: “I don’t have to travel for the course and so I don’t have to be away from work. I was able to schedule my study time since the course materials are accessible at any time of day. The course was comprehensive and easy to use, interesting and interactive.” Dr. Karaseva was able to install the courses on her home computer and access them at her convenience. Other participants that took part in the pilot program were able to access courses via computers at their facilities during the work day. By providing opportunities to complete courses at home or at work, busy health care providers are given the freedom to choose when and where they want to access their courses.

Today, the USAID Quality Health Care Project is working with the Kyrgyz State Medical Institute for Retraining and Continuing Education to scale up e-learning as a cost-efficient, accessible, and enjoyable means of providing continuing medical education to health care professionals. At a time when Kyrgyzstan is moving to incorporate evidence-based guidelines into medical curricula, computer-based courses are perfectly positioned to offer providers the chance to update their skills and improve the quality of health care services without the burdens and barriers that existed in the past.

### **“Practitioner and Champion of Effective Perinatal Care”**

In November 2007, Dr. Damira Seksenbaeva took part in a relatively new training program in Kyrgyzstan called “Effective Perinatal Care” to improve infant and maternal health before, during and after childbirth. Beginning in 2006, USAID partnered with the Ministry of Health and other international donors to implement the World Health Organization’s Effective Perinatal Care (EPC) program in a small number of maternity hospitals throughout Kyrgyzstan. The success of these pilots brought the program to Dr. Seksenbaeva’s hospital, Bishkek City Perinatal Center.

In the past, childbirth in Kyrgyzstan was guided by a set of rigid procedures in place for decades: partners were not involved in the birthing process; women were not informed nor asked for consent before procedures; women had to give birth lying down on their backs in a common labor room with other women; mothers and babies were separated immediately after birth; and family members were not allowed in the postpartum ward. From Dr. Seksenbaeva's perspective, women were not always satisfied with the way they were treated and the quality of health care they received. Dr. Seksenbaeva also noticed that the routines in place did little to prevent infections and health care providers were not adequately prepared for emergency obstetric and newborn care needs.

When the EPC program was introduced in her hospital in 2007, Dr. Seksenbaeva took part in the training program, which consists of five days of theoretical class work and five days of practical skills training. The program is designed to introduce midwives, obstetricians, gynecologists, neonatologists, and pediatric nurses to a patient-centered approach to childbirth that incorporates evidence-based standards of care. To reduce preventable maternal and perinatal deaths during childbirth, the EPC program also focuses on reducing the chances of infection and preparing health providers for medical conditions, like pre-eclampsia, postpartum hemorrhage, and perinatal asphyxia, that require specialized emergency care.

After Dr. Seksenbaeva completed the training program, she quickly moved to incorporate these changes into her work: she provided counseling to allow patients and their families to make informed decisions; encouraged women's partners to provide support during delivery; allowed patients to choose their body positioning and give birth in private rooms; and prescribed only essential medicines during labor and delivery. Since the EPC training program was implemented at her hospital, Dr. Seksenbaeva has noted higher patient satisfaction, lowered costs from using fewer drugs, and better health outcomes: there are fewer serious postpartum complications, more healthy newborns, decreasing numbers of infections, and fewer emergency deliveries.

Since 2006, USAID and the Ministry of Health have expanded the geographical reach of the program, established a team of national trainers to conduct EPC training, and developed national standards and protocols for obstetric care based on internationally-recognized, evidence-based guidelines. Since late 2010, the USAID Quality Health Care Project, in collaboration with the United Nations Population Fund, the World Bank, the World Health Organization, UNICEF, GTZ, and KfW, has continued to expand the EPC program and will develop a training curriculum focused on improving the mentoring skills of oblast and national-level EPC supervisory staff to conduct more effective on-the-job training.

As USAID has expanded the program in Kyrgyzstan, Dr. Seksenbaeva has also experienced professional growth since she attended the EPC training in 2007: she became a national EPC trainer in 2008 and just recently was promoted to deputy clinician in charge of clinical practice in her hospital. As the EPC program takes flight throughout Kyrgyzstan, practitioners and champions of Effective Perinatal Care, like Dr. Seksenbaeva, will be instrumental in institutionalizing evidence-based and patient-centered care for happier and healthier mothers and infants alike.

## **“USAID Trains HIV NGOs to Help Themselves”**

In the corner of the room, a man rose and introduced the person to his left. “This man’s name is Bakhyt. He’s from Pavlodar, is the director of his organization, and he is HIV-positive.” The other participants clapped and applauded his courage while Bakhyt quietly acknowledged them from his seat. Bakhyt and the other participants are managers of HIV/AIDS outreach non-governmental organizations (NGOs) from across Kazakhstan. In March 2011, they took part in a three-day workshop conducted by USAID’s Quality Health Care Project to improve human resources management within their respective organizations. The managers of these NGOs came to Almaty, in southern Kazakhstan, with a diverse set of backgrounds and experiences working in HIV prevention, care and treatment programs. Some managers at the workshop have worked for many years in HIV outreach programs that provide health and social services to people infected with or at risk of contracting HIV. Bakhyt attended the workshop for the same reasons as other program managers, but his experience with HIV prevention and treatment programs is more recently acquired and more intimately connected to his own circumstances.

### **Not Alone**

In December 2007, Bakhyt traveled from his hometown of Pavlodar to the small northeastern Kazakh town of Aksu. HIV-positive since the early 2000s, Bakhyt was invited to Aksu to take part in a support group for people living with HIV. Like many places in the world, living with HIV in Kazakhstan can mean a life of discrimination and stigmatization due to the public’s lack of knowledge and understanding of the disease. While Bakhyt had lived with HIV for several years, he felt heartened by the group’s stories and collective courage. He began to attend weekly group meetings and eventually decided to form his own group in Pavlodar to help his community better understand the medical, social and psychological implications of living with HIV.

After a year of planning, Bakhyt formally opened his organization “You’re Not Alone” in June 2009 to provide support services to people with HIV and those at risk of contracting HIV and to conduct public education campaigns about HIV. In Kazakhstan, like other countries in Central Asia, HIV is mostly concentrated in segments of society that are already discriminated against because of who they are: injecting drug users, commercial sex workers, men who have sex with other men, and prisoners. Individuals from these groups are at higher risk of contracting or already having HIV than the general population, and they are often uncomfortable accessing public health care services due to the stigma and unresponsiveness they usually encounter. The socially-induced shame and fear of being HIV-positive can delay or even keep these people from seeking treatment and support altogether. Private community outreach organizations, like Bakhyt’s, are the main vehicles for providing services to these vulnerable groups that are either unwilling or unable to seek prevention, care, or treatment on their own.

### **Outreach Work and Burnout**

For Bakhyt’s organization, like many HIV outreach organizations in Kazakhstan, a perennial problem is developing and retaining a team of committed and effective outreach workers – individuals who work within the local community to connect people with HIV, or those at risk of contracting HIV, to medical

and social services. Outreach workers can have diverse backgrounds: some may have experience in social work and counseling, while others may be former injecting drug users or commercial sex workers that have personal experiences with HIV. Cultivating a team of outreach workers that is familiar with local issues and context is advantageous in crafting an HIV prevention and outreach plan that makes sense for the community.

While the backgrounds of outreach workers can be quite different, outreach work itself is almost uniformly difficult: staff conduct their work out in their communities, and the emotional strain, poor working conditions and irregular schedules of the job can lead outreach workers to feel exhausted, overburdened, and unsupported. When outreach workers feel overly stressed by the demands of the job, they are less efficient in reaching community members that may need their help and less likely to communicate well once they reach them. More commonly, outreach workers will simply quit their jobs as a result of the stress. High staff turnover can be devastating for outreach organizations: with each worker that leaves, these organizations lose not only a valuable link to the community, but they also lose the money and time spent on training that employee.

### **Plugging the Drain**

To counter this human resource and financial drain, and to empower these organizations to more effectively reach at-risk populations, the USAID Quality Health Care Project prioritizes improving HIV NGO management by organizing the human resource management training workshop for 20 HIV/AIDS outreach NGOs from across Kazakhstan. Managers learned how to recruit, train, supervise and support their outreach staff to reduce turnover and increase their organizations' ability to reach more people in their communities. By improving the capacity of Kazakhstan's non-governmental HIV/AIDS outreach organizations and simultaneously opening more friendly entry points into the public health system to expand services and increase sustainability, USAID is working to counter the spread of HIV in the country and in the region.

Two weeks after the workshop, Bakhyt is back at work in Pavlodar, and he's already applying the things he learned at the workshop to his organization. "The training has revised my attitudes towards outreach workers, and I now have a clear vision of methods to improve the quality of outreach work in Pavlodar. I have since become more involved in the supervision of outreach workers, and I sometimes accompany my staff out into the field to better understand their work," he says. Through this workshop, USAID is helping Bakhyt and his peers become better managers and supporters of their staff as they work together to provide high-quality and accessible HIV treatment and prevention services to their communities.

### **"Sharing Health Reform Lessons and Successes in Central Asia"**

As officials moved through the Chui Family Medicine Center in Kyrgyzstan, looking into rooms and talking to staff, Safar Say-fuddinov peeled off to talk to a few patients about their experiences with Kyrgyzstan's national health care program and State Guaranteed Benefit Package. Later on, standing

outside the center in the hot July heat, Sayfuddinov, the head of reforms and international relations at Tajikistan's Ministry of Health, re-lected on the success of Kyrgyzstan's health system and financing reforms and the large-scale health care reforms that his country, Tajikistan, is readying. "We recognize Kyrgyzstan's achievements, and we need to understand these ideas. Kyrgyzstan has progressed. For us in Tajikistan, we can't go backwards. We have to move forward."

In July 2011, USAID and Kyrgyzstan's Ministry of Health sponsored a delegation from Tajikistan's Ministries of Health and Finance to travel to Kyrgyzstan and learn more about the country's health care reform experiences. Health financing reform was a particular focus of the trip as Tajikistan is preparing a comprehensive overhaul of its health financing system.

After the fall of the Soviet Union, the Government of Kyrgyzstan, USAID, and other international partners began work to restructure Kyrgyzstan's health care system, including transforming health care financing to ensure greater efficiency, equity and access. Among the five former Soviet republics in Central Asia, Kyrgyzstan has successfully implemented the most comprehensive and far-reaching health care reforms in the region.

After a devastating civil war in the 1990s, mountainous, rural, and resource-restrained Tajikistan is now working to improve its health care system and is looking to its neighbor to the north for lessons learned. Tajik officials who took part in the study tour engaged in extensive dialogue with officials from Kyrgyzstan's Ministries of Health and Finance and visited health care facilities to talk to administrators and patients. Financial health care reforms in Tajikistan will be the first step in a greater reform process, and the participation of officials from the Ministries of Health and Finance is key to the blossoming of the nascent Tajikistan health financing reforms.

After many questions and much listening during the tour, Tajik officials are readying themselves for the work ahead as health care reforms gain momentum within Tajikistan's government. As Sayfuddinov noted, "This tour was critical and very useful. We were able to discuss a wide range of topics, including priorities and solutions. There will be challenges for us, but we need to get started."

In the coming months and years, the USAID Quality Health Care Project will be working closely with the Government of Tajikistan and international partners to develop and implement these needed health care reforms to move the country's health care system past challenges and towards the future.

### **"Trust and Sympathy for Successful Care"**

In her early life, Asya Butahodzhaeva was the pupil. Born and raised in Tashkent, Uzbekistan, Asya studied, graduated from medical school and, after working in a psychiatric hospital for a few years, she started working as a nurse in the capital's first TB hospital in the 1970s. A natural-born optimist and people-person, Asya enjoyed working with patients, although most nurses in Uzbekistan then were little more than doctors' administrative assistants: they handed out medications and even sometimes did janitorial work but were rarely involved in direct patient care.

During her first years as a nurse, Asya continued to learn on the job. “The main thing I learned [from the doctors] is that we need to express sympathy with patients and understand the problems of the patients.” For Asya, this lesson was simple enough: her life motto was always “treat others as you want them to treat you.” But while sympathy came easily to her, Asya didn’t always feel confident in her technical knowledge and communication skills. “[In the past] I didn’t talk with our patients about TB and if they asked any questions I would always send them to a doctor for counseling because I wasn’t sure about my knowledge and also didn’t know how to explain properly.”

That changed in 2009 when Asya took part in a USAID and Project HOPE program to train TB nurses in counseling. Before the program’s implementation, studies found that patients who stopped treatment early often felt neglected in hospitals or simply did not understand the importance of finishing their treatment. Patients who end treatment early are not cured and could go on to spread TB to their community or develop a form of TB that is resistant to anti-TB drugs. Nurses, like Asya, were identified as the solution: a perfectly placed caregiver and counselor to whom patients could turn for support and answers.

For Asya, the training program enhanced her knowledge of TB and empowered her to become a confidant and teacher to her patients. Since the training, her confidence has increased, and she is now able to tailor her counseling approach to her patients’ different situations. When Asya works with women who have TB, she is careful to include the woman’s family in her counseling sessions. She knows that if the woman’s family does not understand the importance of finishing the treatment, they may pressure her to return home to take care of the family before she is cured. Thanks to Asya’s efforts, as well as those of other nurses in Uzbekistan, many of whom are women, the number of patients stopping their TB treatment before it is completed has decreased in the last few years.

After 33 years as a nurse, Asya is now a teacher as well. In her hospital she says patients feel comfortable approaching her for help and, in the process, both nurses and patients have begun to trust each other. Asya has also become a teacher to her colleagues: when she has free time, she trains other nurses on interpersonal communication and counseling. The USAID Quality Health Care Project is expanding these successful activities to enable all health professionals, but especially women health professionals representing the vast majority of the primary health care workforce, to improve treatment, care, and support and also contribute to reducing stigma and discrimination through community action for health. For Asya, this is her time to educate others on the importance of building trust and feeling sympathy for patients to help them heal. As she explains it, “I had good teachers in my life, and now I’m teaching my colleagues to understand our patients. For that we only need to put ourselves in their place.”

### **“Family Medicine Gains Momentum and Trust in Tajkistan”**

Dr. Marhabo Bobojonova proudly displays her patient list: she regularly sees more than 20 patients per day. In rural Sugd Oblast in northwestern Tajikistan, where people usually prefer to visit hospitals for

health care and rely upon specialists for treatment, this kind of popularity is a feat for a family physician. Since 2002, USAID has worked with the Government of Tajikistan and international partners to promote family medicine and family physicians, like Dr. Bobojonova, to provide Tajikistan's people with quality health care that they can recognize and trust.

Shortly after Tajikistan achieved independence in 1991, the country made initial steps towards reforming health care and establishing primary health care as the foundation of the new system. The start of a civil war in 1993, however, plunged the country into chaos and arrested nearly all progress towards development. When the country emerged from the war at the end of the 1990s and foreign aid flows largely resumed in 2000, much work remained to rehabilitate the economically-distressed and war-ravaged country.

Beginning in 2002, USAID began working with Tajikistan's Ministry of Health to build a cost-efficient and effective primary health care system for the country. USAID and the Ministry of Health started by developing a training program for a new generation of family physicians and a re-training program to convert the outsized number of specialists into family doctors. In the years that followed, USAID contributed to the development of a unified curriculum, supported the cultivation of national trainers, and helped establish regional family medicine training centers. Today, through partnerships with the Ministry of Health, the World Health Organization, the World Bank, the Swiss Development Corporation, and the Agha Khan Foundation, the USAID Quality Health Care Project continues to work towards building a cadre of capable family doctors, trained in evidence-based medicine and national clinical guidelines based on international standards, to provide high-quality, cost-efficient and accessible health care throughout Tajikistan.

As preferences for health care provision change in Tajikistan, patients and family physicians are both benefiting. When patients get well faster as the result of a correct diagnosis or pay less to visit one family physician instead of several specialists, they will choose to visit family physicians more often. For family physicians, seeing more patients increases their confidence, motivation and capacity to provide quality health care service. As Dr. Bobojonova and her colleagues have come to realize, as people grow to recognize high-quality health care and gain trust in family physicians, they will vote with their feet.

### **“Expanding Horizons for Quality Health Care”**

According to Kazakhstan National Medical University (KNMU) staff, classes in recent years are filled with a new kind of medical student. “The modern Kazakhstani medical student is highly curious, wants to expand his or her horizons, and has a thirst for change.” As the thirst for change in health care grows, the Government of Kazakhstan and USAID are working together to chart a path toward instilling high-quality, evidence-based health care throughout this former Soviet Republic.

In the latest step on this path, the USAID Quality Health Care Project and KNMU staff joined forces in December 2010 and June 2011 to provide a series of interactive lectures to Kazakhstani medical students on improving the quality of health care by integrating evidence-based approaches at all levels

of medical education and service delivery. Since 1994, USAID has collaborated with the Government of Kazakhstan to institute comprehensive reforms and raise awareness of these reforms among patients and medical students. As part of this overall process, USAID outreach to students is introducing and institutionalizing a new way of thinking about health care.

In the past, a punitive environment prevailed in the health care system that discouraged providers and administrators from objectively examining health care practices. As part of the overall health reform process, the Government of Kazakhstan and USAID collaborated to fundamentally transform the health system mentality by introducing a new approach that emphasizes critical thinking, promotes the use of objective data in decision-making, and encourages internal monitoring.

Since the introduction of these quality improvement methodologies in 2005, this approach has produced real results at Kazakhstani health facilities. After one year of implementation in Kazakhstan, participating pilot facilities diagnosed four times as many patients with hypertension as in the previous year. In a country where cardiovascular disease annually claims the most lives out of all public health threats, the quality improvement approach is saving thousands of lives through increased diagnoses and earlier treatment.

Positive results from pilot facilities and a growing acceptance of the quality improvement approach in educational institutions heralds a sea change in health care thought and practice. Through the work of the USAID Quality Health Care Project, the Government of Kazakhstan and USAID are fostering the desire for change among a new generation of medical students to ensure a future of modern, evidence-based health care in Kazakhstan.

**9. APPENDIX B: REGIONAL STRATEGY**



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**CENTRAL ASIAN REPUBLICS**

# QUALITY HEALTH CARE PROJECT REGIONAL STRATEGY



October 31, 2011

This report was produced for review by the United States Agency for International Development. It was prepared by the Quality Health Care Project (QHCP) in the Central Asian Republics.

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**Contract No.:** AID-176-C-10-00001

**Submitted to:** Bryn Sakagawa  
Deputy Director, Office of Health and Education  
USAID Central Asia Regional Mission

# QUALITY HEALTH CARE PROJECT REGIONAL STRATEGY

## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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# ACRONYMS

<b>ACSM</b>	Advocacy, Communication, and Social Mobilization
<b>ANC</b>	Antenatal care
<b>APMG</b>	AIDS Projects Management Group
<b>ART</b>	Anti-retroviral therapy
<b>ARV</b>	Anti-retroviral
<b>CAH</b>	Community Action for Health
<b>CAR</b>	Central Asian Region/Republics
<b>CBO</b>	Community-based organization
<b>CCM</b>	Country Coordinating Mechanism (Global Fund)
<b>CDC</b>	US Centers for Disease Control and Prevention
<b>CME</b>	Continuing Medical Education
<b>CP</b>	Clinical protocol
<b>CPG</b>	Clinical Practice Guideline
<b>CQI</b>	Continuous Quality Improvement
<b>CSW</b>	Commercial sex worker
<b>CVD</b>	Cardiovascular disease
<b>DOTS</b>	Directly observed treatment, short course
<b>DST</b>	Drug sensitivity testing
<b>EBM</b>	Evidence-based medicine
<b>EDL</b>	Essential Drug List
<b>EMOC</b>	Emergency Obstetric Care
<b>EPC</b>	Effective Perinatal Care
<b>EQA</b>	External Quality Assurance
<b>FGPNA</b>	Family Group Practice and Nurses Association (Kyrgyzstan)
<b>FM</b>	Family Medicine
<b>FP</b>	Family Planning
<b>FSU</b>	Former Soviet Union
<b>GFATM</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GHI</b>	Global Health Initiative
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>GMS</b>	Grant Management Solutions
<b>HIS</b>	Health Information System
<b>HSS</b>	Health Sector Strategy or Health System Strengthening
<b>IC</b>	Infection control
<b>ICAP</b>	International Center for AIDS Care and Treatment Programs
<b>ICS</b>	Inventory control system
<b>IDU</b>	Injecting drug user
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IPC</b>	Infection prevention and control
<b>LED</b>	Light-emitting diode
<b>LMIS</b>	Logistics management information system
<b>M&amp;E</b>	Monitoring and evaluation
<b>MARP</b>	Most at-risk population
<b>MAT</b>	Medication-assisted therapy
<b>MCH</b>	Maternal and Child Health
<b>MDR-TB</b>	Multi-drug-resistant tuberculosis
<b>MOH</b>	Ministry of Health
<b>MSM</b>	Men who have sex with men
<b>NCD</b>	Non-communicable disease
<b>NDRA</b>	National Drug Regulatory Authorities

<b>NGO</b>	Non-governmental organization
<b>NTP</b>	National Tuberculosis Program
<b>OR</b>	Operational research
<b>P4P</b>	Pay-for-performance
<b>PA</b>	Professional Association
<b>PD-3</b>	USAID Policy Paper on Population Assistance and Policy Determination 3
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PGI</b>	Post-Graduate Institute
<b>PHC</b>	Primary Health Care
<b>PIU</b>	Project implementation unit
<b>PLHIV</b>	People Living with HIV
<b>PMP</b>	Project monitoring plan
<b>PMTCT</b>	Prevention of Mother to Child Transmission of HIV
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>QMS</b>	Quality Management System
<b>RBF</b>	Results-Based Financing
<b>RH</b>	Reproductive Health
<b>SES</b>	Sanitary Epidemiological Service
<b>SM</b>	Safe Motherhood
<b>SOP</b>	Standard operating procedure
<b>STI</b>	Sexually transmitted infection
<b>STLI</b>	Scientific Technology and Language Institute
<b>STP</b>	Standard Test Procedures
<b>SWAp</b>	Sector-Wide Approach
<b>TB</b>	Tuberculosis
<b>TOT</b>	Training of Trainers
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	U.S. Government
<b>VCT</b>	Voluntary counseling and testing
<b>VHC</b>	Village Health Committee
<b>WHO</b>	World Health Organization
<b>XDR-TB</b>	Extensively drug-resistant tuberculosis

## **1. INTRODUCTION**

The USAID Quality Health Care Project (the Quality Project) is a five-year program to improve the health status of Central Asians by using a health systems strengthening (HSS) approach to build the capacity of public health systems, institutionalize quality improvement methodologies at all levels of health services management, improve health outcomes in tuberculosis (TB), HIV, maternal and child health and cardiovascular disease, and empower communities to respond to their own health needs. The Quality Project will provide technical assistance, training, equipment and commodities to assist the Central Asian Republics (CAR) to improve the quality, scope, and coordination of health services. By incorporating modern quality improvement techniques and evidence-based international standards into ongoing reforms of health systems, the Quality Project will assist Central Asian countries to improve their management, financing, and implementation of health services related to TB, HIV/AIDS, and maternal and child health services and cardiovascular disease.

