USAID | CENTRAL ASIA
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ANATOMY OF HEALTH CARE TRANSFORMATION

USAID'S 20-YEAR LEGACY

OF HEALTH SYSTEMS STRENGTHENING IN CENTRAL ASIA

This document is published by Abt Associates, Inc., under the USAID Quality Health Care Project, the fourth in a series of five-year USAID projects in Central Asia, designed to improve the health of Central Asians by strengthening health care systems and services, particularly in the areas of HIV/AIDS and TB care and prevention. The projects have helped governments and communities meet the needs of vulnerable populations, increase use of health services, and improve health outcomes. The Quality Health Care Project is part of USAID's third objective of investing in people as part of the US Strategic Framework for Foreign Assistance.

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ANATOMY OF HEALTH CARE TRANSFORMATION

USAID'S 20-YEAR LEGACY

IN HEALTH SYSTEMS STRENGTHENING IN CENTRAL ASIA

1994–2015

AUGUST 2015

This report was produced for review by the United States Agency for International Development. It was prepared by the Quality Health Care Project in Central Asia.

USAID

CONTENTS

ABBREVIATIONS. 4
ACKNOWLEDGEMENTS. 5
EXECUTIVE SUMMARY 6
INTRODUCTION 10
COUNTRY SUMMARY: KAZAKHSTAN. 15
COUNTRY SUMMARY: KYRGYZ REPUBLIC. 17
COUNTRY SUMMARY: TAJIKISTAN. 19
COUNTRY SUMMARY: TURKMENISTAN 21
COUNTRY SUMMARY: UZBEKISTAN 23
BUILDING PRIMARY HEALTH CARE. 24
HEALTH FINANCING AND RESTRUCTURING. 27
INTEGRATING SERVICES 35
BETTER HEALTH THROUGH DATA 37
USING EVIDENCE AND BEST PRACTICE TO IMPROVE CARE. 39
IMPROVED DIAGNOSTICS 43
KEEPING CHILDREN HEALTHY. 45
MOVING TB TREATMENT CLOSER TO HOME 50
IMPROVING ACCESS TO FAMILY PLANNING. 53
FASTER, EASIER HIV TESTING 57
NOTHING FOR US WITHOUT US 57
GROWING CIVIL SOCIETY 63
EMPOWERING PATIENTS 65
CONCLUSION AND LESSONS LEARNED 72

ABBREVIATIONS

CAB	Community advisory board
CDC	Centers for Disease Control and Prevention
CQI	Continuous quality improvement
DOTS	Directly observed treatment, short course
FP	Family Planning
GDP	Gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GTZ	Gesellschaft für Technische Zusammenarbeit
ICAP	International Center for AIDS Care and Treatment Programs
HIV/AIDS	Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome
IMCI	Integrated Management of Childhood Illness
MCH	Maternal Child Health
MDR-TB	Multi-drug resistant tuberculosis
MOH	Ministry of Health
NGO	Non-governmental organization
OPHT	Other Public Health Threats
PEPFAR	United States President's Emergency Plan for AIDS Relief
SES	Sanitary Epidemiological Service
TB	Tuberculosis
UNAIDS	The Joint United Nations Response on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

USAID and Abt Associates would like to thank the Governments of the Kyrgyz Republic, Kazakhstan, Tajikistan, Uzbekistan, and Turkmenistan for their partnership and cooperation over 20 years of health system change and improvement.

We also would like to thank our non-governmental partners—those who have strengthened civil society across Central Asia, helped make health care policies and practices more relevant, and enhanced their impact.

Abt Associates, USAID's main implementer of the series of health systems strengthening projects described in this document, is to be recognized for its extensive technical assistance over the years. Their work could not have been carried out without support from subcontractors: American International Health Alliance; American Manufacturers Export Group; AIDS Projects Management Group; Boston University School of Public Health-Center for International Health and Development; CitiHope International; Development Associates, Inc.; E. Petrich and Associates, the International Executive Service Corps; Institute for Sustainable Communities; John Snow Inc.; Morehouse School of Medicine; Project HOPE; Quality Healthcare Resources, Inc.; Scientific Technology and Language Institute; Socium Consult; Training Resources Group; and the Vermont Insurance Institute at Champlain College.