The Quality Project Regional Strategy will serve as a roadmap for where we plan to go and how we plan to get there. It does not detail every step along the road but will guide and inform choices as they emerge in implementation. Two priorities are still under development: 1) detailed implementation sequencing for key program results in 18 months; and 2) detailed Global Fund collaboration strategies.

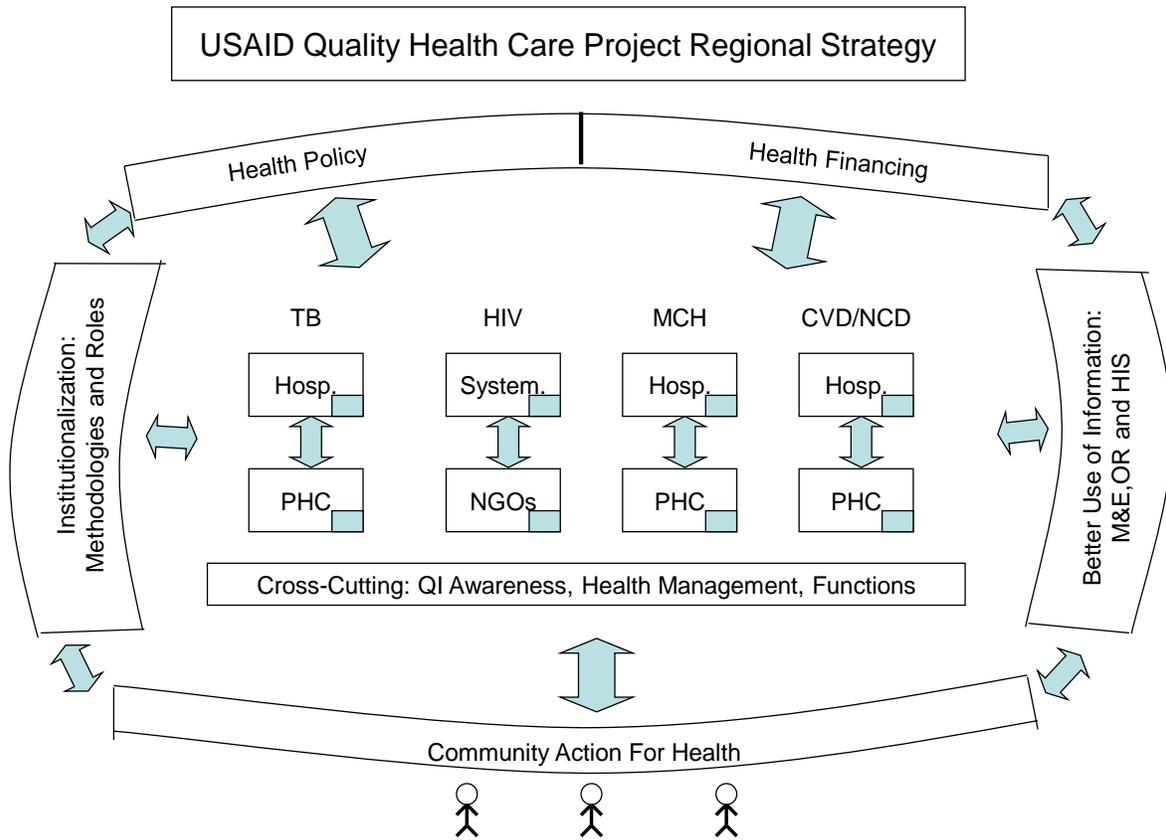
The Quality Project Regional Strategy contains the following three parts:

- Overarching regional strategy including project monitoring plan (PMP) indicators
- More detailed tuberculosis (TB), TB/HIV, HIV, maternal and child health (MCH), family planning (FP) and reproductive health (RH), and cardiovascular/non-communicable disease (CVD/NCD) strategies, including PMP indicators
- Country-specific environment and adaptation of overarching regional strategy

## **2. OVERARCHING REGIONAL STRATEGY**

The Quality Project overarching regional strategy is shown in the chart below. Its purpose is to achieve the USAID strategic objective of increased use of effective public health responses by vulnerable groups, especially for TB and HIV, and to support Central Asian countries in improving quality, effectiveness, access, equity, financial risk protection, efficiency, transparency and responsiveness in their health systems. Sustainable improvement in health outcomes in the priority programs of TB, HIV, MCH, and CVD/NCD requires an approach consisting of both priority program service delivery improvements as portrayed in the center of the chart and HSS as portrayed by the four elements of the circle surrounding the priority programs. If the circle is broken by weakness in any of the four elements, the health system will not be able to deliver on its commitment to improve the health of the population.

**Figure**  
 USAID Quality Health Care Project Regional Strategy



Health policy and financing at the top of the circle set the basic rules for the health sector and are critical to removing health systems barriers for priority program service delivery improvements. Community action for health (CAH) at the bottom of the circle ensures that populations and communities are empowered to take responsibility for their own health. It is directly related to priority program service delivery improvement but also improves governance by strengthening the circle and enabling a balance of power between the government and health system and the individuals and communities it is designed to serve. The two sides of the circle are the glue that holds it together by ensuring institutionalization for sustainability and a dynamic feedback loop through better use of information. Each element portrayed in the regional strategy chart must both perform its specific task and strengthen linkages to produce concrete results and continuous, responsive and sustainable health improvements.

The elements of the regional strategy chart are described in detail below organized by improving priority program service delivery and HSS targeted at removal of barriers or achievement of preconditions for sustainable institutionalization of quality improvement (QI) approaches, especially for TB and HIV. CAH is contained in both priority programs through health promotion and community actions and HSS through civil society organizational development and capacity building. Workplan structure and all management processes are based on the regional strategy chart illustrating priority program service delivery improvement and the HSS circle surrounding it (often referred to as the diagonal approach).

The Quality Project overarching regional strategy is contained in the following five sections: 1) Priority programs; 2) HSS; 3) USAID Public Relations (PR)/Outreach; 4) Collaboration strategies; and 5) Supporting Global Health Initiative (GHI) principles.

## **2.1 PRIORITY PROGRAMS**

### **2.1.1 SERVICE DELIVERY**

Service delivery improvement in the Quality Project priority programs of TB, HIV, MCH, and CVD/NCD is shown in the center of the overarching regional strategy chart. Key interventions for the four priority programs are as follows:

- Implement combination of continuing medical education (CME) and facility-level QI processes focused on priority themes within both the primary health care (PHC) and hospital levels of the system.
- Improve referrals and continuum of care across system levels and entities as represented by the blue arrow between PHC and hospital or outreach and system levels.
- Strengthen specific health systems functions such as lab, drug management, and infection prevention and control (IPC) as represented by the blue box inside each system level.
- Improve HIV and TB service delivery through enhanced counseling and social work (strategy and plan are currently being developed for what is expected to be a major Quality Project activity).

Detailed TB, TB/HIV, HIV, MCH, and CVD/NCD strategies containing service delivery, CAH, and PMP indicators are included in Part II of the Regional Strategy.

### **2.1.2 COMMUNITY ACTION FOR HEALTH**

The Quality Project is developing a detailed CAH strategy which will be completed in fall 2011. It will include new and creative ideas on empowering the community to be responsible for their own health determinants, and it will be consistent with the general strategy described in this section. A focus of the detailed strategy will be developing CAH models or mechanisms in Tajikistan comparable to the Village Health Committees (VHCs) in Kyrgyzstan but adapted to the Tajik environment.

The purpose of the Quality Project CAH approach is to empower individuals and communities to be responsible for their own health by shifting the nature of the relationship between patients and providers so that individuals and communities can take ownership of their own health and demand good care from health care providers. This shift in power is key to a patient-centered system, realigning the health system toward prevention and health promotion and improving health outcomes. Empowering the population to exercise their rights and accept their responsibility for their own health also improves governance.

Simultaneously working from both sides is required to change the nature of the health system and population/community relationship. Individuals and communities must be empowered to take responsibility for their own health and health determinants. The health system must accept its role as partner, not ruler in health care. A knowledgeable, empowered population is essential to improving and maintaining the quality of health care services and to the strength of the overall health sector. CAH is therefore an essential part of all Quality Project program areas.

The Quality Project will use a two-pronged approach consisting of broad CAH for all priority programs and narrow and targeted enhanced counseling, social work, and stigma reduction for most-at-risk populations (MARPs) in HIV and TB programs. Broad CAH activities expand health promotion and population/community involvement in their own health and health determinants. This dynamic is shown at the bottom of the overarching regional strategy chart. Although some CAH activities may benefit many health areas, due to limited project resources CAH activities are generally targeted at the TB, HIV, MCH/FP/RH, and CVD/NCD priority programs. Development and capacity building of non-government organizations (NGOs) or community-based organizations (CBOs) activities are included in the Institutionalization for Sustainability element to recognize their critical contribution to sustainability and governance. Key broad CAH interventions include:

- PHC-initiated health promotion or establishment of patient groups intended to emphasize prevention and health promotion to establish a more patient-centered relationship at the level of health professional/patient interaction and involve patients in their own treatment and health. These activities directly link to some health provider or professional activities in the service delivery element above (e.g. Continuous Quality Improvement (CQI) and interpersonal communications skills training). They are emblematic of the two-sided approach, as they require buy-in from both patients and providers and change doctor and patient interaction and relationships at the core of the health system.
- Population and community involvement in their health and health determinants through existing community entities such as VHCs, mahalla groups, and consumer organizations. A “thousand flowers bloom” philosophy will reign here as the Quality Project will continuously search for new innovative and creative ideas.
- Mass media health promotion activities, including training of journalists, to help develop a culture that supports good health decision-making.

An objective of these activities is to create synergies between service delivery and CAH. It will also empower community entities to identify social and environmental determinants of health and then put

pressure on the overall system and governance. In the long run, the objective is to realign population and community involvement such that people and communities are real partners in the health provider and professional/patient, population, and community relationship. In summary, our strategy is to change the nature of the health system and individual/community relationship from one-directional to two-directional by simultaneously increasing the responsiveness of the health system and empowering individuals and communities.

The second prong of our CAH strategy is to link population involvement and CAH to HIV and TB service delivery improvements consisting of enhanced counseling and social work (strategy and plan are currently being developed for what is expected to be a major Quality Project activity).

## **2.2 HEALTH SYSTEMS STRENGTHENING**

### **2.2.1 HEALTH POLICY**

The Quality Project will engage in dialogue and provide technical assistance to support country partners in improving the legal and policy framework shown as one of the overarching elements of the Regional Strategy Chart. A project priority will be development and strengthening of national health sector strategies including integration of TB and HIV to increase country ownership, strengthening of the legal and policy framework, and ensuring comprehensive and consistent policies particularly for TB and HIV. Improving governance will also be a project priority largely accomplished by civil society advocacy and participation in policy dialogue mechanisms to improve health policy and increase transparency. In the Quality Project Regional Strategy, civil society activities are contained in CAH (activities with population and community audiences), Institutionalization for Sustainability (existence and development of health-related civil society), and Health Policy (policy advocacy targeted at Government audiences). Key health legal and policy interventions include:

- Strengthen policy dialogue mechanisms including working groups
- Support development and implementation of national health sector strategies
- Improve health policy and legal framework for priority programs especially TB and HIV
- Support implementation of approved legal and regulatory framework to address a major barrier to improving health services in Central Asia
- Support policy advocacy in general and particularly by civil society

#### **Indicators**

HSS/Health Policy revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

Process indicators:

- # of OR studies and other policy products that fed into policy dialogue
- # of people from the Ministry of Health (MOH) (other official bodies) trained on health policy issues

- # of legal or regulatory products and laws or regulations developed with project support

Intermediate indicators:

- # of legal or policy changes on topics addressed by OR studies or other policy products
- # of products developed by civil society groups and used for advocacy

Impact indicators:

- # of countries with national health sector strategy enabling comprehensive, consistent and coordinated health policy

### **2.2.2 HEALTH FINANCING**

Shown as the second overarching element of the Regional Strategy Chart, health financing reform is critical to improving health outcomes in the priority programs of TB, HIV, MCH, and CVD/NCD. Establishing universal coverage, equity, and equal financial risk protection disproportionately benefits vulnerable populations. New output-based provider payment systems are essential to health system restructuring, reinvestment of savings, and increasing expenditures for direct patient care in priority programs. Bluntly stated, health providers will not change clinical practice or improve service delivery unless they have financial incentives to do so. The Quality Project health financing strategy is a three-pronged approach: 1) strengthen the foundation of core health financing reforms based on the three health financing functions of collection of funds, pooling of funds, and health purchasing; 2) enhance output-based provider payment systems or introduce results-based financing (RBF) or pay-for-performance (P4P) to strengthen the link to QI in TB, HIV, MCH, and CVD/NCD priority programs; and 3) introduce TB financing reform and improve HIV financing to enable TB and HIV service delivery improvement.

Advocacy for a single-payer model including pooling of funds at least at the oblast level will continue for practical rather than ideological reasons to maintain equity and increase efficiency as health delivery system restructuring is very hard without a single pool accumulating all state health funding (e.g. budget, mandatory payroll tax). An additional Quality Project tenet is that RBF or P4P should be added incrementally or on top of the output-based provider payment systems to ensure appropriate operational mechanisms, avoid inconsistent financial incentives, and increase sustainability. TB financing reform is one of the project's highest priorities as it is critical to addressing the explosion of multi-drug-resistant TB (MDR-TB) and further integration of TB services into PHC. Key health financing interventions include:

- Strengthen core health financing reforms
- Develop and implement RBF or P4P to improve quality in priority programs
- Introduce TB financing reform including a new TB hospital payment system with a regional model developed in Kyrgyzstan and then expanded across countries to the extent possible
- Determine and work to remove barriers to state health budget funding flowing to HIV Prevention NGOs

- Link health financing reform to further restructuring of hospital sector, strengthening of PHC, and human resource retention strategies
- Increase provider autonomy, capacity, and accountability to allocate their own resources and improve financial management

### **Indicators**

HSS/Health Financing revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

#### Process indicators:

- # of health financing products developed to support health financing reform implementation
- # of people trained on health financing-related topics
- # of TB facilities with new provider payment systems

#### Intermediate indicators:

- % of country oblasts with funds pooled at least at the oblast level
- % of health providers paid under new output-based provider payment systems (disaggregated by PHC and hospitals)
- % of health providers paid under both new output-based provider payment systems and results-based financing (disaggregated by PHC and hospitals)
- % of TB service providers paid under new output-based provider payment systems (disaggregated by hospitals and PHC)

#### Impact indicators:

- % of Government budget allocated to health
- Deviation of the level of state health funding to territorial units of the average over the region
- % of health budget allocated to PHC
- % of health budget allocated to SGBP with appropriate pooling and purchasing arrangements

### ***2.2.3 PRIORITY PROGRAM CROSS-CUTTING ACTIVITIES***

Priority program cross-cutting activities efficiently benefiting all priority programs and creating a critical mass for system-wide change is shown in the chart by the box surrounding all priority programs. Key interventions for the priority program cross-cutting activities are as follows:

- Increase awareness, acceptance, and knowledge of QI methodologies
- Improve health provider management required to effectively perform and manage all service delivery activities
- Integration or linkages across priority programs for health systems functions such as lab or drug management
- Development of CAH capacity which is a cross-cutting activity as it benefits all priority programs

## **Indicators**

HSS/Priority Program Cross-Cutting revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

### Process Indicators:

- # of health officials or managers trained in QI methodologies or health management.
- # of community volunteers trained to enable community to perform community action for health
- # of medical and para-medical practitioners trained in evidence based clinical guidelines

### Intermediate Indicators:

- # of facilities with functioning Quality Committees
- # communities containing trained volunteers

### Impact indicators:

- # of facilities that have graduated into self-sustaining CQI efforts

## **2.2.4 INSTITUTIONALIZATION FOR SUSTAINABILITY**

Institutionalization for sustainability requires incorporation of improved methodologies, technologies, and tools into clear and appropriate institutional structure, roles, and relationships (“the right institution doing the right thing”). The Quality Project Regional Strategy separates program area into two key interventions both of which include capacity building.

### **2.2.4.1 Methodologies and Tools**

The Quality Project will support country partners in developing, implementing, and institutionalizing a wide range of methodologies and tools to increase country ownership and sustainability. These include evidence-based medicine (EBM) promotion mechanisms; Clinical Practice Guideline (CPG) development methodology; CME delivery mechanisms; incorporating general improvements and evidence-based content of clinical content into undergraduate and graduate medical education; human resource development and retention tools; and health management methodologies.

### **2.2.4.2 Institutional Structure, Roles, and Relationships**

Appropriate institutional structure, roles, and relationships are critical to institutionalization. If the right institution is not doing the right thing or institutions have unclear, duplicating, or overlapping roles, it is hard to imagine how implementation of new policies, methodologies, or practices will continue after USAID assistance ends. This activity also includes development of civil society and delegation of health sector functions to them to improve governance, increase transparency, and ensure appropriate separation of functions and decentralization. Specific priorities include MOH structure; health purchaser; EBM Center; educational institutions or clinical training centers/training practices;

accreditation or quality assurance bodies; professional associations (PA); other NGOs; CBOs; relationship between public health entities and vertical systems including TB and HIV; relationships between civilian and prison sectors; and roles of republican institutes in QI.

### **Indicators**

HSS/Institutionalization for Sustainability revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

Process indicators:

- # of CAR countries with an approved Clinical Protocol (CP)/CPG development methodology and process
- # of undergraduate or graduate medical or nursing faculty or students trained on new evidence-based CPGs or new methodologies or tools

Intermediate indicators:

- # of evidence-based CP/CPGs developed according to the nationally-approved methodology
- #CME modules (including distance education) developed and consistent with evidence-based clinical protocols or guidelines
- # of new methodologies or tools institutionalized into health sector entities
- # of health sector entities formed/changed their functions, roles or relationships consistent *with health system strengthening*
- # of civil society entities receiving organizational development support from the Quality Project

Impact indicators:

- # of CPGs developed with indicators that are used to monitor facility-level implementation of CPGs

### **2.2.5 BETTER USE OF INFORMATION**

#### **Monitoring and Evaluation (M&E), Operations Research Studies, and Health Information Systems**

One of the key aspects of the Quality Project M&E program element is operational research (OR) studies. OR findings will allow the Quality Project to identify best practices, refine implementation strategies and document successful innovation for replication. In addition, OR studies will be used to inform policy-makers and other stakeholders about urgent issues or positive results in the health system contributing to evidence-based policy decisions and an improved feedback loop. OR studies will also contribute to more transparent and improved governance through the involvement of people, communities, and civil society in OR studies and promoting their results. The Quality Project strategy is to initiate and promote OR studies to create demand and enable gradual institutionalization of improved M&E/OR functions in MOH and other country health institutions.

To portray the role of OR studies in the Quality Project, exemplary OR studies are described including possible policy implications in Table 1, below. In general, OR studies will cross project years.

**Table**  
*Exemplary OR Studies*

Country	OR #	OR Description	Timing	Status	Possible Policy Implications
Kazakhstan	OR #1	Analysis of legal and other barriers to receiving public funds by NGOs engaging in HIV prevention activities.	Year 1	Data analysis in process	<ol style="list-style-type: none"> <li>1. Increase of public funding for NGOs engaged in HIV prevention;</li> <li>2. Increase of NGOs' capacity in public fund raising.</li> </ol>
	OR #2	TB patients' satisfaction survey: assess the quality of services provided to TB patients at all health system levels: baseline survey.	Year 1- Year 2	Methodology development in process	<ol style="list-style-type: none"> <li>1. Increase the quality of service delivery for TB patients;</li> <li>2. Increase responsiveness to TB patients at all levels.</li> </ol>
Kyrgyzstan	OR #1	Impact/effect of TB facility restructuring on service delivery for TB patients at all levels and readiness to introduce new TB financing mechanisms	Year 1	Data analysis in process	<ol style="list-style-type: none"> <li>1. To document TB facility restructuring to date ;</li> <li>2. Provide baseline for further TB facility restructuring under new TB financing systems.</li> </ol>
	OR #2	TB patient satisfaction survey for baseline and to assess patient satisfaction to refine project TB strategy	Year 2	Methodology development in process	<ol style="list-style-type: none"> <li>1. Increase the quality of service delivery for TB patients;</li> <li>2. Increase responsiveness to TB patients at all levels.</li> </ol>
Tajikistan	OR #1	Baseline for impact of introducing new health financing mechanisms on hospital efficiency	Year 1	Data analysis has recently started	<ol style="list-style-type: none"> <li>1. Further restructuring of health facilities to increase their efficiency;</li> <li>2. Introduction of new financing mechanisms.</li> </ol>

In addition to planning and executing OR studies to refine implementation, create demand for evidence-based policy decisions, and establish a dynamic feedback loop, the Quality Project will also support countries in developing and improving national M&E frameworks. Quality Project health information systems (HIS) activities will consist of three main activities: 1) supporting health financing by operating provider payment systems and linking data collection to payment to improve data quality; 2) contributions to improving TB and HIV information systems and surveillance; and 3) engaging in dialogue and providing technical assistance to help countries design, develop, and implement unified information systems. Unified information systems will reduce the paperwork burden and help ensure improvement and consistency in indicators used for monitoring and quality assurance.