A particular thanks goes to USAID staff, Khadijat Mojidi, Arman Dairov, Elisa Adelman, Lisa Jacques-Carroll, and Hector Gonzales in Kazakhstan; Dilorom Kosimova inTajikistan; Chynara Karmarli in Kyrgyzstan; Alisher Ishanov in Uzbekistan; and Elena Samarkina in Turkmenistan for their strong partnership in guiding the documentation of project successes throughout the region.

Over the past two decades, many individuals—including doctors, nurses, pharmacists, health economists, non-governmental organization (NGO) leaders, community members, patients, policymakers, and others—have dedicated their lives to building sustainable improvements in the health of their countries. While it would have been easier to follow the traditional path, many worked diligently to adapt to new ways of doing things to ensure the best possible health outcomes despite extremely limited resources. Many individuals gave up their evenings and weekends and pushed themselves harder to overcome challenges faced and work for a brighter future for the populations of Central Asia.

The successes and achievements documented in this report are the result of a long-term collaborative effort of many dedicated professionals whose work was often unnoticed or uncelebrated. This document is one way of celebrating their hard work and commitment.

LIMITATIONS

Given the size and complexity of USAID's support for health system strengthening across five different countries in Central Asia over the past 20 years, this document does not cover all activities and interventions exhaustively. The authors attempted to incorporate a balance of examples of interventions and achievements across technical areas and countries. This document covers only work implemented by projects led by Abt Associates in the region. Any work left out is no less appreciated by USAID and Abt and more importantly, by the citizens of the countries who benefit from it.

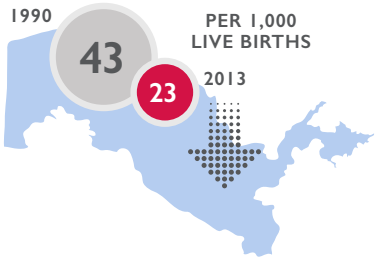
USAID'S 20 YEARS OF WORK

IN HEALTH SYSTEMS STRENGTHENING

IN CENTRAL ASIA

UZBEKISTAN:

DECREASE IN INFANT MORTALITY

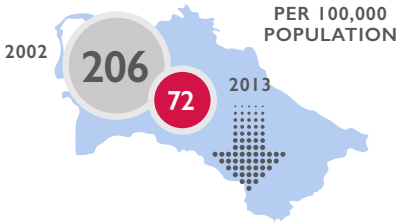


Source: World Health Organization Global Health Observatory

TURKMENISTAN:

INCIDENCE OF TUBERCULOSIS

65% DECREASE



Source: WHO Statistical Profile.

EXECUTIVE SUMMARY

It has been 20 years since USAID first came to Central Asia to help the newly independent countries strengthen their health systems. At the time, Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan faced a daunting task: coping with the realities of a post-Soviet world in which Moscow's financial and administrative support abruptly ended. The five countries had to undergo a dramatic transformation not only in the structure of their systems, but also in the very way that they thought about health care.

With USAID as a catalyst, this positive transformation has occurred. The institutions, processes, and the citizens of Central Asia have evolved to a degree that would have been difficult to imagine back in 1994. These changes have resulted in improved health indicators across the region. For example, maternal and infant mortality rates, often considered a barometer of a nation's health, have decreased dramatically.

USAID and its team of partners, led by Abt Associates, helped create a strong primary health care (PHC) sector. As a result, today patients have access to skilled physicians, nurses, and community health care workers who can provide preventive medicine and treat conditions before they worsen. By helping craft new educational institutions and prepare family medicine trainers, USAID has strengthened the skills of the doctors and nurses who serve as a first point of contact for the population.

Before USAID's intervention, the reality for most Central Asians was that specialists and hospitals were the only way to handle an illness. These days patients, doctors, and policymakers alike see the benefit of treating patients at the primary care level. With strengthened primary health care patients are able to stay out of hospitals and instead live healthier, more productive lives.