### **Indicators**

HSS/M&E- OR Studies- HIS revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

#### Process indicators:

- Number of project monitoring reports, OR deliverables developed and disseminated in priority areas

#### Intermediate indicators:

- Number of policies and clinical guidelines in priority areas (TB, HIV, MCH, CVD) with M&E instruments developed
- Existence of policies and regulatory documents supporting effective health information system in the country

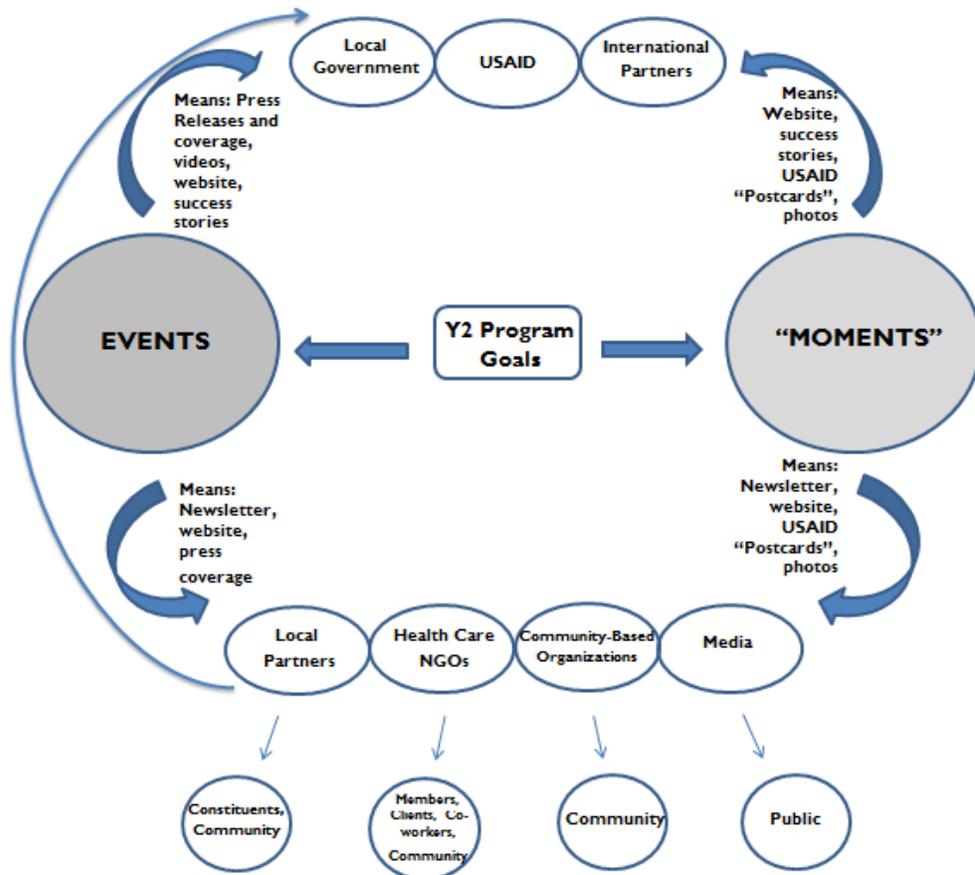
#### Impact indicators:

- # of adopted HIS modifications to streamline data collection or improve data use

### 2.3 USAID PR/OUTREACH

The Quality Project public relations and communications strategy is designed to highlight USAID assistance in the region while magnifying project impact and raising health awareness among different audiences through various communications vehicles and public relations activities. As depicted in the chart below, the Quality Project public relations and communications strategy is driven by yearly workplans and program goals. To better classify how goals and achievements can promote USAID and the overall project, the Quality Project envisions two broad categories of activities: events and “moments”. Events mark important and visible accomplishments, and can take the form of public ceremonies, ribbon-cuttings, openings, the launch of a major training series, roundtable discussions, equipment delivery, etc. In comparison, “moments” are milestones or accomplishments that should be publicized but do not necessarily require large-scale promotion. An example of a “moment” is the delivery of a software program to a health facility as part of the Quality Project HIV component. This activity is important to capture and promote as it connects with the Quality Project’s larger goal of helping countries modernize their IT systems to better track HIV medication needs, but “moments” like

**Figure**  
Quality Project PR and Communication Strategy



this can be publicized in subtler ways: through photos on the project website; distribution of success stories inspired by “moments”; USAID “Postcards”; or references in the project’s newsletter.

In the chart, events and “moments” are linked to different communication vehicles depending on the audience. Events and “moments” can flow up and be publicized to a broader USAID audience, a country’s government, and international partners through press releases, media coverage, videos, the project website, and success stories. They can also flow down to beneficiary-level groups, including local partners, PAs, local NGOs, community leaders, and the media, through the project newsletter, the project website, press coverage, USAID “Postcards”, and photos. In turn, beneficiary-level groups can further disseminate Quality Project materials to their constituents.

As depicted by the arrow leading away from local partners up to local government, the Quality Project will also empower beneficiaries, country health champions, health providers, PAs, other NGOs, CBOs, and the community itself to interact with their respective governments and advocate for further delegation of functions or improved policies using evidence-based information. In this way, USAID PR/Outreach and information dissemination will also influence public health policy and improve governance.

To further connect with beneficiaries, the Quality Project will release a semi-annual newsletter to heighten awareness of project activities and important health issues in Central Asia. The newsletter will underline the Quality Project’s unique HSS approach and highlight cross-cutting themes and linkages to provide a broad-picture portrayal of the project’s work in the region.

As media coverage plays an important role in disseminating information on key health issues, USAID’s role in the region, and the Quality Project itself, the project will seek to cultivate deeper relationships with the media. The Quality Project will engage individuals from different media outlets, primarily through “Press Cafes” but also through journalist training programs, to strengthen health reporting and encourage a more accurate understanding of important health topics.

The project website is designed to be a simply structured yet effective communication vehicle to provide access to information for the layperson, expert, and media alike. The website will contain additional information on project activities, including general project descriptions, success stories, photos, and videos, and provide access to technical reports and links to partner organizations’ websites.

## **2.4 COLLABORATION STRATEGIES**

Collaboration with other donors and projects is a key Quality Project implementation strategy. Our strategy is to collaborate to comparative advantages meaning that each partner works to its strengths such that their day-to-day routine work naturally aggregates into greater impact. Our highest priority is a productive collaboration with the Global Fund. The Quality Project will collaborate with donors, projects, and agencies described below to leverage funding, ensure unified health policy messages,

broaden the scope or comprehensiveness of country health reforms, and expand activities to reach a critical mass for sustainability.

#### **2.4.1 U. S. GOVERNMENT PROJECTS**

##### **2.4.1.1 USAID Dialogue on HIV and Tuberculosis Project**

As the Quality Project and the USAID Dialogue on HIV and Tuberculosis Project (the “Dialogue Project”) work together to build a complementary and cooperative relationship, the Quality Project will continue to focus on geographic areas where the Dialogue Project works in order to assure that USAID funds invested in direct support of outreach are harmonized with USAID-funded efforts to improve the accessibility and quality of care available for MARPs. In addition to geographic overlap, the Quality Project envisions contributing to Dialogue Project efforts in the following ways:

- The Quality Project is working to improve the long-term, sustainable relationship between civil society and the government health sector, assuring that NGOs financed by USAID/the Dialogue Project can interface with government partners in a productive manner.
- The Quality Project is providing high-level technical support and training to a cadre of NGOs, including Dialogue-supported NGOs, to update outreach methodology and ensure the use of best-practices in working with MARPs and people living with HIV (PLHIV).
- The Quality Project is providing technical expertise where comparative advantages exist to support the Dialogue Project in advancing key programs, such as pharmacy-based naloxone distribution.

The Quality Project is providing technical support to design and implement tools to improve outreach and increase access to TB treatment for MARPs by collaborating on the development, finalization, and implementation of National Strategies on Advocacy, Communication, and Social Mobilization (ACSM) for TB control. The team is working jointly with the Dialogue Project to develop educational materials targeting MARPs.

To support and institutionalize these strategies and tools, the Quality Project is conducting interpersonal communication trainings for health providers and implementing CQI activities at Dialogue Project sites to reduce stigma and improve access to friendly services for MARPs (e.g. assuring undocumented TB patients will receive services). The Quality Project will implement intensified case finding efforts to increase case finding of TB patients among people living with HIV through introducing improved screening of HIV patients within the HIV system and through the introduction of GeneXpert. Additionally, the Quality Project will conduct TB infection control (IC) activities for social workers in TB prevention to reduce the occupational risks associated with working with infectious patients (e.g. work place risk assessment, training, and monitoring). The project will maintain regular coordination meetings with the Dialogue Project team to address ongoing issues and identify emerging opportunities for collaboration.

#### **2.4.1.2 USAID TB CARE Project**

The Quality Project will work to ensure a productive collaboration with TB CARE. While USAID is still finalizing the separation of project activities, per extensive dialogue with USAID and TB CARE, the collaboration framework is expected to be close to the following:

- Quality Project on integration into PHC using both health-system-level interventions and provider-level QI processes, and TB CARE on TB in prisons should enable a productive collaboration to help ensure continued TB treatment for released prisoners.
- Quality Project on HSS interventions required to turn off the MDR-TB tap, and TB CARE on treatment of MDR-TB cases.
- Quality Project on TB financing and TB hospital restructuring required to realign the system and improve IPC by separating MDR-TB and non-MDR-TB cases across hospitals and also reinvesting some savings to further integrate into PHC, and TB CARE focus on IPC in hospitals and prisons.
- Quality Project on drug supply management and TB/HIV.
- Sharing of activities in lab including development of National Strategic Laboratory Plans; GeneXpert implementation; human resource development; M&E; enhanced counseling; social work; social support; CAH using strategies and plans currently being developed; TB among migrants; pediatric TB.

#### **2.4.1.3 Grant Management Solutions (GMS) Project**

With guidance from USAID, the Quality Project will work closely with GMS to support Country Coordinating Mechanisms (CCMs) and build their capacity in TB and HIV stewardship including applying for and managing Global Fund projects. The Central Asian CCMs are consistently weak in organizational structure, management capacity, transparency, and human resources. Given receipt of Global Fund technical assistance funding for Year 2, the Quality Project will develop a strategy taking into account our respective comparative advantages of GMS experience in CCM capacity building; ability to parachute in and make strong statements; thorough understanding of country environments; and continuous on-the-ground support. The nature of the strategy will vary by country and depend on whether countries request GMS assistance. In all countries, the Quality Project will work closely with GMS both in the U.S. and in Central Asia to obtain information on process and progress to date and support implementation of recommendations. Quality Project staffing for Global Fund technical assistance funding will consist of Abt/U.S. staff currently working on the GMS project; GMS consultants experienced in Central Asian CCM development; and on-the-ground TB, HIV, legal, and HSS teams.

In addition to CCM support, the Quality Project will also engage in dialogue on overall health sector governance including the relationship between national health sector strategy stewardship and CCM/Global Fund organizational structure and processes. This is particularly true in Kyrgyzstan where the Global Fund is promoting further integration of their TB and HIV projects into the national health sector strategies, Manas Taalimi and Den Sooluk, and the sector-wide approach (SWAp).

#### **2.4.1.4 US Centers for Disease Control and Prevention (CDC) ICAP/ Support Project**

The Quality Project will work closely with the CDC/PEPFAR-funded International Center for AIDS Care and Treatment Programs (ICAP)/SUPPORT Project to assure that activities are complementary and supportive of each other. As the SUPPORT Project evolves as a primary technical support mechanism for vertical system specialists, they are envisioned to lead the clinical training component for the republican AIDS centers and narcology centers, as well as address major capacity and strategy issues in M&E within the vertical systems. The Quality Project will be focusing more heavily on increasing access to care within the primary care system, and improving appropriate linkages to specialized care.

In special topical areas, where comparative advantages exist for one project to handle a specific task, responsibilities will be negotiated.

#### **2.4.2 GLOBAL FUND ON TB AND HIV**

Multilateral support for the Global Fund and its large role in HIV and TB activities in the Central Asia region mean that collaboration and coordination are essential to improving TB and HIV outcomes. Developing a strong collaboration with the Global Fund is the highest Quality Project collaboration priority due to this linkage with TB and HIV programs. Our Global Fund collaboration strategy will be consistent with the overarching collaboration strategy outlined above including providing technical assistance and operational support leveraging funds to achieve policy objectives, implement programs, and maximize impact of commodity investments. The Quality Project will develop and implement country-level Global Fund collaboration strategies building on the past very successful HSS collaboration experience between USAID, World Bank, and the World Health Organization (WHO).

The major comparative advantage of the Quality Project is to support improved implementation of existing Global Fund project activities by providing technical assistance and operational support to enhance activities and build capacity and ownership. However, the Quality Project will also support development of Global Fund applications including using the application process as an opportunity for productive policy dialogue and strategy development.

#### **2.4.3 WORLD BANK AND WHO ON HSS, HEALTH FINANCING, AND M&E**

The fifteen-year collaboration between USAID, the World Bank, and WHO has helped drive HSS and health financing reform in Central Asia, and has resulted in substantial improvement of country health systems serving the population, including the recognition of health financing reform as international best practice. The comparative advantages in this partnership have been World Bank commodities and political leverage, USAID implementation support, and WHO health policy and M&E. The Quality Project expects this strong collaboration to continue and evolve to improve the legal and policy framework; solidify health financing and structural reform; support improvement and integration of TB and HIV services; and enhance country health policy analysis, operations research, and M&E.

#### **2.4.4 WHO, UNICEF, UNFPA, OTHER BI-LATERALS ON MCH**

The Quality Project will continue to collaborate with WHO on advocating for national evidence-based standards and protocols and scaling up ANC, Effective Perinatal Care (EPC), and Integrated Management of Childhood Illness (IMCI). In addition, the Quality Project and WHO are providing Ministries of Health with technical support to conduct assessments of ANC and hospital-level perinatal care quality; results from the assessments will inform future MCH policy. The Quality Project will complement United Nations Population Fund (UNFPA) efforts on reproductive health commodity security with FP training for providers and community engagement to improve awareness of modern contraceptive methods. Collaboration with the United Nations Children’s Fund (UNICEF) will be focused on implementation and scale-up of IMCI at the PHC, hospital, and community levels.

In Kyrgyzstan, the Quality Project is working closely with UNICEF, GIZ, and UNFPA to achieve national EPC scale-up through their respective pilot regions and with Swiss Red Cross on CAH activities. In Tajikistan, the Quality Project is an active member of the MCH advisory council and is cooperating with GIZ and UNFPA to strengthen ANC quality through national standards and counseling training. All Quality Project activities in Turkmenistan will be conducted in close cooperation with WHO and/or UNFPA.

### **2.5 SUPPORTING GLOBAL HEALTH INITIATIVE PRINCIPLES**

The Quality Project is exceptionally well-aligned with the seven GHI principles as described below:

#### **Focus on Women, Girls, and Gender Equality**

The Quality Project includes gender considerations in the design and implementation of all project activities. As 75% or more of PHC services are provided to women and children, the project focus on strengthening PHC inherently incorporates gender considerations. All MCH/FP/RH activities directly target women and children. Specific HIV activities also take gender into account, for example, the focus on female harm reduction. Gender considerations in the former Soviet Union (FSU) must focus on men as well as women, due to the extremely high burden of cardiovascular disease (CVD) and its disproportionate impact on men which is addressed through our CVD activities. CAH activities are designed to increase knowledge on healthy lifestyles, disease prevention, risk signs, and appropriate care seeking and can increase gender equity in accessing health services for women, encourage men to utilize PHC for preventive care and screening, and help everyone live longer, healthier lives and be more productive in the workforce and society. Finally, building capacity of health sector workers, many of whom are women, also serves to empower women in the workplace, as well as in their communities and homes.

#### **Encourage Country Ownership and Invest in Country-Led Plans**

Increasing country ownership underlies the entire Quality Project approach. National health sector strategies are country-led plans by definition and the Quality Project supports design, development, and implementation of national health sector strategies in Kazakhstan, Kyrgyzstan, and Tajikistan. A key

Quality Project strategy is supporting step-by-step implementation by country partners in all program areas to build strong relationships with partners and enable realization of policies and plans. Empowering partners to implement and institutionalize improvements increases pride and ownership. An example is the project's work in QI processes. In some cases, local health facilities design and implement QI action plans and processes with limited technical assistance and support from the Quality Project. In other cases, QI is supported and coordinated by grants to NGO PAs delivering services to their membership such as the Family Group Practice and Nurses Association (FGPNA) in Kyrgyzstan or the Kazakhstan Association of Family Practitioners. The dual benefit of enabling health providers to improve quality and building capacity of NGOs, including PAs, is a powerful contributor to country ownership.

The Quality Project has a specific Institutionalization for Sustainability sub-component which focuses on increasing country ownership by institutionalizing methodologies and tools as well as appropriate institutional structure, roles, and relationships. If Quality Project program activities contribute to the right institution doing the right thing, country ownership and sustainability will increase.

### **Build Sustainability Through HSS**

Building sustainability through HSS is a core premise of the Quality Project. The HSS Component consists of five sub-components: 1) health policy; 2) health financing; 3) priority program cross-cutting activities; 4) institutionalization for sustainability; and 5) M&E/HIS. In addition, the Quality Project Regional Strategy goes further than incorporating HSS: it explicitly states how HSS can remove barriers leading directly to QI in the priority programs of TB, HIV, TB/HIV, MCH/FP/RH, and CVD/NCD. In turn, the Quality Project's disease-specific or priority program activities are designed to simultaneously reduce the direct impact of and disease and also build the health systems that fight ill-health.

### **Strengthen and Leverage Key Multilateral Organizations, Global Health Partnerships, and Private Sector Engagement**

A key Quality Project implementation strategy is collaboration to comparative advantages with all other U.S. Government (USG) and USAID projects as well as with development partners. Collaborate to comparative advantages means that each partner works to its strengths such that their day-to-day routine work aggregates into greater impact and improvement in health systems serving the citizens of Central Asia. Providing technical assistance and operational support to projects of key multilateral organizations such as the Global Fund and World Bank increases the effectiveness of these projects. Collaborating to ensure unified policy messages, constant coordination, and leveraging funding to expand health interventions to reach a critical mass for institutionalization benefits both country partners and development partners.

At a minimum, the Quality Project collaborates with WHO, World Bank, and the European Union on HSS; Global Fund and other USG/USAID projects on TB and HIV; and WHO, UNICEF, UNFPA, and other bilateral projects on MCH/FP/RH. The Quality Project also seeks to include a wide range of partners in its efforts to improve health care quality in the countries of Central Asia. This is exemplified by the project's approach to improving the continuum of care for HIV. The project works with NGOs, other civil society organizations, health facilities, national-level health institutions, broader government bodies,

and international donors to create a seamless and welcoming system of care for populations most at risk for HIV.

#### **Increase Impact Through Strategic Coordination and Integration**

Strategic coordination requires an overarching strategy to guide visualization of linkages, mechanisms, and processes for strategic coordination. The tenets in the Quality Project Regional Strategy enable country partners and collaborations with development partners to improve strategic coordination both within the health sector and beyond the health sector by improving governance including public finance management and building civil society. Integration is a core premise of the Quality Project Regional Strategy and general approach. It contains two basic elements. One element is integration consisting of restructuring to reduce substantial efficiency problems resulting from the enormous excess capacity plaguing post-Soviet health systems whose budgets have collapsed leaving unaffordable and unsustainable infrastructure. Secondly, Quality Project activities include QI processes to integrate services in vertical TB and HIV systems with the general health system, and also integrate across levels of care to improve the continuum of care.

#### **Improve Metrics, M&E**

M&E in post-Soviet health systems has generally been politicized and not based on objective or accurate information. The Quality Project Regional Strategy contains a feedback loop whereby development, use, and promotion of M&E and more accurate information will gradually lead to evidence-based policy decisions. The project will also support development and implementation of national M&E frameworks to improve use of information; refine policies and implementation strategies; and enable improved development partner collaboration and coordination. For example, the national health sector strategy Manas Taalimi/SWAp in Kyrgyzstan contains a national M&E framework that is used by both country partners and development partners. Finally, Quality Project HIS activities include supporting development of a unified health information system with reduced paperwork burden enabling one source of information for M&E and decision-making.

#### **Promote Research and Innovation**

In collaboration with WHO, the Quality Project is working to expand the use of OR studies in Central Asia. Supporting partners in OR studies helps refine implementation and strengthen the feedback loop to drive evidence-based policy decisions. In addition, the Quality Project is supporting innovation and the use of new technologies in Central Asia. For example, the introduction of GeneXpert to improve TB diagnosis will not only improve clinical practice but be used to enable full integration of TB treatment in outpatient care consistent with international best practice.

### 3. DETAILED TB, HIV, MCH/FP/RH, AND CVD/NCD STRATEGIES

#### 3.1 TB

The Quality Project TB Strategy is shown in the charts and described below. It is intended to achieve two related overall objectives:

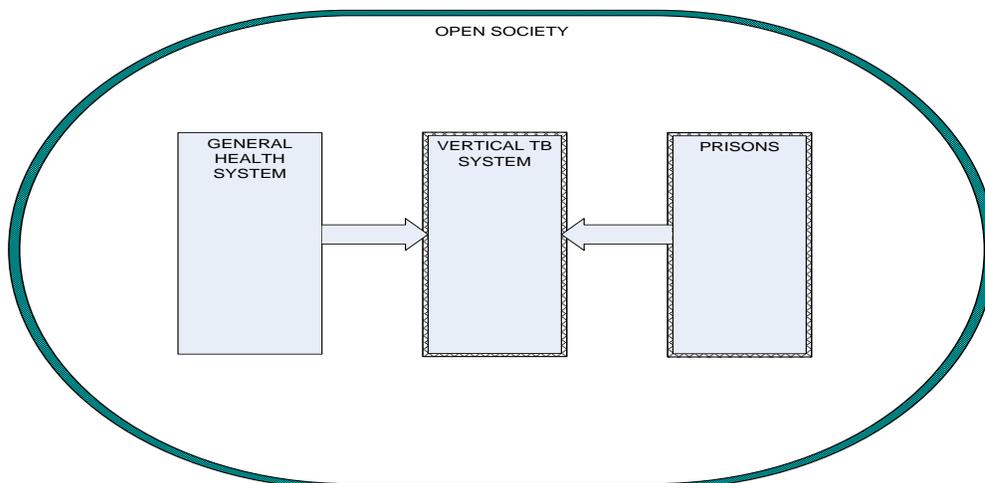
- Introduce QI processes which simultaneously improve quality and turn off the MDR-TB spigot.
- Improve integration of TB services into PHC through a HSS approach appropriate for the unique post-Soviet Central Asian environment.

As reflected in the chart below, the FSU TB system consisted of closed institutions linked by a strong system of control and characterized as follows:

- Substantial separation of the general health system and the vertical TB system.
- Strong walls around the prisons and vertical TB systems controlling the location and treatment of TB patients.
- Strong administrative controls moving TB patients released from prison to the civilian vertical TB system and TB cases identified in the community or general health system to the vertical TB system.

#### Figure

*TB System: Soviet Union*

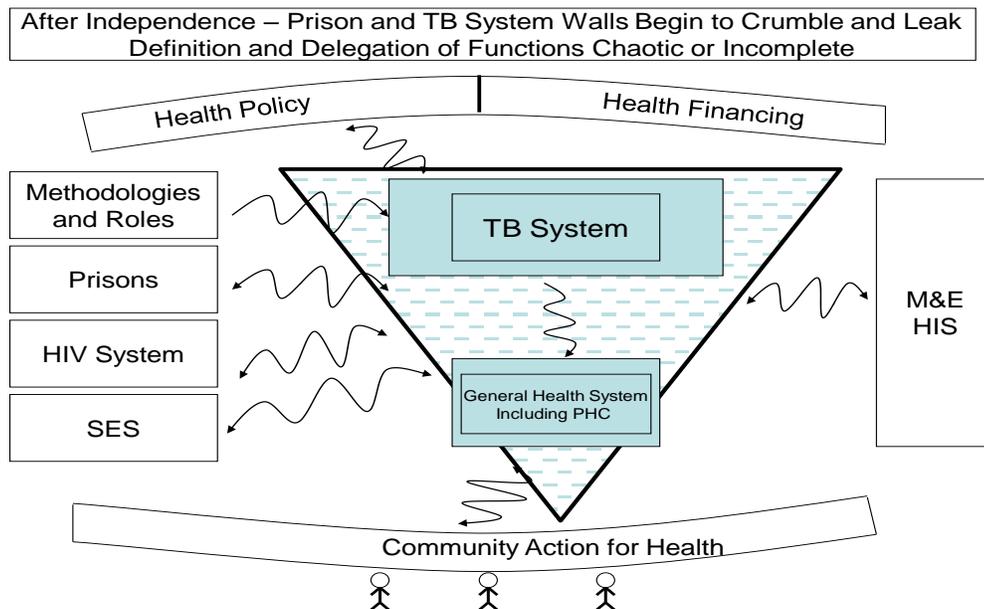


The following three charts portray the post-independence TB control problems and the proposed two-phase solution. The charts are consistent with the overarching regional strategy chart (see above) in that they show service delivery in the middle, the bottom-up close connection to population/community involvement in their own health enabling a patient-centered approach, the top-down contributions of health policy and health financing, and the how-to glue or drivers of constant movement in institutionalization for sustainability and better use of information completing the circle at the left and right sides of the chart. In addition to institutionalization of methodologies and tools, the left side of the chart identifies the institutions for which solidifying TB-related roles and relationships are most critical (prisons, HIV/AIDS Centers, and the Sanitary Epidemiological Service (SES)).

After independence, the general situation and problems in Central Asia TB services is shown in the chart below and characterized as follows:

- Budget collapse, weaker administrative controls, and increased human rights resulted in leakage of patients and health system functions from the walls of the prisons and vertical TB systems into open society. In essence, the walls started to crumble. In the chart below, this leakage is represented by the undulating lines or arrows.
- No broad governance/stewardship or institutional roles and relationships existed to manage this leakage from the prisons and the vertical TB systems resulting in significant and substantial gaps in the overall system that contribute to increased TB transmission. Chaotic or inappropriate management of the gaps is also represented by the undulating arrows.
- The core strategy of the three previous USAID “Zdrav” projects was inverting the health delivery system pyramid from inefficient, overly specialized and often unnecessary hospital care to cost-effective and patient centered primary health care. The inverted pyramid is also inherent in the Quality Project TB strategy and the chart shows the heavy reliance on the vertical TB system and its excessive hospitalization rather than PHC and outpatient TB treatment, which is seen in most of the rest of the world and is considered international best practice. Although the vertical TB system has started to delegate service delivery functions to PHC, the undulating arrow portrays that the policy, systems, and processes need clearer definition, strengthened coordination, and improved management. Very importantly, no arrow from health financing shows that the level of reform or changes in service delivery are limited, restructuring of the excess capacity in the vertical TB system has not occurred, and significant functions have been delegated to PHC with no corresponding financing.

**Figure**  
*TB System: After Independence*



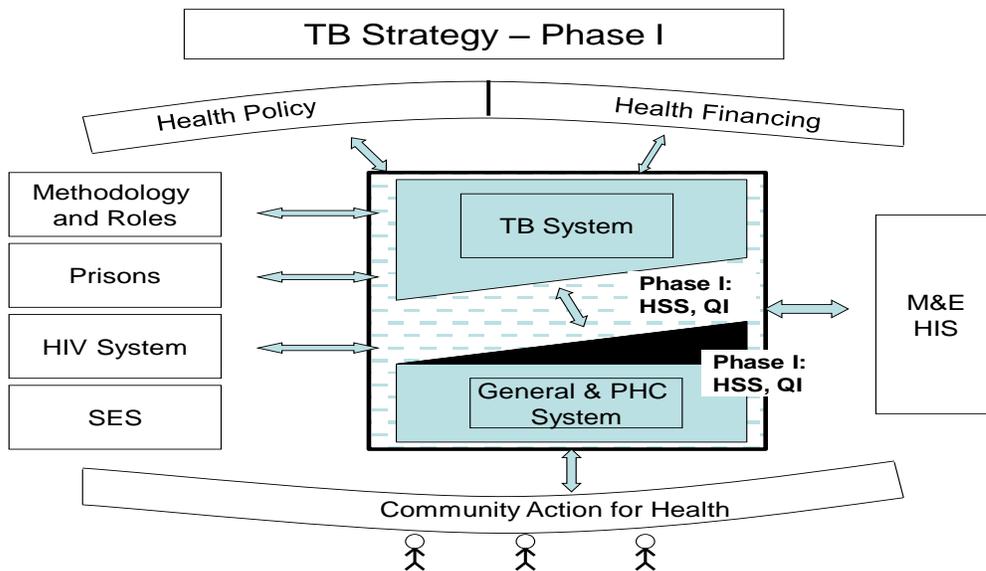
The Phase I and Phase II charts below portray how the Quality Project TB strategy will support country partners in implementing a combination of QI processes and HSS to improve TB control through the following three specific strategies:

- Accelerate and improve integration of TB services into PHC as shown by the black expansion of PHC services and corresponding reduction in vertical TB system services. Specific elements of this aspect of the TB strategy include piloting and extensive roll-out of TB PHC QI sites, and TB financing reform enabling restructuring of TB hospitals and reinvestment of savings in direct patient care costs of hospital and PHC services for susceptible and MDR-TB.
- Improve continuum of care and coordination of services between the vertical TB system and PHC as shown by the narrowing of the gap between the two systems and converting the undulating arrow to a straight and stronger line or arrow to represent the better defined policies; realized legal framework and improved systems; management; and coordination that the Quality Project will support country partners to establish. Specific elements of this aspect of the TB strategy include actions to improve coordination of services such as placement of TB specialists in outpatient services with enhanced supervision responsibilities, and strengthening health systems functions or services such as lab; drug management; IPC; and MDR-TB service delivery.
- Improve management and coordination or convert undulating arrows to straight and strong lines or arrows for health systems functions or institutional roles and relationships with the TB system. Specific elements of this aspect of the TB strategy encircle TB services as in the Regional

Strategy chart and include: 1) Evolving to a more patient-centered approach by creating synergies between service delivery and CAH or population and communication involvement in their own health; 2) Strengthening health policy and financing; 3) Better use of information through M&E, operations research, and unifying HIS; 4) Institutionalizing methodologies and tools; 5) Improving referrals from prisons and services for former prisoners; and 6) Improving TB/HIV services and coordination between the vertical TB and HIV/AIDS systems. Phase I does not include comprehensive reform or coordination with SES. Due to limited resources and the broad scope of the task, the initial focus will be on removing barriers imposed by SES.

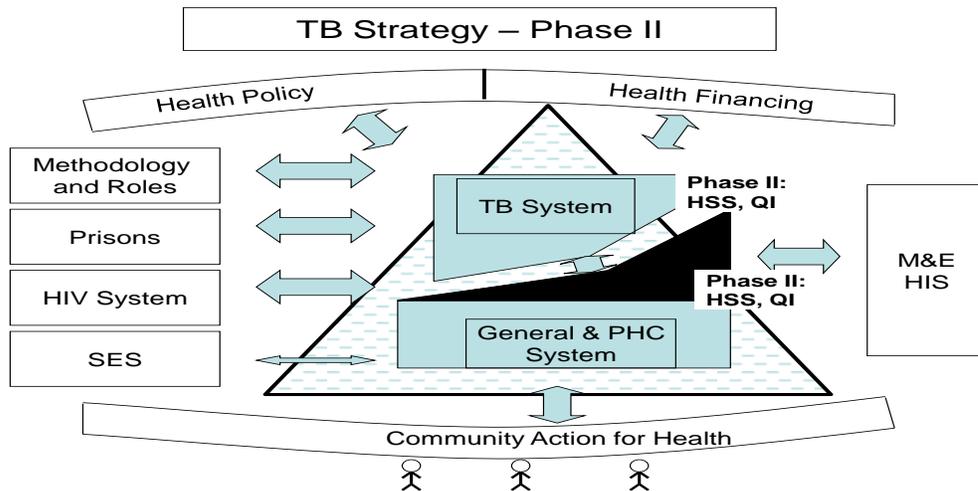
During the five years of the Quality Project, it is expected that reaching a critical mass to complete and institutionalize Phase I can be achieved.

**Figure 5**  
*TB Strategy - Phase I*



Phase II is shown in the chart below and is planned to solidify the integration of TB services into PHC (larger black box); improve coordination between the vertical TB system and PHC (smaller space and stronger line or arrows between two systems); and solidify functions and roles and relationships including between SES and the TB system (stronger lines or arrows). Building on the critical mass, improvement, and institutionalization achieved during Phase I, it is expected that completing Phase II will take ten years in most Central Asian countries.

**Figure 6**  
*TB Strategy - Phase II*



MDR-TB is a health systems problem and turning off the MDR-TB tap requires a HSS approach. MDR-TB services cannot be completely separated from non-MDR-TB services as they are contained within the same overall systems and very intertwined, especially as solving the MDR-TB problem requires improvements in diagnosis and treatment success of non-MDR-TB cases. In summary, the Quality Project TB strategy is consistent with our overarching regional strategy, and all project activities will be guided by the TB strategy in that they will be consistent with the three premises or tenets:

- Further integration of TB services into PHC
- Closer linkages and coordination between the TB system and PHC to improve quality and the continuum of care
- Solidify functions, roles, and relationships across the health sector and a number of health systems including community involvement; relationships with prisons, HIV system, and SES; use of institutionalized methodologies and tools (e.g. standard CPG development methodology, undergraduate medical education curriculum); unified and consistent national legal and policy framework; health financing with appropriate incentives; and better use of information and improved feedback loops.

**Implementation Strategy**

The major TB strategy implementation dilemma is establishing direct relationships between discrete HSS activities and CQI activities as their nature and timing is very different. Without these linkages it is very difficult or even impossible to implement significant reform or improvement in TB services in Central Asia. The Quality Project implementation strategy is to find and develop linkages or synergies between these discrete HSS and CQI activities to step-by-step drive relatively rapid change and improvement in TB outcomes (the core of the diagonal approach). Examples include:

- The decision on full integration of TB into PHC is a discrete political decision. All Quality Project technical leadership and management including TB team and HSS/Health Financing team will engage in dialogue with countries to develop step-by-step plans for full integration of TB services into PHC through a pilot and roll-out process. Initial plans call for a three phase approach with Phase I of integration of non-MDR-TB smear negative cases and children; Phase II integration of non-MDR-TB smear positive cases; and Phase III integration of MDR-TB. Critically, the initial TB PHC CQI activities are designed to both find and improve quality gaps in services or functions currently delegated to PHC and to continuously prepare the PHC system for further integration of TB services in Phases I, II, and III.
- The Quality Project strategy for introduction of GeneXpert in Central Asia contains a direct linkage to full integration into PHC. Using GeneXpert for diagnosis should help mitigate the reluctance of TB specialists, ensure that no drug resistant cases are fully integrated into PHC in Phase I, and enable improvement in referral processes of rifampicin-resistant cases for advanced diagnostics and likely hospitalization at least until the clinical regimen is clear and conversion has occurred.
- Establish direct linkages and create synergies between TB PHC CQI and the addition of P4P based on TB indicators to the PHC per capita payment system. The discrete health-system-level provider payment system change can be linked to CQI in TB services at the PHC level by identifying real quality gaps to fix with CQI processes; developing indicators for payment that take into account the quality gaps and improvement; and using the financial incentives in the PHC per capita payment system/P4P to drive relatively rapid roll-out of best practices from the initial TB PHC QI sites. These synergies between discrete health financing, payment changes, and CQI are already developing in Kazakhstan.
- Establish direct linkages and create synergies between the discrete health financing step of introducing a new TB hospital payment system driving TB hospital restructuring and the reinvestment of savings for full integration into PHC and continuous improvement in hospital-level MDR-TB treatment. There is also a critical short-term relationship between a new TB hospital payment system and TB hospital restructuring and improving hospital IPC by both separating MDR-TB patients across hospitals and enabling improving IPC within hospitals.
- Using epidemiological data and small on-the-ground operations research studies to strengthen feedback loops by improving targeting of CQI activities and advocacy for further discrete or health- systems-level political decisions is a core element of our overarching regional strategy and TB strategy.

The Quality Project TB Strategy varies from the Quality Project overarching Regional Strategy in the health systems functions of lab and drug management. Brief descriptions of TB lab and drug management strategies are below. As described in the HSS/Cross-Cutting Activities section, to the extent possible, the Quality Project will incorporate and leverage activities into improvement in lab services and drug management across the entire health system to increase sustainability and help ensure adequate funding of TB lab services in the future.

### **3.1.1 LAB**

The Quality Project will support national TB programs in their efforts to provide high quality laboratory services and improve TB program performance, including increasing TB case detection and improving treatment outcome. At the PHC level, the Quality Project will focus on strengthening the capacity of smear microscopy labs to detect smear positive cases. Based on results from the regional evaluation study on external quality assurance (EQA) policies and procedures conducted during Year 1, the Quality Project will plan activities to meet the specific needs of each country for trainings, and provide supportive supervision and development of implementation protocols. The Quality Project will also introduce LED fluorescent microscopy, develop standard operating procedures (SOPs) for this method, and implement EQA.

At the hospital level, the Quality Project will work on QI of culture and drug sensitivity testing (DST) for *M. tuberculosis* in order to enable implementation of the WHO recommendation on the availability of culture and DST with ensured quality for every TB patient. Quality Project activities will include the development of SOPs; trainings in quality assurance of culture and DST; training in advanced methods for laboratory diagnosis; and supportive supervision of culture laboratories.

The Quality Project will also work on strengthening national TB program capacity for MDR- and extensively-drug-resistant TB (XDR-TB) management by introducing GeneXpert technology at different levels of health services. Early and accurate diagnosis of MDR-TB is the basic pre-requirement for successful treatment of TB, prevention of treatment failures and spread of infection with resistant strains of *M. tuberculosis*. GeneXpert will be introduced at the oblast and/or rayon level taking into account the TB and TB/HIV epidemiological situation; infrastructure; estimated workload; direct linkage to further integration of non-MDR-TB treatment into outpatient care; and the TB program capacity to ensure appropriate treatment and care of diagnosed MDR-TB cases. A GeneXpert MTB/Rif implementation strategy will be developed to optimize the usefulness of the technology under routine program conditions and to ensure maximum efficiency. Lessons learned and data collected during the implementation process, will be analyzed to evaluate the impact on TB Program performance.

At the national level, the Quality Project will participate in the development and implementation of the Laboratory Quality Management System (QMS) and prepare a team of trainers to lead cascade trainings to introduce the system at all levels of the TB laboratory network. QMS will introduce internationally-accepted quality standards in laboratory services in all aspects of laboratory functioning, including laboratory organization and infrastructure; technical procedures; IC and bio-safety; laboratory equipment; commodity management and the referral system.

The Quality Project will also support the development process of the strategic plan for laboratory strengthening for TB and the general lab system as a more efficient overall lab system will improve operations and increase sustainability of TB lab services. The plan will identify all interventions required for strengthening the TB laboratory network and its capacity for effective diagnosis of TB, including MDR- and XDR-TB, and it will include all technical, legal, quality, financial, and logistical aspects while

taking into account country specifics, infrastructure, human capacity, financial resources, and levels of international organizations' engagement.

In order to increase efficiency and ensure optimal use of lab capacity, all planned activities will be linked with other program components and will be coordinated with national and international partners.

### **3.1.2 DRUG MANAGEMENT**

The Quality Project will support national TB programs to strengthen drug management and ensure that anti-TB drugs reach and are appropriately used by patients. The Quality Project will focus on improvements in drug selection, procurement, distribution, and use, as well as in management support that can help to maintain an adequate flow of anti-TB drugs in CAR countries.

Proposed activities could ensure uninterrupted drug supply through selection of anti-TB drugs according to treatment protocols and the Essential Drug List (EDL); accurate quantification of anti-TB drug needs; regular and timely provision of Logistics Management Information System (LMIS) data; and appropriate usage of available anti-TB drugs.

The selection of medicine for treatment of TB and MDR-TB cases will focus on the selection of drugs, regimens, formulations, and packaging that affect the procurement, forecasting, and distribution of medicines used in the national TB programs. To ensure appropriate drug selection, the programs should consider EDL and standard test procedures (STP) and confirm the registration status of selected drugs.

The Quality Project will assist the national TB programs in the selection process through participation in thematic working group meetings and revision of EDL and STP. The Quality Project will both work with national drug regulatory authorities (NDRA) to ensure that a lack of registration of anti-TB drugs (first and second line) is not a barrier to product availability, and consult with NDRA and communicate with manufacturers in order to minimize potential delays related to registration and importation. Moreover, the Quality Project will assist national TB programs (NTP) in facilitating anti-TB drug registration, including translation of registration dossiers and submission of registration dossiers to NDRA.

In CAR, the main source of financing for procurement of anti-TB drugs is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (Kyrgyzstan, Turkmenistan-Global Fund Round 9; Uzbekistan – Global Fund Round 8, Tajikistan – Round 8, Rolling Continuation Channel). An exception is in Kazakhstan, where drugs are purchased with funding from the state budget. At present, specialists involved in the process of drug quantification and ordering have weak skills, especially for second line drugs. Taking this into account and considering that an uninterrupted supply of anti-TB drugs is an important element of the Directly Observed Treatment, Short Course (DOTS) strategy, the Quality Project will support the process of ensuring an uninterrupted supply of quality anti-TB drugs in coordination with the GFATM Project Implementation Unit (PIU), Global Drug Facility, Green Light Committee, and other international mechanisms. The Quality Project will also assist local partners in estimating drug needs, preparing drug

orders, and applying for grants, including preparing grants to the Global Fund for pediatric TB drugs, by conducting training workshops on drug needs quantification and procurement procedures for key NTP specialists involved in the process of anti-TB drug ordering and procurement.

To address TB drug stock-outs, which are largely due to poor information flows between the periphery and central levels, the Quality Project will focus on further strengthening LMIS in the framework of TB and MDR-TB country programs. In order to determine the weaknesses of system functionality, the Quality Project will conduct an assessment of LMIS performance in the countries. Based on the results of the assessment, the Quality Project will conduct specific activities, including training workshops and on-the-job-trainings, to improve the knowledge and skills of staff responsible for LMIS at all levels. Considering that LMIS is closely linked with inventory control systems (ICS), Quality Project plans will include activities on improvement of ICS within NTP in each country of the region as well.

Since anti-TB drugs are available in the open market without a prescription, the Quality Project plans to strengthen the legal and policy framework related to anti-TB drugs, including restricting or prohibiting access to over-the-counter anti-TB drugs on the open market. The Quality Project will review existing MOH prikazes and regulations on drug prescription, and hold roundtable discussions to discuss the availability of anti-TB drugs in the open market and to identify additional strategies to reduce antibiotic resistance in the region.

The Quality Project will support rational drug use, especially for antimicrobial medicines, by strengthening the legal and policy framework for anti-TB drugs; promoting restricted access to open-market, anti-TB drugs without a prescription; and conducting roundtable discussions and rational drug use trainings for medical staff.

### **Indicators**

Priority Program/TB revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

Process indicators:

- # of TB products developed to improve service delivery
- # of people trained on TB topics
- # CQI supportive supervision site visits
- # suspects examined by sputum microscopy or rapid diagnostic test in CQI sites
- # of laboratories participating in EQA system
- # of facilities included in drug management system
- # providers trained on interpersonal communication
- # of individuals trained on TB including stigma and discrimination (incl. journalists)

Intermediate indicators:

- # policies/regulations developed or changed as a result of project contribution/recommendations
- # of TB CQI sites (disaggregated by type, phase)
- % TB suspects who are managed according to diagnostic algorithm in CQI sites
- % SS+ cases detected at PHC level in CQI sites
- # released prisoners initiating or continuing treatment in civil sector
- % of notified MDR cases put on DOTS+ treatment
- % monitored PHC facilities implementing priority TB IC measures
- % suspects diagnosed with SS+ TB in CQI sites
- % of facilities regularly submitting correct national LMIS reports
- % increase in patient satisfaction survey including patient rating of attitude/kindness of attending physician
- # of articles published, radio and TV program developed and broadcasted by trained journalists
- # of TB awareness campaigns (CAH) conducted by CBOs

Impact indicators:

- % of new SS+ TB cases cured and completed treatment under DOTS (i.e. treatment success rate) in USG-supported areas
- % of SS+ patients with delays in treatment initiation in CQI sites
- # of MDR-TB cases notified
- % cured for MDR cohort
- # of confirmed TB cases among HCWs
- Number of TB cases reported to the NTP per year per 100,000 population
- % labs with acceptable performance for EQA
- % of facilities that experienced a stock out at any point during a given time period
- % of TB cases registered in a specified period that interrupted treatment for more than 2 consecutive months

### **3.2 TB/HIV**

Given that the Quality Project contains both TB and HIV programs, the Quality Project plans to work to this comparative advantage to develop an innovative and integrated TB/HIV strategy. Development of a detailed TB/HIV strategy is in process and expected to be completed in fall 2011. The general TB/HIV strategy is to work across all levels as follows:

- Health system level – broad policy dialogue and HSS activities including health financing to clarify roles and relationships between the vertical TB and HIV systems, general health system and vertical TB and HIV systems, and to the extent possible between SES and the vertical TB and HIV systems; appropriately incorporate co-infected patients into new TB hospital payment systems.

- Service delivery level – ensure TB patients are tested for HIV and HIV MARPs and AIDS patients are tested for TB; incorporate co-infected patients into enhanced counseling and social work activities; improve TB/HIV CPGs; incorporate evidence-based information into medical education; and introduce CQI processes to improve the continuum of care for co-infected patients.
- Population/community level – creative and innovative ideas to organize patients, enhance community support, reduce stigma, and link to enhanced counseling and social work activities.

### **Indicators**

Priority Program/TB/HIV revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

Process indicators:

- # of TB staff trained in HIV pre and post test counseling

Intermediate indicators:

- % of TB patients receiving counseling when tested for HIV

Impact indicators:

- % of all registered TB patients who are tested for HIV through USG-supported programs
- % of registered HIV+ individuals screened for TB

## **3.3 HIV**

The Quality Project contributes to national and local HIV prevention, treatment, care, and support efforts by working with national governments, civil society, and health services to link people at risk of and affected by HIV to the programs and services they need.

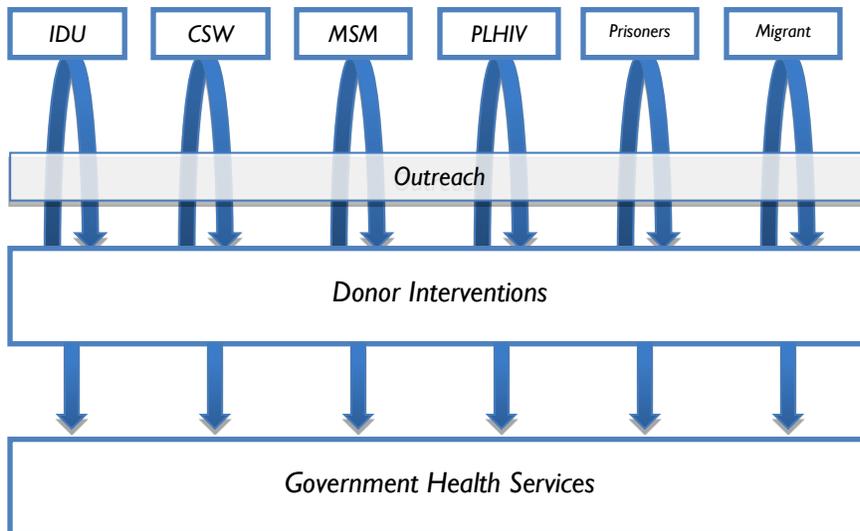
By working with programs and agencies engaged with MARPs, the Quality Project provides technical assistance to government partners and service providers in the form of trainings, mentoring, and expert consultations to ensure that MARPs have a supply of services which have sufficient geographical reach, breadth, and quality to meet their needs. Simultaneously, the Quality Project works with civil society partners to support them in increasing MARPs' demand for services, and meeting that demand with a range of high quality support services. Using a HSS approach, the Quality Project also addresses systemic and other barriers that stand in the way of enhancing the continuum of care for MARPs.

### **The Current Situation**

Considering access to HIV prevention, care and treatment services from a health systems perspective, the Quality Project identifies barriers for MARPs' care as depicted in the diagram below.

**Figure 7**

*Current Model of HIV Intervention for MARPs*



This diagram illustrates the dominant model being employed at present. The Quality Project identifies three primary weaknesses with this model:

- 1) MARPs are not empowered to seek care when and how they choose. Donor-funded outreach efforts identify particular populations as at-risk for HIV infection and transmission and seek them out based on specific behaviors. MARPs with hidden behaviors are not reached, and MARPs with multiple cross-cutting risks may be underserved: a sex worker may be a wife and mother; and a drug user may sell sex or be a man who has sex with men. However, this individual may be seen only as a sex worker and offered targeted services that exclude other needs.
- 2) Vertical outreach programs may work with one risk behavior and a specific population. For instance, a targeted program may distribute harm reduction commodities and provide information on voluntary counseling and testing (VCT), but not address a myriad of other health-related issues that could engage MARPs into care, including overdose prevention, drug counseling, RH needs, and basic PHC services that are often denied to MARPs. In the current system, MARPs have little recourse to seek services without assistance.
- 3) Even the most effective models of outreach are subject to problems of long-term practicality and sustainability. Donor-funded outreach projects that often devote a relatively high level of resources per capita are difficult to scale up financially. Therefore, these interventions generally remain limited in scope in terms of both geography and range of services.

Moreover, the success of these programs is often defined narrowly: it is expressed as the number of people reached with a single intervention, rather than as a change in health-seeking behavior or a long-term reduction in risk behavior.

The government health system is isolated and disengaged from the process of identifying MARPs in need of services. The system does not engage in outreach, and the demand for services, created by donor-funded outreach, is often met with stigma and discrimination. When care is provided, it is often of low quality. MARPs are often unable to access care when they present without NGO accompaniment (either physical escort or a voucher or other bargaining document).

These limitations make it unlikely that any country will be able to significantly reduce HIV incidence and impact in the long-term.

Pockets of access exist where MARPs are able to receive a more acceptable level of care, and/or outreach NGOs and government health services have a more complex and sustainable partnership established in providing care for MARPs. The Quality Project views these facilities, which provide a higher-than-average level of access to care for MARPs, as model Entry Points for MARPs into the government health care system.

#### **Why work with Entry Points?**

The facilities that the Quality Project chooses to work with as model Entry Points are already serving MARPs more often than the average facility. This may be because of their proximity to MARP concentrations, because of the motivation of the facility's Director, or because they have an agreement with a neighboring NGO that provides services to MARPs.

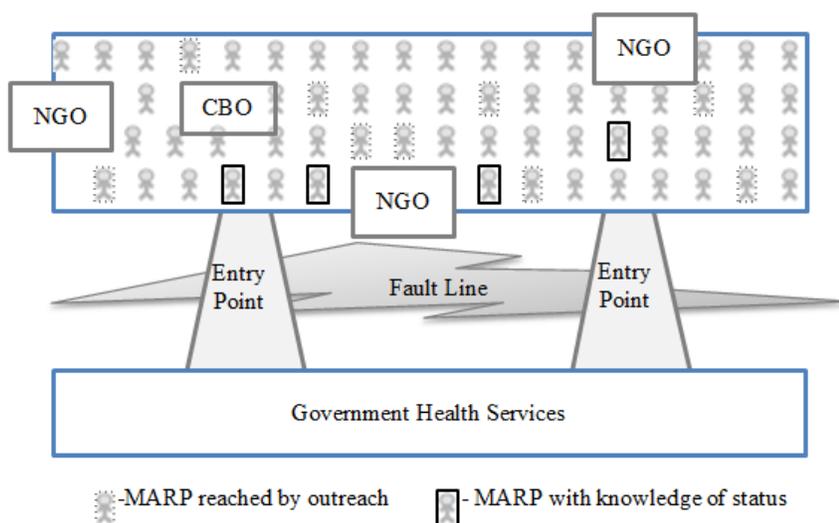
So why work with these facilities, if they are already above average in serving MARPs?

The quality of services accessible to MARPs remains low. While VCT may be available, the accompanying counseling may be inadequate, and other health needs of MARPs may not be considered. Physicians and nurses, especially in primary care facilities, may not be trained to deal with the complex health needs of MARPs or be aware of the increased risk of other infections and health complications that can accompany high-risk behaviors.

Facilities that offer even the most basic care to MARPs remain limited, and to date, there has been no significant documentation of successes or sharing of experiences from MARP-friendlier facilities. By working with a handful of best practice institutions to improve the quality of their services, the Quality Project will identify specific factors that may help to identify other potentially MARP-friendly facilities for capacity-building and will develop tools for various types of health facilities to assist them to increase their reach in MARP populations.

The current, limited number of Entry Points available to MARPs are not without problems. Figure 2, below, illustrates challenges faced in the current system.

**Figure 8**  
*Challenges to Opening the Entry Points*



Access to Entry Points remains limited both in terms of number of MARP-friendly facilities and in terms of the procedures by which MARPs can access care. Entryways into Entry Points remain narrow: they are difficult to navigate without escort or referral from an NGO. Only MARPs reached by outreach services are able to access VCT, which limits the number of MARPs with knowledge of HIV status. These Entry Points require “opening” in order to allow easier access to health care services for MARPs.

**How does the Quality Project open the Entry Points?**

The Quality Project examines and supports these pockets of improved access, and works with communities, NGOs, and services to open these entry points further so that MARPs can access the full range of services they need.

Working with key staff at Entry Point facilities, the Quality Project examines the structural obstacles, including staff training; attitudes and behaviors; task allocation within the service; health financing; and issues of identification documents, to increased access in these services and works with services and governments to address them.

**A Localities-Based Approach**

While working directly with targeted Entry Point facilities, the Quality Project also works to strengthen the supportive services in the locality surrounding government facilities, to assure that MARPs can access the full range of services they need.

Working with NGOs and CBOs involved in outreach programs through the USAID Dialogue Project, Global Fund sub-grants, and other donor initiatives, the Quality Project assists these bodies to develop USAID Quality Health Care Project Regional Strategy

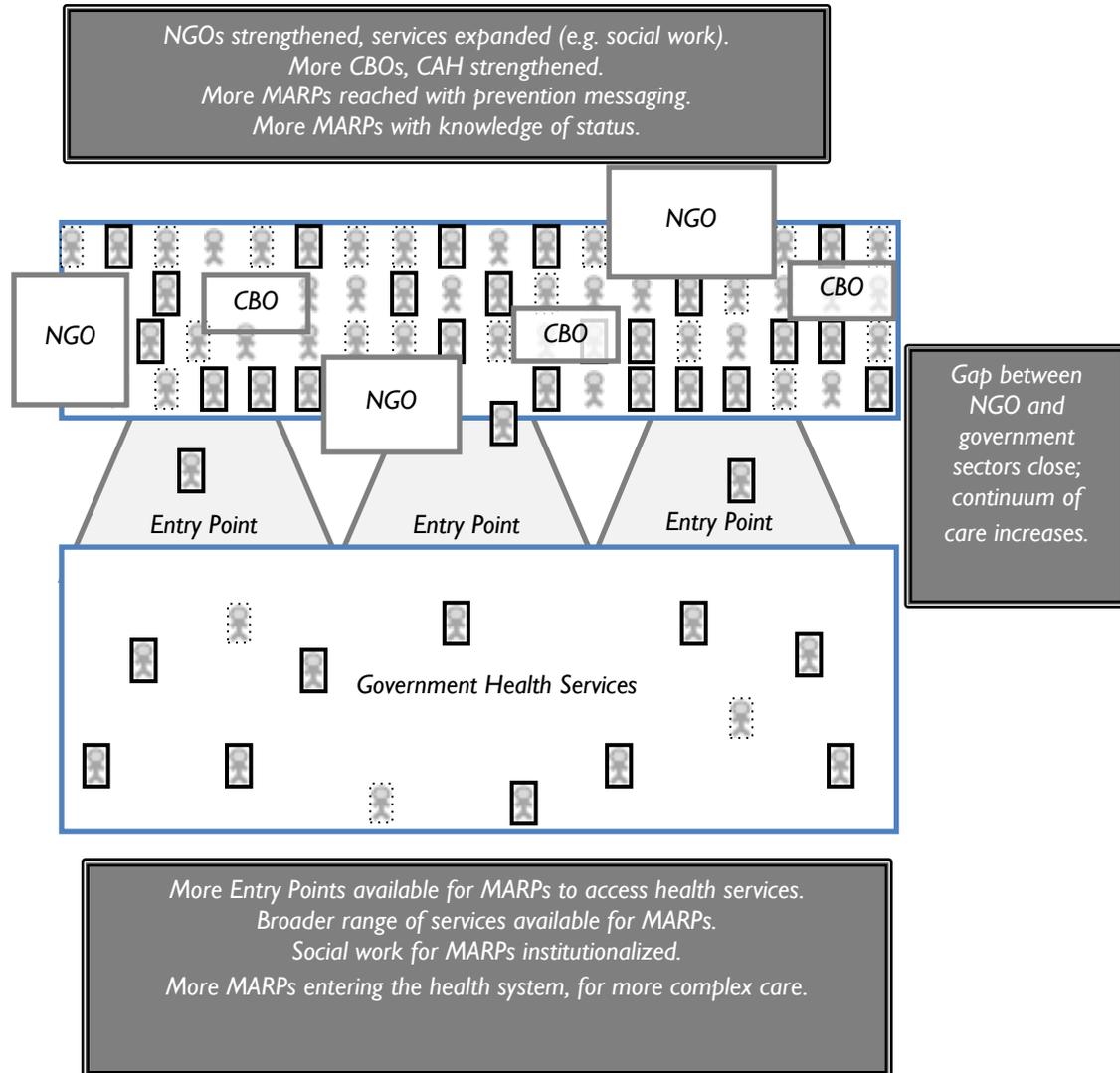
more effective referral strategies, brokering systems, and other pathways to ensure that MARPS reach services and develop long-term health-seeking relationships with service providers.

The Quality Project also helps to expand the range of services that NGOs and CBOs offer. In particular, the Quality Project will work to establish a standard of practice for social work specifically for dealing with the issues of MARPs. The trained cadre of social workers will be able to provide appropriate, in-depth pre- and post-test counseling, as well as assist MARPs in managing complex, long-term health challenges such as drug dependency.

Additionally, the Quality Project works to address the fault line between government and non-governmental services, which prevents NGOs and government health services from working together optimally and limits the continuum of care. These efforts work to build partnership, trust, and respect between health services providers and NGOs, and this leads both sides to work constructively to hold each other accountable for the overall quality of care, and to work together to solve access and quality problems as they occur. Strengthening and systemizing the interactions between these services is essential to assuring improved care for MARPs.

The ultimate goal of the Quality Project HIV strategy is to balance outreach services with MARPs' entry into the health system. This can only be achieved once Entry Points are "opened" and supportive services from NGOs and CBOs are well-coordinated with government health services.

**Figure 9**  
Balancing Outreach with Entry



In this scenario, Entry Points are more numerous, and open widely and accessibly for MARPs. MARPs are empowered to enter the system without an NGO escort and will seek a broad range of health services within government facilities. This results in a dramatic increase in knowledge of status and improved health-seeking behaviors.

MARPs also have access to a broader range of support services through strengthened NGOs and CBOs, including non-medical health services such as voluntary counseling and rapid testing. The NGO and

government health services sector are also working collaboratively, with the gap between their services closed to improve the continuum of care for MARPs. Some NGOs or CBOs may even “overlap” with government health services, with models where health care workers actively engage in outreach, or NGO social workers spend a designated amount of time each week working in government facilities.

**Working Beyond Localities**

The Quality Project will focus on intensive work in localities where MARPs are concentrated and development partners (particularly the Dialogue Project) are active. However, the Quality Project recognizes the need for a mix of locality-level and national-level interventions to address some of the systemic barriers that prevent MARPs from accessing care. Therefore, the Quality Project will engage in national-level work including high-level capacity building; assistance in updating relevant guidelines and policies; improving medical education; and working to comparative advantages with the GFATM to improve the effectiveness and efficiency of grant implementation. Where relevant, the Quality Project may also work at the oblast level to strengthen policies and capacity. The diagram below presents illustrative activities at varying levels of the system.

**Figure 10**

*Levels of Quality Project Engagement in HIV Activities*

<p><b>Regional Level</b></p> <ul style="list-style-type: none"> <li>• Work with Dialogue Project and other regional initiatives</li> <li>• Regional strategy</li> <li>• Regional policy dialogue/advocacy</li> <li>• Regional networking/training/experience sharing</li> </ul>	
	<p><b>National Level</b></p> <ul style="list-style-type: none"> <li>• Work with Dialogue and other national projects</li> <li>• Global Fund implementation support</li> <li>• National guidelines/policies</li> <li>• Health worker pre-service curricula</li> <li>• In-service training</li> <li>• Work with Republican AIDS Center</li> <li>• Work with National MOH and other Ministries – health system reform</li> <li>• Health Financing and other System Strengthening to remove obstacles</li> </ul>
	<p><b>Oblast/City Level</b></p> <ul style="list-style-type: none"> <li>• Cross city referral patterns</li> <li>• Work with Oblast and City AIDS Centers</li> <li>• Work with city-level government and NGOs</li> </ul>

			<p>Locality Level (service area)</p> <ul style="list-style-type: none"> <li>• Working with services and NGOs to create and meet demand for HIV prevention and care services for MARPs</li> <li>• Expand access to VCT</li> <li>• Improve access to HIV treatment and care</li> <li>• Work with NGOs to improve quality and range of services</li> <li>• Link with other specialized care to improve access for MARPs: drug treatment/narcology, STI, RH/MCH</li> </ul>
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In Years 2-5, the Quality Project will work to expand and institutionalize all successful lessons learned in localities up to the national level, assuring that the system supports a well-prepared cadre of professionals, nationally, to provide quality HIV prevention, care, and treatment services for MARPs.

### **Crosscutting Themes within HIV**

Within the framework of the strategy outlined above, the Quality Project gives particular focus to the following thematic areas:

- *Gender Issues:* With a particular focus on harm reduction services for at-risk women (primarily injecting drug users (IDUs)), the Quality Project focuses on addressing the needs of women who are overlooked by most harm reduction programs. The Quality Project also focuses on addressing the risks of, and identifying for testing, the sexual partners of male IDUs. Through these activities, the Quality Project will reach two ‘hidden’ female populations whose needs currently remain unaddressed.
- *People Living With HIV:* The Quality Project focuses on improving the lives of PLHIV with a dual purpose: 1) To improve treatment outcomes and quality of life for this target population, and 2) To seize the opportunity for positive prevention by supporting PLHIV to make choices that reduce the risk of further transmission of HIV. With recent research proving a definitive link between success on antiretroviral treatment and reduced transmission of HIV, the Quality Project considers all activities aimed at improving treatment quality (including supply chain, prescribing, and adherence) to double as positive prevention.
- *HSS:* The underlying core of the Quality Health Care Project is HSS. The HIV component of the project uses every opportunity to work within the existing health system to strengthen services along the spectrum from primary care to tertiary care, and integrate multiple services in a single location, with a particular focus on improving MARPs services at primary care outlets. While early activities focus on Entry Point facilities in particular localities, the Quality Project will work to scale up and institutionalize service integration and other best practices at the national level. The Quality Project also works at the national level to help ensure sustainable financing for HIV services and address critical health system needs, including strengthening of procurement and supply management systems; addressing issues of co-infection and IPC (e.g. TB, HCV); and

updating of clinical protocols (CP) and practice guidelines related to HIV (e.g. sexually transmitted infections (STI)), which provide overarching benefits to the health system.

### Indicators

Priority Program/HIV revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

#### Process indicators:

- # health care workers trained, in-service (PEPFAR Direct); By type: social worker; By topic: Minimal Counseling Skills, Advanced Counseling Skills
- # health care workers trained, in-service (PEPFAR Direct); By type: government medical worker, NGO worker; By topic: VCT
- # health care workers trained, in-service (PEPFAR Direct); By type: government medical worker; By topic: MARPs prevention and care
- # of government health care facilities mentored on a quarterly basis to improve quality of prevention & care for MARPs
- # of clinical protocols related to HIV prevention updated to meet international standards/best practices
- # of AIDS Centers (or other facilities) utilizing anti-retroviral (ARV) forecasting software.
- % of patients on anti-retroviral therapy (ART) who are entered into forecasting software.
- # health care workers trained, in-service (PEPFAR Direct); By type: government medical worker, NGO worker; By topic: medication-assisted therapy (MAT)
- # health care workers trained, in-service (PEPFAR Direct); By type: NGO worker; By topic: MARPs prevention and care
- # of HIV products enhancing policy dialogue or service delivery
- # of specific technical support requests from GFATM projects successfully met by Quality project support

#### Intermediate indicators:

- # of target localities (disaggregated by type, phase)
- # of target localities that move up one level (e.g. Level 2 to Level 3) on the Level of MARPs Service Provision Scale.
- # of ARV stock-outs experienced, nationally
- % Registered IDUs on MAT, nationally
- % MAT protocols harmonized with international best practices and/or standards (where standards exist)
- % of NGO trainees who report use of new skills and knowledge provided during training, at 6 months
- % of NGOs with at least one service financed by the government
- # of legislative or policy changes positively affecting MARPs care

- HIV policy harmonized with national health strategy: number of core indicators included in both health and HIV strategies

Impact indicators:

- % of MARPs who have been tested and known their HIV status in the last 12 months
- % improvement of quality of services at target government health care facilities, over baseline
- % decrease of average mortality of patients enrolled in ART
- % increase in quality of services as perceived by IDUs
- % of those on ART who are IDUs/former IDUs
- % change from 2010 MAT Policy Inventory
- # of MARPs reached with individual or small group level intervention (PEPFAR Direct)
- % improvement of quality of services of partner NGOs, over baseline
- % of all in need of ART who are receiving ART
- % of facilities in localities with at least one HIV/MARPs social worker either partially- or fully-funded by the government

### **3.4 MCH/FP/RH**

Although mortality rates are decreasing overall, significant inequities exist in access to quality maternal and child health care in many parts of Central Asia. Complications of pregnancy and childbirth still rank among the leading causes of death and disability in young women and babies. This can be attributed to a lack of access to services, as well as a lack of providers' capacity to identify and manage complications. To help individual countries make progress towards achieving Millennium Development Goals 4 and 5, the Quality Project seeks to use evidence-based approaches linked to removal of health system barriers and equitable financing for vulnerable women and children in order to prevent these deaths and improve the quality of care women and children receive.

#### **3.4.1 MATERNAL HEALTH**

The Quality Project will strengthen antenatal care (ANC), labor and delivery, neonatal care, and child health services; and use our overall QI approach in the following priority areas.

##### **3.4.1.1 Scaling up Safe Motherhood (SM) model**

The ZdravPlus II SM model, including EPC and ANC, will be scaled up to strengthen the continuum of care across PHC and hospital levels and empower antenatal, intrapartum, postpartum, and neonatal providers to provide coordinated, comprehensive care using a training/mentoring approach. New sites will be included, and in some countries, capacity of ZdravPlus II pilot sites will be strengthened. Capacity of national trainers will be further developed with the goal of achieving sustainable, institutionalized expansion of EPC coverage.

### **3.4.1.2 Improving management of obstetric and neonatal emergencies**

Every Central Asian country identifies management of obstetric emergencies and effective neonatal resuscitation as areas that need considerable attention. Unfortunately, no effective model to improve care in these areas has been developed in Central Asia. Some work with mid-level providers has been done in Tajikistan (“Life Saving Skills”), but only in small pilots. GIZ formed a working group in Kyrgyzstan to develop a curriculum, but the materials developed to date are more appropriate for an intensive post-graduate curriculum rather than in-service skills training.

The Quality Project will develop a draft training program based on existing competency-based curricula and ask country-level working groups to review and adapt with the goal of delivering a short course that can be used for competency-based certification of providers in management of OB emergencies and neonatal resuscitation. These new skill-strengthening modules will be developed in collaboration with WHO and other key development partners so that roll-out beyond Year 2 of the project can continue. The Quality Project believes that introducing these new areas even with limited time will have the greatest impact on MCH health outcomes.

### **3.4.1.3 Developing CAR expertise in supervision and mentoring**

The Quality Project plans to implement a strategy to shift from great reliance on FSU SM consultants to Central Asian consultants. There is already strong country-level expertise among trainers, but they need additional skills in order to become effective mentors. The Quality Project will aim for full institutionalization of EPC by building the capacity of national EPC trainers to effectively conduct mentoring and supportive supervision visits after training.

The Quality Project will develop a mentoring curriculum to establish a standard way of conducting follow-up at sites after training and use this new curriculum with country-level trainers to improve supportive supervision efforts so that monitoring and mentoring visits can be done without the use of regional consultants. This requires a significant shift in the “culture” of quality monitoring and control. The mentoring training curriculum has been drafted and tested with the Quality Project team. It will be refined for country adaptation and approval with roll-out beginning in the last quarter of Year 1 and continuing into Year 2.

The Quality Project will expand supportive supervision efforts related to implementation of QI activities after initial EPC/ANC training, and will improve quality of services by revising monitoring tools to enable staff to undertake improvements as soon as possible after data collection. This means working more closely with facilities on follow-up after data collection to ensure QI plans are feasible and being implemented. In order to facilitate a quicker turnaround time on the outcome of supervision visits, the Quality Project will define, integrate, and develop thresholds for what is acceptable for a pre-determined set of critical indicators. Performance improvement plans will take into account where a facility lies within these thresholds. By taking a subset of critical indicators, sites can be analyzed quickly and performance issues addressed immediately.

#### **3.4.1.4 Improving screening for HIV/HIV risk factors and Prevention of Mother to Child Transmission of HIV (PMTCT) coverage**

Mother-to-child transmission is a leading cause of HIV infection in children. In cooperation with other development partners, the Quality Project will support PMTCT trainings for maternity staff and PHC doctors. In addition, HIV pre- and post-test counseling trainings will help improve skills of primary care providers to counsel pregnant women about HIV infection.

### **3.4.2 FAMILY PLANNING AND REPRODUCTIVE HEALTH**

Because of limited time and resources, the main focus for RH/FP activities would be during ANC and postpartum visits where patients could be counseled on FP and STIs. Questions in monitoring tools have been designed in order to better assess whether women are being counseled for FP and if they accepted a method, and whether women are being asked about STIs and other HIV risk factors.

It is important to note that all countries in CAR experience problems with the availability of contraceptive supplies and commodities. The Quality Project understands that USAID will not be procuring commodities, so close coordination and collaboration with UNFPA or other agencies that are bringing in supplies is essential.

For all FP activities, the Quality Project will ensure compliance with regulations related to FP and abortion, including the following provisions and policies: Helms, Leahy, Biden, Siljander, Kemp-Kasten, Deconcini, Tiaht, Livingston, and PD-3.

### **3.4.3 CHILD HEALTH**

The Quality Project will improve the continuum of care for infants and children by strengthening IMCI at the PHC level, expanding IMCI to hospitals (building on lessons learned from hospital IMCI in Turkmenistan and Uzbekistan), and developing clear referral criteria including ambulance and tertiary services. In Kyrgyzstan, a training of trainers (TOT) on hospital IMCI has been conducted, and training will be initiated (has already been introduced in Uzbekistan, Turkmenistan, and Kazakhstan). The Quality Project will simultaneously develop a model of follow-up supervision and monitoring using a quality checklist, similar to the EPC model used during ZdravPlus II. Other limited child health activities may occur in some countries depending on country priorities.

**Table**

*Summary of Objectives, MCH service delivery results, and general HSS results*

Objective	MCH Service Delivery Results	General HSS Results
Scale up WHO SM program using ZdravPlus II model of training/monitoring/mentoring cycles	<p>Adoption of modern best practices in MCH, starting with critical elements of EPC and neonatal resuscitation, promoted through targeted training of health care providers.</p> <p>More effective newborn care techniques introduced to address preventable fatalities due to such simple threats as hypothermia.</p> <p>Birth preparedness schools established to provide information on childbirth, essential newborn care, and danger signs through quality prenatal classes.</p>	<p>SM training institutionalized.</p> <p>Cadre scope of service and training in rural areas re-examined and simple Human Resources for Health strategies including motivation and retention tested.</p>
Develop capacity of physicians and mid-level health personnel to provide Emergency Obstetric Care (EMOC)	<p>New skills-based training curriculum developed</p> <p>Physicians and mid-level providers in pilot facilities trained in EMOC</p>	<p>Emergency response paradigms with clearly identified team roles created for neonatal resuscitation and OB emergencies.</p> <p>Improved collaboration with MOH and key development partners to scale up EMOC training.</p>
Develop mentoring skills and	Mentoring training curriculum developed	SM monitoring/mentoring cycles

capacity of oblast- and rayon-level supervisory staff	Oblast- and rayon-level supervisors trained in mentoring and supportive supervision.	institutionalized.
Institutionalize QI processes at the facility level	<p>Follow-up clinical mentoring visits to trained staff at district- and rayon-level maternities and PHC facilities.</p> <p>Skills of newly trained health workers reinforced, helping them transfer their learning to clinic responsibilities and identify problems faced in managing cases.</p> <p>CQI principles at the facility level scaled up in KG and introduced in other countries.</p>	Develop capacity to use QI methodologies to address quality gaps at service-delivery level.

### Indicators

Priority Program/MCH-FP-RH revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

#### Process indicators:

- # of MCH/FP/RH products developed to improve service delivery
- # of people trained in FP/RH
- # of people trained in maternal/newborn health
- % of pregnant women who attended Birth Preparedness classes (at least one class)
- # trained in IMCI

#### Intermediate indicators:

- # of MCH CQI sites (disaggregated by type, phase)
- % of postpartum women in Quality project sites choosing modern method of FP before discharge

- % of women in Quality project sites who had at least 4 prenatal visits during which they received counseling on breastfeeding, danger signs, HIV testing/prevention, and postpartum contraception
- % of newborns with hypothermia two hours after birth in project sites
- % of newborns with Apgar score above 7 at 5 minutes after birth
- % of deliveries with actively managed third stage of labor in project sites
- % of pregnant women in monitoring sites screened for preeclampsia (blood pressure and Urine protein) during each ANC visit

Impact indicators:

- Existence of national policy documents on MCH/RH and mechanisms (national standards, clinical protocols, monitoring tools etc.) supporting institutionalization and sustainability of evidence-based service delivery
- % of women with postpartum hemorrhage (PPH) in project sites
- # children hospitalized for diarrhea

### **3.5 CVD/NCD**

CVD is the leading cause of death in Central Asia, and over 60% of the mortality gap between CAR and western European countries can be attributed to CVD. In fact, mortality rates from heart attacks and strokes in CAR are some of the highest in the world. It is anticipated that control of NCD will be added to the Millennium Development Goals in September 2011, so it is timely that the Quality Project is focusing attention on improvements in quality of care of CVD.

Our regional CVD strategy, which is also applicable to other NCD, aligns perfectly with our overarching project strategy through the use of interventions that simultaneously improve service delivery while strengthening health systems to better deal with other public health threats, including infectious diseases such as TB and HIV. In addition, the Quality Project anticipates the development of a package of effective interventions for targeting CVD that can be promoted throughout the region and even worldwide which will demonstrate USAID's continued success in developing and implementing models for QI. Specific elements of the Quality Project CVD/NCD Strategy that will contribute to improving quality and sustainability through institutionalization consistent with our overarching regional strategy are as follows:

- Strengthen PHC facility-level QI processes, health promotion, and population/community involvement
- Improve the continuum of care between PHC and hospital levels
- Increase QI awareness and acceptance
- Solidify CPG development and CME implementation mechanisms
- Determine institutional roles and relationships in the health sector including the roles of civil society (e.g. PAs, VHCs)
- Solidify core health financing and management system for the state guaranteed benefit package

- Enhance quality, comprehensiveness, and visibility of national health sector strategies and improve health policy dialogue processes
- Strengthen and promote better use of information, M&E and operations research, and the feedback loop enabling evidence-based policy decisions
- Develop a package of documents that show all elements of CVD/NCD QI including EBM/CPGs, medical education, facility-level QI processes, health promotion and population/community involvement policy, financing, roles, and relationships, M&E
- Promote the package of documents using a number of mechanisms including advocacy through Central Asian institutional champions

Development of an effective model was initiated under ZdravPlus II using a bottom-up and top-down approach to reduce the burden of CVD. Monitoring at ZdravPlus II CQI sites throughout Central Asia revealed significant blood pressure lowering within one year. Recent health statistics from Kyrgyzstan looking at trends between 2007 and 2009 show a 14% decline in CVD mortality; up to 73% reduction in number of treated hypertensive emergencies; 31% reduction in hospitalizations for hypertension; and 20% reduction in ambulance calls related to hypertension. The model consists of a comprehensive approach at all health system levels targeted at improving the detection and management of hypertension (the primary risk factor for CVD in CAR) and treatment of the most common causes of CVD morbidity and mortality. Primary activities include development of evidence-based recommendations, strengthening of mechanisms to ensure *implementation of new guidelines* at the service delivery level (provision of CME and the introduction and coordination of CQI), and CAH activities targeted at hypertension screening and raising population awareness of CVD risk factors. CQI accelerates the process of guideline implementation by continuously reminding health care workers of the new recommendations and helping to identify and address barriers to QI existing at all health systems levels. Table 1 lists objectives of the model and demonstrates how activities in Kyrgyzstan led to both specific CVD results and general HSS outcomes. Quality Project CVD/NCD activities will solidify, enhance, expand, and institutionalize the model and experience shown in Table 1.

The Quality Project will focus on enhancing and expanding this model, and will take a similar approach to implementing new evidence-based guidelines at the hospital level, improving coordination of care between the PHC and inpatient sectors, and continuing to address identified system barriers. The Quality Project will continue to work through republican institutes and PAs, strengthening their capacity and leadership role, and improving their collaborative work in order to ensure their ability to sustain gains in CVD care and use the same model to address other NCDs during and beyond the Quality Project. Once results are available from inpatient activities, the Quality Project will invest time in describing this model of addressing CVDs through a technical report and package of documents that summarizes the overall approach, specific methodologies, health system barriers, how barriers were addressed, and results achieved. It will also include a set of CQI instruments that can be easily adapted to target CVD in other countries or for addressing other priority health threats.

Although specific plans will evolve with project funding, country environments and other external factors, an estimate of timeframe and general country approach is described below:

1) Timeframe

- Year 1 – initiate CVD/NCD activities consistent with above strategy and model.
- Year 2 – solidify country implementation and develop institutionalization package.
- Year 3 – disseminate and promote institutionalization package using regional funds.

2) Country Approach

- Kazakhstan – consistent with regional model except unlikely to extend to hospital level.
- Kyrgyzstan – completely consistent with regional model.
- Tajikistan – consistent with regional model except emphasis more on core building blocks including PHC strengthening and introducing family medicine (FM); health financing reform; development of EBM/CPG and CME methodologies; developing population/community involvement mechanisms; and creating demand for operations research and evidence-based policy making.
- Turkmenistan – emphasis on core building blocks, particularly EBM/CPG, and initiating some CVD/NCD facility-level QI with acceptance and acceleration of activities achieved through promotion of the CVD/NCD institutionalization package.
- Uzbekistan – solidify and expand CVD/NCD activities and promote institutionalization package in collaboration with World Bank Health 3.

**Table**

*Summary of Objectives, CVD service delivery results, and general Health System Strengthening (HSS) Results*

Objective	CVD Service Delivery Results	General HSS Results
Ensure existence of current, evidence-based clinical guidelines	New evidence-based CPGs developed	Nationally-approved CPG methodology
	Hypertension	Clear process in place for CPG development
	Acute coronary syndrome with ST segment elevation	Increased capacity within EBM center(s) to support guideline developers
	Acute coronary syndrome without ST segment elevation	Increased capacity of tertiary institutes to develop evidence-based and methodologically-sound guidelines
	Stable angina	
	Myocardial infarction	

<b>Develop system and clarify/strengthen institutional roles and relationships needed for successful implementation of guidelines</b>	CPG implementation indicators developed for hypertension and myocardial infarction	Capacity for developing implementation indicators increased (EBM center and guideline developers)
	Tertiary institute-led TOT for CME developers on content of new CVD guidelines	Process in place for development and use of implementation indicators
	CME course based on CPG developed and led by FM trainers for PHC providers	Improved cooperation between internal (CQI) and EQA processes
	PA of family physicians led facility-level CQI activities on hypertension	Improved cooperation between tertiary institute and Post-Graduate Institute (PGI)
	HA preparing to lead CQI on myocardial infarctions in hospitals	Strengthened capacity of PGI faculty to develop CME curriculum based on new clinical guidelines
		Strengthen role of PA to coordinate CQI activities
		MOH delegating and financing QI role of PA
<b>Address health system barriers to quality</b>	Essential hypertension drugs are provided at discounted rate as part of additional drug benefit package (proposal to add lipid-lowering drugs which are currently cost-prohibitive)	Improve collaboration between national drug center, health insurance fund, and tertiary institutes to update EDL and Additional Drug Benefit Package based on problems prioritized by MOH and recommendations in evidence-based CPGs

	<p>Joint Annual Review of HSS used as platform to discuss 1) absence of essential CVD lab services at rayon level; 2) appropriate placement and role of cardiologists; and 3) procurement of essential diagnostic equipment for oblast-level cardiology consultants (procured for three oblasts)</p>	<p>Effective use of HSS reviews to address cross-cutting barriers to quality care</p>
<p><b>Promote decision-making based on evidence / data</b></p>	<p>Operations research to evaluate prescription and use of generic versus branded drugs</p>	<p>Strengthened capacity of health policy analysis center and PAs to conduct OR</p>
	<p>Operations research to evaluate system effectiveness in detecting and treating hypertension, stroke, and myocardial infarction</p>	<p>Improved use of evidence for decision making by MOH and tertiary institutes</p>
	<p>Operations research to look at effectiveness of CQI</p>	<p>Increase in demand for operations research by MOH</p>
	<p>FGPNA conducted analysis of barriers to PHC-level registration of patients with hypertension</p>	
	<p>Results of OR used to develop national CVD strategy</p>	

## **Indicators**

Priority Program/CVD-NCD revised PMP indicators are listed below (see full PMP submission for detail on indicator definition, measurement, applicable countries, etc.):

Process indicators:

- # of CVD/NCD products developed to improve service delivery
- # of healthcare workers trained on national CVD clinical protocols/guidelines

Intermediate indicators:

- Presentation of CVD quality improvement “package” (with methodological approach, instruments, summary of results)
- Number of beneficiaries of USG-funded service-oriented programs to reduce non-communicable diseases
- # of CVD CQI sites (disaggregated by type, phase)
- HIS reported prevalence of hypertension in adults in CQI sites
- % of hypertensive patients who received counseling on important lifestyle changes (smoking, diet, exercise)
- % of patients hospitalized for acute coronary syndrome in CQI sites that receive standard package of evidence-based services (EKG, aspirin and beta-blocker within one hour of arrival)

Impact indicators:

- % patients diagnosed with hypertension who reported taking their prescribed medication in the last 24 hours
- % hypertensive patients in program areas who have achieved target BP

## **4. COUNTRY-SPECIFIC ENVIRONMENT AND APPLICATION OF REGIONAL STRATEGY**

The regional strategy portrayed above applies to all countries although each country will implement it differently depending on the maturity of health reforms and the general country environment. A summary of country environments and how the regional strategy will generally be applied or adapted in each country follows. It is assumed that MCH/FP/RH and CVD/NCD strategies will be implemented in a relatively similar way in all the countries although they are in different phases of the process. The main variations described below relate to health policy/national health sector strategy, health financing reforms, institutionalization for sustainability, M&E/OR studies, TB, HIV, and CAH/civil society.

### **4.1 KAZAKHSTAN**

The Quality Project Regional Strategy fully applies to Kazakhstan. However, due to limited and declining project funding and the broad, sophisticated, and fluid nature of health system development in

Kazakhstan, Quality Project activities will be targeted and generally aimed at institutionalization through the rapidly increasing health sector budget.

A national health sector strategy exists in Kazakhstan and health policy dialogue will be incorporated into policy dialogue and development mechanisms under the national health sector strategy. The World Bank Technology Transfer and Institutional Reform Project, including collaboration with Twinning Partners, also provides opportunities to improve policy dialogue and strengthen content of the legal and policy framework. Health financing reform is mature but fluid and a focus will be the pooling of funds function for the State Guaranteed Benefit Package.

Great opportunities exist to institutionalize for sustainability including incorporating methodologies and tools into routine work, and realigning institutional structure, roles, and relationships to further decentralize and solidify delegation of functions including to civil society. Although Kazakhstan has not shown great interest in the past in enhancing M&E or linking OR studies directly to policy decisions, growing acceptance of the importance of M&E and OR studies provides opportunities to strengthen feedback loops leading to improved policy decision-making.

It is expected that full integration of non-MDR-TB treatment into outpatient care can be implemented in Kazakhstan although likely in a second phase following Kyrgyzstan. All HIV activities should be realized in Kazakhstan subject to funding restrictions.

CAH including civil society entities will differ significantly from the rest of Central Asia due to the much higher proportion of urban population, more open society, growing income, and media sophistication. Since it is unlikely that entities such as VHCs will be established in Kazakhstan, CAH will rely on the health system which is enhancing its ability to engage (e.g. adding social workers) and urban NGOs, including PAs and consumer leagues.

## **4.2 KYRGYZSTAN**

The Quality Project Regional Strategy fully applies in Kyrgyzstan. Through support for country partners and collaboration with other development partners, the Quality Project expects all elements to be implemented in the Central Asian country with the most advanced health reforms.

A national health sector strategy exists in Kyrgyzstan. Most of our health policy dialogue will be conducted through Manas Taalimi (current) and Den Sooluk (future) health sector strategies and accompanying SWAp, including bi-annual joint annual technical reviews and health summits. Health financing reforms are mature and activities will include strengthening the pooling and purchasing arrangements for the State Guaranteed Benefits Package; initiating RBF for MCH services; and introducing TB financing including a new TB hospital payment system and TB hospital restructuring.

The Quality Project will support the health sector in continuing to institutionalize new methodologies and tools for sustainability. Institutional structure, roles, and relationships priorities will be MOH

USAID Quality Health Care Project Regional Strategy

capacity building to improve stewardship; realigning roles and relationships following the separation of the Mandatory Health Insurance Fund from MOH; and further capacity building and delegation of functions to PAs. M&E/OR studies are also mature in Kyrgyzstan due to the Manas Taalimi M&E framework and MOH use of OR studies to inform health policy decisions.

Pilots on full integration of non-MDR-TB treatment into outpatient care are expected to begin in 2012 linked to new TB hospital payment system and restructuring to provide experience and lessons learned for Central Asia. The full range of HIV activities will be implemented as Kyrgyzstan is a priority country for PEPFAR funding. In collaboration with the Swiss Red Cross, Quality Project CAH activities will be accomplished through VHCs established throughout the country. Unfortunately, declining funding will impact the Quality Project's ability to use this effective and well-established vehicle to its full potential.

### **4.3 TAJIKISTAN**

The Quality Project Regional Strategy fully applies in Tajikistan. Given that Tajikistan is at an earlier stage of the comprehensive health reform process enabling improvement in priority programs of TB, HIV, MCH/FP/RH, a greater emphasis is needed on a number of foundation building blocks including health financing reform and strengthening PHC. While the environment remains difficult, Tajikistan is gradually beginning to accelerate their health reform and improvement process.

A national health sector strategy exists in Tajikistan. However, implementation of it remains problematic as capacity is limited and country ownership is still solidifying around the national health sector strategy. The Quality Project will support the national health sector strategy and corresponding working groups to serve as the main policy dialogue vehicle, but more fragmented policy dialogue on various programs is still required. One of the keys to priority program quality and outcome improvement is expanding health financing reforms, and the Quality Project will support MOH and Ministry of Finance, and collaborate with all donors/projects to start phased implementation in 2012.

The Quality Project will support the health sector in continuing to develop, implement, and institutionalize new methodologies and tools for sustainability. Priority areas for improvement of institutional structure and strengthening/clarifying roles and relationships will include MOH capacity building to improve stewardship; establishment of a health purchaser; strengthening the EBM Center and Drug Information Center; and solidifying PGI training practices. M&E/OR studies have been introduced in Tajikistan but they are still immature and politicized. The Quality Project will collaborate with WHO to strengthen this function and the feedback loop to inform evidence-based policy decisions.

Tajikistan is moving rapidly on full integration of TB treatment into outpatient care, possibly too rapidly as there is interest in starting community MDR-TB treatment very soon. The Quality Project will engage in dialogue and provide technical assistance to develop step-by-step plans to integrate TB treatment into outpatient care while mitigating the risks of increasing MDR- or XDR-TB. Although the environment is difficult, the full range of HIV activities will be implemented as Tajikistan is a priority country for PEPFAR funding.

The Quality Project plans our most intensive CAH work in Tajikistan. This includes both establishing entities or mechanisms to perform CAH and the community actions themselves. CAH activities in Tajikistan are intended to improve access to health care, improve the quality of health care, and reduce the social drivers of ill health through mobilizing communities to take responsibility for their own health. It utilizes activities that have been proven to work in a Tajik cultural context. This includes drawing on the Islamic and Tajik values of caring for neighbors, working within existing community structures, and collaborating with mass media.

Tajikistan CAH efforts will be based on working with patients, communities, health care providers, and the health system simultaneously. The Quality Project will explore establishing new entities and also community interventions based on existing community leadership such as religious leadership, business owners, and schoolteachers. The Quality Project will support communities to set their own health goals, and encourage the health system to partner with the community.

#### **4.4 TURKMENISTAN**

The Quality Project Regional Strategy does not fully apply to Turkmenistan. Although Turkmen health reforms are not yet broad or comprehensive, when new programs are introduced in Turkmenistan they are rapidly accepted and implemented. The Quality Project will use this comparative advantage to work step-by-step with Turkmen partners to broaden the scope of health improvements.

A national health sector strategy does not exist in Turkmenistan. The Quality Project will use a two-pronged approach to health policy dialogue to engage in dialogue to enable approval of specific policies for specific programs and engage in dialogue on the further development of a HSS strategy which has been initiated with WHO support. Health financing reform has not been introduced other than the establishment of voluntary health insurance and health financing data is difficult or impossible to obtain in Turkmenistan. Nevertheless, the Quality Project believes that some opportunities exist and should be gradually pursued, particularly in converting voluntary health insurance to mandatory health insurance and small changes in health purchasing including improvements in provider payment systems.

A strength of the Turkmen reforms is immediate institutionalization of improved methodologies and tools. The Quality Project will use this strength to continue to introduce new methodologies and tools including mechanisms to promote EBM and develop CPGs as well as improve medical education curriculum. Potential to decentralize and separate functions to increase transparency, or improve institutional structure, roles, and relationships is limited. However, some opportunities exist here: for example, the establishment of an EBM Center. In the past, introduction of improved M&E systems or OR studies was very difficult, but as the Turkmens have increased their ownership of programs such as IMCI and SM, they have become more interested in improving M&E. The Quality Project believes that opportunities will exist in TB and MCH.

It is unlikely that pilots on full integration of non-MDR-TB treatment into outpatient care will begin soon, but the Quality Project will work to improve TB services currently delivered at the PHC level. HIV is a sensitive topic, but it appears that opportunities to work in HIV prevention are slowly developing. NGOs/CBOs will not be established for CAH, but the health system accepts health promotion activities and opportunities exist to expand health promotion activities through PHC providers.

#### **4.5 UZBEKISTAN**

The Quality Project Regional Strategy does not fully apply to Uzbekistan. In general, Uzbekistan's health reform strategy had been to take one level of the health system at a time and implement comprehensive reforms including restructuring; renovation and equipment; financing; HIS; medical education/clinical training; new CPGs; QI for priority programs, including MCH and CVD; and health promotion. Uzbekistan started with rural PHC through pilot oblasts leading to national roll-out, and then planned to move to urban PHC followed by the hospital sector. However, the reforms have slowed over the last few years, and the operating environment has become significantly more difficult.

Adapting to the new environment, the Quality Project implementation strategy is narrower and more fragmented. It consists of using Project HOPE registration and operating processes to implement the TB program; collaboration with the World Bank Health 3 Project and Abt Associates international technical assistance for HSS, including health financing and hospital restructuring, EBM/CPGs, medical education, and QI in MCH and CVD; and AIDS Project Management Group (APMG) international technical assistance for the HIV program.

Uzbekistan does not have a comprehensive national health sector strategy, but policy dialogue and decisions are guided by the Presidential Decree on "Main Direction of further deepening of the reform and implementation of State program of healthcare development" (#3923 from 19.09.2007). The Quality Project will use all available policy dialogue mechanisms to improve the legal and policy framework enabling implementation of program activities. Health financing activities will include providing technical assistance to develop a long-term vision; strengthen existing PHC per capita payment systems; design and develop a new hospital payment system; and support master planning for hospital sector restructuring.

A number of methodologies and tools have been institutionalized in Uzbekistan including mechanisms to promote EBM; CPG development methodology; significant improvements in medical education; and acceptance of QI processes. The Quality Project will provide technical assistance to further strengthen and institutionalize these methodologies and tools. Further improvement in institutional structure, roles, and relationships are also possible including capacity building of the oblast health department as health purchaser and further strengthening of the EBM Center and educational institutions. While M&E/OR studies are expected to be limited, the Quality Project has received some requests to support improved monitoring including in health financing.

It is unlikely that pilots on full integration of non-MDR-TB treatment into outpatient care will begin soon, but the Quality Project will work to improve TB services currently delivered at the PHC level. HIV is a sensitive topic, but the Quality Project will continue to pursue opportunities to develop HIV prevention activities. NGOs/CBOs will not be established for CAH, but the health system accepts health promotion activities particularly through patronage nurses at the PHC level. The Quality Project will support health promotion activities where possible.

## 5. QUALITY PROJECT WORKPLAN AND MANAGEMENT STRUCTURE

The structure in the table below will frame future project workplans and management processes to ensure consistency with the Regional Strategy; create synergies between priority program service delivery improvement and HSS (diagonal approach); assist all staff in the large project to know where their specific program area fits within the overall project; and empower project management to determine how best to integrate and link across program areas to maximize project impact. It will implicitly and explicitly guide project priorities, ensure no contradictory directions, and enable completion of the multitude of varied project activities in a way that leverages and aggregates into production of concrete and sustainable results.

### Structure:

*Component*

*Sub-component*

*Element*

*Sub-element*

*Objective and Activities – in Excel Workplan Tables*

### Table

*Workplan and Management Structure*

Component	Sub-component	Element	Sub-element
Priority Programs	TB	National level	Legal and Policy
			Drug management
		Service Delivery	PHC Level
			Hospital level
	CAH	Lab	
	TB/HIV		
	HIV	National level	Prevention, Care, and

			Treatment
			Social Support
			Legal and Policy
		Locality strengthening	Prevention, Care, and Treatment
			Social Support
	MCH/FP/RH	Maternal Health	
		FP/RH	
		Child Health	
	CVD/NCD		
HSS	Legal and Policy		
	Health Financing		
	Priority Program Cross-Cutting		
	Institutionalization for Sustainability		
M&E, OR, and HIS			
Project PMP			
USAID PR/Outreach			

#### Notes on Quality Project Workplan and Management Structure:

- TB/National Level – specific TB legal, policy, and strategies; capacity building and support for NTP to develop and implement the program in a comprehensive way extending beyond the boundaries of the vertical TB system; and CPGs and other standards.
- TB/Service Delivery – QI in PHC, hospitals, and labs including non-drug-resistant fully ambulatory TB treatment; susceptible and MDR-TB CPG implementation; and continuum of care/referrals across all levels of care including from prison to civilian sectors.
- CAH – large variation by priority program with TB fully specified due to its size and structure; HIV aggregated as program inherently links service delivery and CAH in outreach/NGOs; and MCH/FP/RH and CVD/NCD aggregated largely due to program size. Civil society capacity building is included in Institutionalization for Sustainability, not CAH.

- TB/HIV – separate Element to emphasize importance and allow project management to ensure contributions from both TB and HIV teams.
- HIV/Prevention, Care, and Treatment – includes all activities focusing on VCT, acknowledging that VCT is both an important part of prevention, as well as the gateway to care and treatment. Partners and audiences in these activities include both governmental and non-governmental partners.
- HIV/Social Support – reserved for non-medical services that provide psychosocial support, as well as community-based advocacy and support, to improve prevention, care, and treatment outcomes. This element most heavily relies on CAH and civil society (NGOs), but activities may involve government health structures from time to time to assure appropriate linkages.
- FP/RH – separate Element but the close linkage to the SM Program will continue.
- HSS)/Legal and Policy – related to broad national health sector strategies or impacting more than one priority program, and also including NGO/CBO advocacy and representation in policy dialogue (governance connection).
- HSS/Institutionalization for Sustainability/Methodologies and Tools – a variety of methodologies and tools including EBM/CPG development; CME delivery mechanisms, incorporating evidenced-based content of clinical practice into undergraduate and graduate medical education; selected human resource retention practices; and health management.
- HSS/Institutionalization for Sustainability/Roles and Relationships – including but not limited to MOH structure and capacity building; health purchaser; EBM Center; clinical bases; integration of public health entities; linkages between TB and HIV-related institutions or stakeholders; delegation of functions and capacity building in PAs; and general capacity building (not program content) in HIV NGOs/CBOs and other civil society entities.
- M&E, OR & HIS – M&E activities include improving country M&E frameworks and processes and OR studies informing implementation and creating demand for objective information for evidence-based policy decisions. Health information is inherent in many project components, sub-components, elements, and sub-elements but is separated here to reflect activities targeted at gradual development of unified HISs and reducing duplicating and unnecessary information and paperwork burden.

## ***10. APPENDIX C: PARTICIPANT TRAINING INFORMATION***

USAID Quality Health Care Project  
 Training Data  
 Year 1  
 (October 1, 2010- September 30, 2011)

Training description (Priority Program Area/HSS)	Kazakhstan			Kyrgyzstan			Tajikistan			Turkmentistan			Uzbekistan			Total		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
TB	355	101	254	598	114	484	745	225	520	207	89	118	66	33	33	1927	541	1386
HIV	273	76	177	202	49	153	107	77	30	110	52	58	0	0	0	672	254	418
MCH	423	86	279	1917	75	1842	833	83	750	226	60	166	0	0	0	3341	304	3037
CVD	0	0	0	303	148	155	40	2	38	0	0	0	0	0	0	112	6	115
HSS	485	193	292	7188	1774	5414	3127	1290	1837	35	10	25	4	0	4	10701	3200	7478
TOTAL	1536	456	1002	10208	2160	8048	4852	1677	3175	578	211	367	70	33	37	16753	4305	12434

## ***11. APPENDIX D: YEAR 1 KEY OUTPUTS***

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	TB	Engage in dialogue with MOH to approve the development of PAL CPG (NCTP)	June 2011	Completed. KAFP President Damilya Nugmanova participated in a one-week workshop of the national PHC CPG working group. This WG works within the World Bank Project. Damilya's proposal to develop PAL CPG for PHC in Kazakhstan was approved. The
Kazakhstan	TB	Overcoming Barriers to TB Control: The role of advocacy, communication and social mobilization (ACSM)	July 2011	Completed. Nineteen national leaders representing NTBP, NHLSC, and NGOs were trained in ACSM; a national WG was formed to develop a National ACSM Strategy. Eight TWG meetings carried
Kazakhstan	TB	Improve quality of laboratory services at PHC and hospital levels based on the findings of the QMS assessment.	August 2011	Completed. Twenty laboratory specialists were trained in two workshops on smear microscopy in Semey and Ust-Kamenogorsk cities.
Kazakhstan	TB	Conduct rapid assessment on HIV pre- and post-VCT linked to CQI processes in selected TB sites (Almaty, EK Oblast TB hospitals, AIDS Centers, providers)	August 2011	Completed. Fifty-seven patient cards in Regional TB Hospital in Talgar Rayon were reviewed. 93% of TB patients were tested on HIV and have record forms in the cards; 89.4% of TB patients received counseling when tested for HIV.
Kazakhstan	TB	Create on-site multidisciplinary QI teams for TB to begin process of identification of quality gaps and problem prioritization in selected sites; provide orientation workshop on CQI basics (NCTP, Almaty, EK OHDs, providers)	September 2011	Completed. Seven CQI teams created in SVA Tuzdibastau (April); SVA Besagash (June); and SVA "Molodejnyy" and SVA "Tavrisheskiy" in Ulanskiy Rayon (June). Four new CQI teams in Talgar Rayon were formed after the CQI training in September at which 25 PHC workers were trained.
Kazakhstan	TB	Create links between TB CARE and Quality Project to ensure PHC-Based QI sites incorporate recommendations on treatment for children with TB and link to MCH services; start developing a process of information exchange regarding such patients (Almaty, EK Oblast TB hospitals)	September 2011	In progress. Quality Project and TB Care discussed the issues of TB treatment in children; as agreed between the projects, Quality Project analyzed the legal base of Kazakhstan and developed conclusions regarding legal barriers.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	TB	Training on TB Infection Prevention and Control for staff of selected facilities (Almaty, EK Oblast/Rayon providers)	September 2011	Completed. Sixteen participants from the Regional TB Hospital in Talgar Rayon were trained.
Kazakhstan	TB	Initiate development of QMS for laboratory network (Almaty, EK/Rayon TB hospitals)	September 2011	Completed. QMS Assessment of Almaty and EK oblasts conducted. Trip reports prepared. Technical report is being finalized in the first quarter of Year 2.
Kazakhstan	TB	Follow-up visits to provide supportive supervision, review indicator results and action plans; organize monthly QI WG meetings (NCTP, Almaty, EK OHDs, providers)	September 2011	Completed. Ongoing follow-ups are continuous in East Kazakhstan, Ulanskiy Rayon, and Almaty Oblast's Talgar Rayon with coverage of six SVAs.
Kazakhstan	TB	Overcoming Barriers to TB Control: Advocacy, communication and social mobilization (ACSM)	September 2011	Completed. Fifteen health providers who work with TB patients were trained through five-day TOT on Interpersonal Communication Skills.
Kazakhstan	TB	Explore availability of TB medications in KZ open market to develop advocacy strategy for regulation of TB medications in the open market	September 2011	Completed. Rapid survey with USAID Dialogue Project was conducted and 26 anonymous questionnaires filled out by pharmacists were analyzed. Results of the survey will be used for future workshops.
Kazakhstan	TB	Assess the functioning of LMIS (first- and second line drugs) and on the job training on LMIS assessment and application of QI	September 2011	Completed. LMIS implementation and a drug management assessment was done in East Kazakhstan and Almaty Oblasts. Recommendations and future trainings on improvement planned for Year 2.
Kazakhstan	TB	Provide assistance in drafting of Round 11 proposal to GFATM. (GFATM PR, PIU, TB CARE, Dialogue Project)	September- October 2011	Completed. Quality Project supported a CCM Meeting on preparing a proposal for the Global Fund. Technical assistance and an international consultant were provided to start formulating a TB proposal for GFATM.
Kazakhstan	HIV	Female IDU harm reduction assessment in Central Asia	May 2011	Completed. Fourteen individuals participated in a workshop addressing the improvement of access to services for female IDUs

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	HIV	Methadone Dialogue for implementation of substitution therapy for IDUs.	May 2011	First MAT Dialogue meeting conducted in Astana in May with 18 local experts from Pavlodar, Temirtau, and Ust-Kamenogorsk (physicians and nurses working with patients on
Kazakhstan	HIV	Conduct training on technical management of IDU/harm reduction programs (MOH, RAC, Narcology Center, NGOs)	July 2011	Completed. Twenty government health care managers and NGO representatives were trained.
Kazakhstan	HIV	Conduct human resources management training for outreach managers with focus on burnout prevention (NGOs)	September 2011	Completed. Fifty-four NGO managers and coordinators from all Kazakhstan regions were trained through three trainings (two rounds in March and September).
Kazakhstan	HIV	Workshop on Participatory Policymaking for CCMs (CCM)	September 2011	Postponed. The training was moved to December. A new Kazakhstan CCM has been formed and NGO participants are being
Kazakhstan	HIV	Assess major barriers to care for MARPs transitioning from prison back into the public realm, including referral mechanisms, to develop detailed plans for Year 2	September 2011	Completed. Quality Project contributed to a roundtable discussion organized by the Dialogue Project jointly with the Almaty City/Oblast Penitentiary System (KUIS).
Kazakhstan	HIV	Conduct training on HIV VCT for PHC doctors	September 2011	Completed. Two trainings conducted in Almaty and Temirtau. Forty-two PHC doctors were trained.
Kazakhstan	HIV	Invite and support attendance of key people to Pavlodar Methadone Conference (Narcology Center, RAC, MOH)	September 2011	Postponed. Conference was moved.
Kazakhstan	MCH	Provide technical assistance to revise ANC training module for further institutionalization (KMPA, MOH)	June 2011	Completed. Preliminary discussions held with Almaty and Astana MCH centers, and obstetrics-gynecology chairs of Astana, Almaty, and Karaganda medical universities to finalize the revision of the ANC module and submit to MOH for approval. On the initiative of Karaganda Medical University, the ANC module is currently being

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	MCH	Conduct assessment of quality of hospital care for mothers and newborns in two urban maternity hospitals in Kyzyl-Orda (Kyzyl-Orda OHD, KMPA, MCH Almaty)	June 2011	Completed. The February 2011 assessment report is ready in Russian. The report with recommendations was provided to Kyzyl-Orda OHD, maternity hospitals, and polyclinics providing feedback for quality improvement. The results were also discussed during a joint final meeting with Kyzyl-Orda health providers and health managers to address identified problems and identify quality improvement steps. As an example, at PHC a recommendation was made to introduce gravidogram and Body Mass Index calculation
Kazakhstan	MCH	Update FP/RH training course, and provide methodological guidance and mentoring to ensure quality training	July 2011	Completed. Quality Project supported three FP TOT workshops funded by MOH and OHD. Sixty PHC workers were trained in Almaty and Astana.
Kazakhstan	MCH	Initiate development of strategy for institutionalization of ANC improvements including design of package and documents (KMPA, MOH)	September 2011	Completed. Quality Project together with WHO, MOH, and KMPA developed a resolution on improvement of MCH care including ANC, IMCI, and EPC. The resolution was approved by MOH and will serve as a strategy for institutionalization of ANC improvements. The resolution outlines major steps for institutionalization of MCH programs and the development of a package of standard implementation assessment instruments. The steps include
Kazakhstan	MCH	Provide technical assistance to Astana and Almaty MCH centers to build capacity for SM national implementation and support the ongoing quality improvement process	September 2011	Completed.
Kazakhstan	MCH	Expand IMCI package of materials to include CQI and implementation tools piloted in the previous ZP projects, and linked with IMCI (National IMCI Center, MOH)	September 2011	In progress. Quality Project collaborated with WHO to develop the IMCI full package and adapt it to Kazakhstan. The package includes standard instruments to monitor and assess implementation and includes the Facility Assessment Checklist, Patient Survey, Medical Worker Interview Instrument, and Health Manager Interview Instrument as part of quality improvement processes. After

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	MCH	Conduct training on CQI for Ob/Gyn and MWs PHC (two Women Consultations) and Perinatal Center/Maternity Hospitals (Kyzyl-Orda OHD)	September 2011	Postponed. Plan revised. CQI training has been moved to the second quarter of Year 2.
Kazakhstan	HSS/HF	In selected oblasts, analyze proportion of funding for PHC and general hospital care after moving pooling of funds from state to republican level (MOH, MOF, OHD)	September 2011	In progress. The consolidated data on overall health budget allocation across oblasts was obtained; additional data required for the analysis (PHC and hospital care split) is currently collected. This full set of data will serve as a base for final analysis.
Kazakhstan	HSS/HF	Provide technical methodological expertise to MOH to further develop and promote the clinical statistical groups for hospitals (average payment per case to increase efficiency)	September 2011	Completed. New model of hospital payment based on CSG was developed and approved. Step-down accounting methodology technical meetings were conducted with 15 MOH and oblast-level specialists.
Kazakhstan	HSS/HF	Engage in policy dialogue and design of TB PHC P4P (second level of existing PHC per capita payment system)	September 2011	Completed. New indicators (outcome and process) for TB PHC P4P included in MOH draft prikazes.
Kazakhstan	HSS/QI	CPG Implementation Indicators Seminar	June 2011	Completed. Forty-eight representatives of MOH, HCDI, Astana and Almaty MCH centers, and TB service trained in developing CPG
Kazakhstan	M&E; Better Use of Information	Conduct OR study on government funding for HIV/AIDS	September 2011	Completed. The HIV/AIDS OR study focusing on analysis of a current legal environment for funding NGOs from the state budget

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kazakhstan	M&E; Better Use of Information	Review paperwork load of outpatient MCH health personnel (obstetricians, gynecologists) and provide recommendations on reducing duplicative reporting forms and data; exclude collection of outdated data from current forms and include new data (KMPA, MOH)	September 2011	In progress. MOH tasked Astana MCH Center to organize a WG to develop a standard information exchange form (obmennaya karta) that will be approved by MOH for national use. Quality Project will work with the WG to contribute to the development of the form. The WG has not yet been formed.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	CVD	Develop CQI indicators and instruments for hospital level care of AMI patients (based on new CPG) to support implementation of national CVD program, optimizing use of CVD equipment recently purchased through SWAp (NICT)	June 2011	Completed. CQI indicators on AMI and CQI instruments developed.
Kyrgyzstan	Health Financing	Engage in dialogue on general TB financing reform strategy and on specification of new TB hospital payment system (MOH, MHIF)	June 2011	Completed. Initial TB financing system specified.
Kyrgyzstan	HIV	Provide on-site training on interpersonal communication skills (focused on stigma and discrimination) to facility health managers and providers at selected entry points (RAC, MOH facilities)	March 2011	Completed. Forty-six participants trained.
Kyrgyzstan	HIV	Hold VCT training workshop with interactive discussions of VCT practices (RAC, MOH facilities)	March 2011	Completed. Quality Project trained 120 managers and providers.
Kyrgyzstan	HIV	Ongoing mentoring for entry points to improve the friendliness of care environment for MARPs, including proper use of interpersonal communication, VCT, referrals (RAC, MOH facilities)	September 2011	Postponed. Mentoring will be conducted in November 2011.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	HIV	Assist facilities in reviewing IPC guidelines; host an IPC workshop to reduce gap between guidelines and practices (MOH facilities)	September 2011	Postponed. Guidelines are still being reviewed.
Kyrgyzstan	HIV	Invite and support attendance of key people to Pavlodar Methadone Conference in September 2011. (Narcology Center, RAC, MOH)	September 2011	Conference was postponed.
Kyrgyzstan	HIV	Naloxone introduction workshops, PSM for Naloxone (Narcology Center, RAC, MOH)	June 2011	Completed. Thirty participants took part in workshops.
Kyrgyzstan	HIV	Conduct Methadone Dialogues (Narcology Center, RAC, MOH)	June 2011	Completed. Sixty participants took part in MAT Dialogues.
Kyrgyzstan	HIV	Conduct human resources management training for outreach managers with a focus on burnout prevention (NGOs)	March 2011	Completed. Twenty participants trained in first round; forty participants trained in follow-up rounds.
Kyrgyzstan	HIV	Conduct training on technical management of IDU/harm reduction programs (MOH, RAC, Narcology Center, NGOs)	September 2011	Completed. Twenty participants trained.
Kyrgyzstan	HIV	Workshop on Participatory Policymaking for CCMs (CCM)	June 2011	Completed. Twenty CCM members trained.
Kyrgyzstan	Human Resources	Develop system of CB/WB CME course approval and assignment of credit hours (KSMIRCE)	September 2011	Completed. Quality Project supported the development of the following CQI courses, which were developed and approved by MOH: "DOTS Strategy: New Provisions of the
Kyrgyzstan	Human Resources	Participate in development of CPs on priority topic for mid-level providers (nurses, feldshers, midwives)	September 2011	Completed. CP on TB is being developed. At present, the CP on hypertension for nurses is available which has been developed according to the nurse procedure. However, it

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	Institutionalization for Sustainability	Engage in dialogue and provide technical assistance to determine the roles and relationships of MOH and MHIF including contributing to a draft legal and regulatory document per Manas Taalimi/SWAp recommendation (Government, Parliament, MOH, MHIF, MOF)	June 2011	Completed. Quality Project provided technical support and assistance to develop regulatory documents related to changes in economic expenditure classification for health financing from infrastructure to health insurance and with implementation of state health insurance mechanisms. Two meetings have been conducted with MHIF to discuss rules and principles of state health insurance. A workshop discussion was conducted for 33 participants on the role of
Kyrgyzstan	Institutionalization for Sustainability	Initiate organizational development and sustainability planning for professional associations (MAC, FGPNA, FMA, and HA)	September 2011	Completed. Framework for professional association organization
Kyrgyzstan	Institutionalization for Sustainability	Provide technical assistance to EBM unit to develop process for development/review/approval of CP/CPG implementation indicators (EBM unit, MOH)	March 2011	Completed. Written process for development of CP/CPG indicators submitted to MOH for approval.
Kyrgyzstan	Institutionalization for Sustainability	Conduct general CQI training for FMC directors, deputy directors, quality committee members	September 2011	Completed. FMC leaders and members of the quality committee were involved in the training on CQI implementation on TB conducted in Ak-Suu Rayon in Issyk-
Kyrgyzstan	Institutionalization for Sustainability	Support local health promotion center mentoring of VHCs in Issyk-Kul and Jalal-Abad Oblasts (VHCs, Oblast Health Promotion Centers)	September 2011	Completed. CAH activities have been conducted to prevent iodine deficiency, hypertension, and alcohol abuse. Quality Project supported health promotion campaigns on nutrition for children from six months to two years; sanitation and

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	Legal and Policy	Participate in policy dialogue and technical review of Manas Taalimi through active participation in twice-yearly joint annual reviews (MOH, MOF, MHIF, health sector entities)	June 2011	Completed. Quality Project provided counseling and methodological assistance to develop technical specifications to provide counseling services to 1) revise operational guidelines concerning additional financing that is allocated by the World Bank to continue SWAP II Health Project for
Kyrgyzstan	Legal and Policy	Provide technical assistance to working group as well as to MOH, MOF, MHIF, and other health sector entities to develop National Health Sector Strategy for 2012-2016 and its implementation plan (MOH, MHIF)	September 2011	Completed. Quality Project took part in the WG meeting on Den Sooluk program development to identify expected results and main activities on priority programs (TB, MCH). Key activity directions have been identified to improve TB care of health sector. Quality Project provided technical assistance and support to develop calculation tables and
Kyrgyzstan	Legal and Policy	Participate in final design process of World Bank RBF Project and contribute to the development of detailed plans for implementation (MOH, MHIF)	June 2011	Completed. Quality Project took part in the World Bank mission to develop and identify financial terms of RBF project. Key issues have been discussed with representatives from MOH and MHIF regarding bonus
Kyrgyzstan	M&E; Better use of Information	Design OR study to analyze effectiveness of new provider payment systems in TB; collect baseline data	September 2011	Completed. The survey was conducted, base data collected, and preliminary results were submitted for discussion.
Kyrgyzstan	MCH	EPC basic training in Jalalabad oblast	March 2011	Completed.
Kyrgyzstan	MCH	Follow-up EPC trainings in Bishkek maternities (former ZdravPlus sites)	June 2011	Completed. EPC training completed in Bishkek maternities.
Kyrgyzstan	MCH	Provide ANC clinical mentoring/reinforcement visits	September 2011	Completed. Quality Project conducted ANC clinical mentoring/reinforcement visits to 20 ANC providers from Kochkor Rayon and Naryn City.
Kyrgyzstan	MCH	Support existing birth preparedness schools and scale up to new sites	June 2011	Completed. Quality Project provided monitoring and supportive supervision to six birth preparedness school.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	MCH	Provide technical assistance in development of the national ANC clinical protocols	September 2011	In progress. CPs are currently being developed.
Kyrgyzstan	MCH	CQI trainings in Kochkor maternity	March 2011	Completed. Providers of Kochkor maternity completed CQI
Kyrgyzstan	MCH	CQI training in Naryn Oblast maternity	March 2011	Completed. Naryn Oblast maternity providers completed
Kyrgyzstan	MCH	CQI training in Bishkek maternity	March 2011	Completed. Twenty providers from Bishkek City Perinatal
Kyrgyzstan	MCH	Conduct training for VHCs on SM topics	June 2011	Postponed until early 2012.
Kyrgyzstan	MCH	Train midwives on family planning and IUD insertion	September 2011	Completed. Rural midwives complete IUD training.
Kyrgyzstan	MCH	Follow-up monitoring and supportive supervision to trained midwives	September 2011	Completed. Monitoring and mentoring the clinical skills of 22 trained midwives from Nookan and Ala-Buka Rayon was
Kyrgyzstan	MCH	Revision and adaptation of WHO Hospital IMCI Pocket Guideline	March 2011	Completed. Guideline has been revised, adapted, and printed.
Kyrgyzstan	MCH	Development of IMCI facility checklist, monitoring tools	March 2011	Completed. IMCI monitoring tools are developed and have been used for baseline assessment.
Kyrgyzstan	TB	Obtain MOH/regional/facility approvals and buy-in for site work	June 2011	Bishkek was postponed to next year; Chui was approved.
Kyrgyzstan	TB	Create multidisciplinary TB quality team at the rayon level	September 2011	Completed. Rayon-level TB quality team created and are meeting monthly.
Kyrgyzstan	TB	Select two to four priority problems to address via CQI	June 2011	Completed. TB PHC-based QI sites selected problems for quality improvement after multi-disciplinary team identified
Kyrgyzstan	TB	Examine laws and regulations regarding the role of PHC in TB care	March 2011	Completed. Legal review of PHCs role and involvement in TB services conducted.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Kyrgyzstan	TB	Support TB CARE initiative by linking between TB CARE and Quality Project to ensure inclusion of treatment of former prisoners, migrants, MDR-TB patients, and children with TB at PHC-based QI sites	Continuous	Four meetings have been conducted with the TB CARE country representative, and joint activity plans have been discussed. TB CARE activity will be started soon.
Kyrgyzstan	TB	Train personnel in TB IPC practices	September 2011	Completed. One TOT conducted, and 20 participants were trained. Three cascade trainings were conducted, and 60
Kyrgyzstan	TB	Development of QMS for the laboratory network	September 2011	In progress. Laboratory network has been assessed in Issyk-Kul and Naryn Oblasts.
Kyrgyzstan	TB	Provide technical assistance and operational support for maintenance and enhancement of country TB drug LMIS ensuring uninterrupted supplies of anti-TB drugs and supplies	September 2011	MOH decree #359 was approved 'On pilot project implementation regarding second line TB drugs management information system in Jalal-Abad, Chui, and Issyk-Kul Oblasts and in Bishkek City.' Three workshops have been conducted, and 37 specialists have been trained.
Kyrgyzstan	TB	Per agreement with Swiss Red Cross, support development of TB CAH to be implemented in Year 2 in all VHCs nationwide	September 2011	In progress. Communities are working on action plans.
Kyrgyzstan	TB/HIV	Assessing capacity and availability of pre- and post-test VCT for TB patients tested for HIV	September 2011	Completed. Potential capacities have been evaluated; recommendations on how to improve activity in Issyk-Kul and Naryn Oblasts are under development.

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Tajikistan	CVD	Develop plans for implementation and scale-up of CVD/NCD QI at PHC level within context of National Health Sector Strategy	June 2011	In process. CVD/NCD QI process roll-out plan will be prepared for Year 2.
Tajikistan	CVD	Delivery of CME courses in CPGs for CVD and chronic diseases	September 2011	Completed. Courses have taken place.
Tajikistan	CVD	Support MOH Press Center together with EBM Center to develop public awareness strategy and materials to inform population of the impact on CVD and other chronic diseases managed by PHC providers (Centers of Excellence)	September 2011	Not completed. MOH chose to focus on emerging information needs rather than a CVD plan.
Tajikistan	HIV	Use tracer methodology to conduct a baseline assessment (preceded by a desk review) to elucidate current MARP service use patterns, barriers, and opportunities (RAC)	June 2011	Completed. Three sites, including Dushanbe CHC # 10, #4, and Vakhdat PHC were selected, and the assessment was completed.
Tajikistan	HIV	Conduct review of Dialogue Project case management/referral, training materials, and guidelines	March 2011	Not completed. Quality Project is still discussing with Dialogue Project how best to do this.
Tajikistan	HIV	Hold national meeting to discuss use of a common Unique Identifier Coding system across all service working with MARPs (RAC, MOH, National Center GFATM PR)	June 2011	Postponed to November 2011.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Tajikistan	HIV	Select entry points (where MARPs are accessing health care) for scale-up of prevention, VCT, treatment and care services (RAC, MOH facilities)	March 2011	Completed. Three sites were selected.
Tajikistan	HIV	Provide on-site training on interpersonal communication skills (focused on stigma and discrimination) to facility health managers and providers at selected entry points (RAC, MOH facilities, PGMI/RFMC)	March 2011	Completed. Forty-five managers and providers trained.
Tajikistan	HIV	Ongoing mentoring for entry points to improve the friendliness of care environment for MARPs, including proper use of interpersonal communication, VCT, and referrals (RAC, MOH facilities)	September 2011	In process. Forty-five managers and providers trained.
Tajikistan	HIV	Work with Dialogue Project and CARHAP consultants to adapt Pathways to Recovery training course	September 2011	Postponed.
Tajikistan	HIV	Conduct Methadone Dialogues (Narcology Center, RAC, MOH)	June 2011	Completed. Sixty participants took part in the Dialogues.
Tajikistan	HIV	Conduct human resources management training for outreach managers, with focus on burnout prevention (NGOs)	June 2011	Completed. Twenty participants trained in first round.
Tajikistan	HIV	Select NGOs for technical assistance to become referral brokers (NGOs, MOH facilities)	September 2011	Completed. Six NGOs selected.

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Tajikistan	HIV	Workshop on Participatory Policymaking for CCMs (CCM)	June 2011	Postponed to the second quarter of Year 2. Twenty CCM members trained.
Tajikistan	HIV	Provide assistance in drafting Round II proposal to GFATM (GFATM PR)	June 2011	Completed.
Tajikistan	Institutionalization for Sustainability	Participate in developing CME concept which is in line with international standards (provide technical assistance to improve and institutionalize methodology for development of CME courses) (PGMI)	June 2011	Not completed. MOH plans to approve CME concept in the second quarter of Year 2.
Tajikistan	Legal and Policy	Provide technical assistance to refine EDL and Basic Drug Formulary to reflect an increased range of medications to be used and prescribed in FM practice (DIC, TSMU)	June 2011	Completed. Technical assistance was provided through EBM Center and DIC; EDL is under revision by MOH, and a final version is expected in December 2011.
Tajikistan	Legal and Policy	Based on SWAp experience in Kyrgyzstan, support development of standardized worksheet to calculate % health budget to total government expenditures (MOH)	September 2011	Not initiated. Current political environment has not been supportive.
Tajikistan	Legal and Policy	Engage in dialogue on selection of option for pooling funds and establishment of health purchaser; development of legal framework and implementation plan (MOH, MOF)	September 2011	In progress. Draft decree on pooling was sent to the government for approval. The decree is expected to be signed in November 2011.

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Tajikistan	Legal and Policy	Design new hospital payment system for implementation once funds pooling discussion is resolved	September 2011	In progress. Simulation analysis is expected by the end of December 2011.
Tajikistan	MCH	Conduct EPC baseline assessment in two new sites	June 2011	Completed. Data from two maternities was collected, entered, and analyzed; feedback to facilities was provided.
Tajikistan	MCH	Provide EPC clinical mentoring/reinforcement visits for new sites	September 2011	Completed. Monitoring/mentoring is conducted in two new target maternities.
Tajikistan	MCH	Training for midlevel personnel in rural areas (midwives/feldshers/nurses) on implementation of the national standard on physiological birth management	June 2011	Completed. Forty-four midwives trained.
Tajikistan	MCH	Neonatal resuscitation trainings	September 2011	Completed. Eight-five providers trained.
Tajikistan	MCH	Provide small renovations in maternity facilities	September 2011	Completed. Birth preparedness school in Vakhdat is renovated. In addition, sixteen newborn resuscitators, sixteen newborn suction, and two newborn simulators provided to two sites (Vakhdat and Tursun-Zade).
Tajikistan	MCH	Support Public Awareness and Access Campaign on FP/RH (MOH Press Centre)	September 2011	Completed. Campaign conducted.
Tajikistan	QI	Select two to four priority problems to address via CQI	September 2011	Completed.

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Tajikistan	QI	Utilize data and participants from past successes to demonstrate QI principles and to advocate for scale-up of QI techniques	September 2011	Completed. Six Dushanbe City and Vakhdat health care facilities selected as CQI sites; scale up to new facility will be in Year 2.
Tajikistan	TB	Assess current status of CPGs relating to PAL and revise where necessary (EBMC, DIC)	March 2011	Completed. Assessment completed; CPGs revised and ready for approval.
Tajikistan	TB	Provide training on TB diagnostic algorithm and PAL for all PHC providers in select sites (RHD, CoE, PGMI/RFMC)	September 2011	Not yet completed. National PAL strategy has not yet been approved.
Tajikistan	TB	Conduct situational analysis at two pilots for TB/MDR-TB continuum of care including TB/MDR-TB case management	March 2011	Completed. Report and base line indicators of pilots are available.
Tajikistan	TB	Adapt relevant protocols on TB/MDR-TB and TB/HIV management models based on previous USAID projects (MOH, RI, EBM Center)	March 2011	Completed. Protocols ready for approval.
Tajikistan	TB	Provide TOT on improving MDR-TB case management	June 2011	Completed. MDR-TB case management TOT held.
Tajikistan	TB	Assess IC risks of TB facilities of pilots (SES, RHD, OHD)	March 2011	Completed. Assessment report ready for approval.
Tajikistan	TB	Small renovations in TB facilities	September 2011	In progress.
Tajikistan	TB	Develop national manual on SLD management	June 2011	In progress. Manual being finalized.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Tajikistan	TB	Based on gaps identified through previous surveys, design and initiate CAH materials and activities for general population, as well as asymptomatic high risk non-MARPs and MARPs. Utilize materials at PHC-based TB QI sites and roll out	September 2011	In progress. Action plan currently being developed.
Tajikistan	TB/HIV	Revise protocols on continuum of care in PHC for TB and HIV services and develop additional if required (MOH, RI, EBM Center)	June 2011	Postponed to Year 2. Roundtable discussion is expected to take place in December 2011.

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Turkmenistan	TB/HIV	Assist NAP and NTP in elaboration and implementation of short- and medium-term plans for TB/HIV co-infection management	September 2011	Completed. The Quality Project participated in the discussion on the development of national HIV/TB activity plan.
Turkmenistan	Institutionalization for Sustainability	Provide roundtable/training on EBM, CPG development	June 2011	Completed.
Turkmenistan	Institutionalization for Sustainability	Meet with TSMU to discuss steps for opening EBM center and explore how project can best support process (e.g., arrange study tour with Kyrgyzstan EBM unit)	June 2011	TSMU confirmed their intention to establish EBM center. Need prikaz issued by MOHMIT to proceed.
Turkmenistan	Laboratory Quality	Develop plans for lab TOT in quality management and improvement	September 2011	Postponed. Please see workplan notes on timeline. The activity is being conducted with WHO and TB Supranational
Turkmenistan	Laboratory Quality	Training in advanced methods for lab diagnosis (Hain, MGIT, GeneXpert)	September 2011	Postponed.
Turkmenistan	Legal and Regulatory	Engage in policy dialogue to continue development of a national health systems strengthening (HSS) strategy and/or process which was initiated by WHO over the last year and appears to be progressing	September 2011	Quality Project initiated the participation of two ministry officials in the Barcelona HSS Conference planned for November 21-25. The Cabinet of Ministers approved the participation of representatives from MOHMIT and MOF.
Turkmenistan	M&E; Better Use of Information	Workshop for MCHI leaders on data for decision-making in MCH care	September 2011	The workshop is postponed until Year 2, but the Quality Project provided financial support for MCHI's M&E Team through ANC M&E activities.
Turkmenistan	MCH	Scale-up EPC by conducting two ten-day trainings, each followed by roundtable discussion to present and approve action plans on incorporating EPC/ANC recommendations into practice (Akhal and Balkan Velayats).	June 2011	Completed. Seventy-one specialists trained as well as 50 health managers from Balkan and Akhal maternities.

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Turkmenistan	MCH	Continue to promote creation of birth preparedness schools. Experiences from Dashoguz HOH # 1 will be shared and used in scale-up in HOHs in new velayats including Ashgabat, Mary, Balkan and Lebap.	September 2011	Preliminary agreement reached on creation of birth preparedness schools , but need prikaz. Currently working with UNFPA on this issue. Please see workplan notes on timeline. The Quality Project provided limited financial support for HOH #1 in Ashgabat. Through support of the team from MCHI in ANC M&E activities, health workers in Mary, Balkan and Lebap Velayats received technical
Turkmenistan	MCH	Organize and conduct two ANC courses for 40 ob/gyns and family doctors (20 at each course) working in HOHs (two velayats in Year 1 and remaining two velayats in Year 2 in Akhal, Mary, Lebap, Dashoguz, and Balkan velayats) (includes health education information)	September 2011	Completed. Thirty-nine ob/gyns and family doctors have been trained in Akhal and Dashoguz Velayats; five RH specialists were provided consultations on ANC.
Turkmenistan	MCH	Support implementation of new WHO IMCI "0 to 2 months" Training Program, using National Trainers trained by WHO in November 2010. Organize five three-day training courses in five velayats of the country.	June 2011	Completed. One hundred family doctors trained.
Turkmenistan	MCH	Support "Keeping Children Healthy Campaign" providing information to the population including messages on IMCI, SM, HIV	September 2011	Completed.
Turkmenistan	TB	Map and select potential sites for PHC-based TB QI	September 2011	Completed. Map finalized, and initial rayon and urban PHC-based QI sites in Mary Velayat and city selected.
Turkmenistan	TB	Review existing scope of services of PHC providers in regard to TB services to identify gaps in delivery of those services	June 2011	Completed. Existing TB scope of services for PHC providers reviewed, gaps identified, and technical recommendations provided for improvement.

Country code/Regional	Technical Focus	Activity	Date of Completion	Status and Comments
Turkmenistan	TB	Workshop on new methods of TB diagnosis and MDR- and XDR-TB treatment (co-funding by WHO conducted in collaboration with SNRL staff)	March 2011	Completed. Twenty-five participants trained. Workshop reports including findings and recommendations available
Turkmenistan	TB	Organize three training courses on "Child and Adolescents TB Prevention and Control"	June 2011	Completed. The first training for 20 TB specialists was approved by MOHMIT for June 22-24. Two more training courses were conducted in July. The Ministry was greatly interested in continuing
Turkmenistan	TB	Conduct training on TB IPC	June 2011	In Progress. IPC guidelines have been developed. TB IPC