Thanks to assistance from USAID and other donors, medical evidence now forms the foundation for medical practice. Health care agencies can use data for decision making and implementing policies and best practices that benefit patients. Patient outcomes have improved dramatically as a result. Fewer children are stunted or undernourished. More mothers survive pregnancy

and childbirth. More patients with infectious diseases such as tuberculosis and HIV receive the medication and treatments that they require.

Improved access to family planning enables couples to decide to have children according to their own timelines. Patients with chronic illnesses know better how to manage their conditions. These advances are the result of 20 years of hard work on the part of government officials, health care workers, patients, and citizens.

With national and international partners, USAID also worked to strengthen the population's involvement in its health care. Through support for village health committees, patient support groups, and local non-profit organizations, USAID helped effect change in the way that Central Asian governments interact with their citizens. Individuals can now advocate for themselves within the government-run health care systems. Even those marginalized by geography or social stigma have better access to quality care. In addition, health groups helped pave the way for the creation of civil society organizations and now testify before legislative committees to provide a grassroots perspective.

A key tenet of USAID's approach has been to work hand-in-hand with local partners to achieve change. USAID's work simultaneously strengthened the health care system, while leading to direct improvements in health outcomes. The sweeping changes that have taken place over the past 20 years will last because they have been country-led and have involved building the capacity of policymakers and medical workers, as well as empowering citizens to hold government accountable to provide quality care.

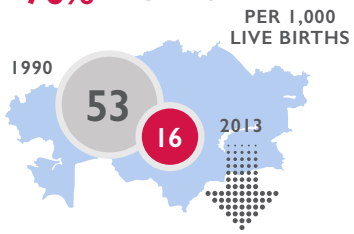
Since 1994, the percentage of health sector budgets targeted to primary health care and priority services have increased; institutions have come to effectively implement their delegated roles and functions, evidence-based policies and guidelines have been codified and put in practice, and national governments have taken on innovative approaches, such as government directly funding HIV NGOs to provide services, unimaginable in Central Asia even just a few years ago.

USAID has been involved in all of these improvements. This document highlights some of the many developments that have contributed to advanced health outcomes in the region.

PROFOUNDLY IMPROVED HEALTH CARE IN THE REGION

KAZAKHSTAN:

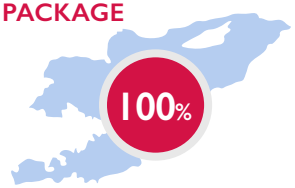
UNDER-5 MORTALITY RATE 70% DECREASE



Source: WHO Statistical Profile.

KYRGYZ REPUBLIC:

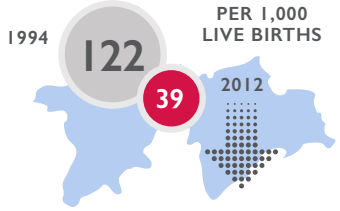
POPULATION COVERED BY A BASIC HEALTH BENEFITS PACKAGE



Source: Ministry of Health, Kyrgyz Republic.

TAJIKISTAN:

ABORTIONS 68% DECREASE



Source: European Health for All Database.

"A PRIMARY HEALTH CARE APPROACH IS THE MOST EFFICIENT, FAIR, AND COST-EFFECTIVE WAY TO ORGANIZE A HEALTH SYSTEM. IT CAN PREVENT MUCH OF THE DISEASE BURDEN, AND IT CAN ALSO PREVENT PEOPLE WITH MINOR COMPLAINTS FROM FLOODING THE EMERGENCY WARDS OF HOSPITALS. DECADES OF EXPERIENCE TELL US THAT PRIMARY HEALTH CARE PRODUCES BETTER OUTCOMES, AT LOWER COSTS, AND WITH HIGHER USER SATISFACTION."

Dr. Margaret Chan, Director-General World Health Organization
Speaking in Almaty, Kazakhstan, 2008

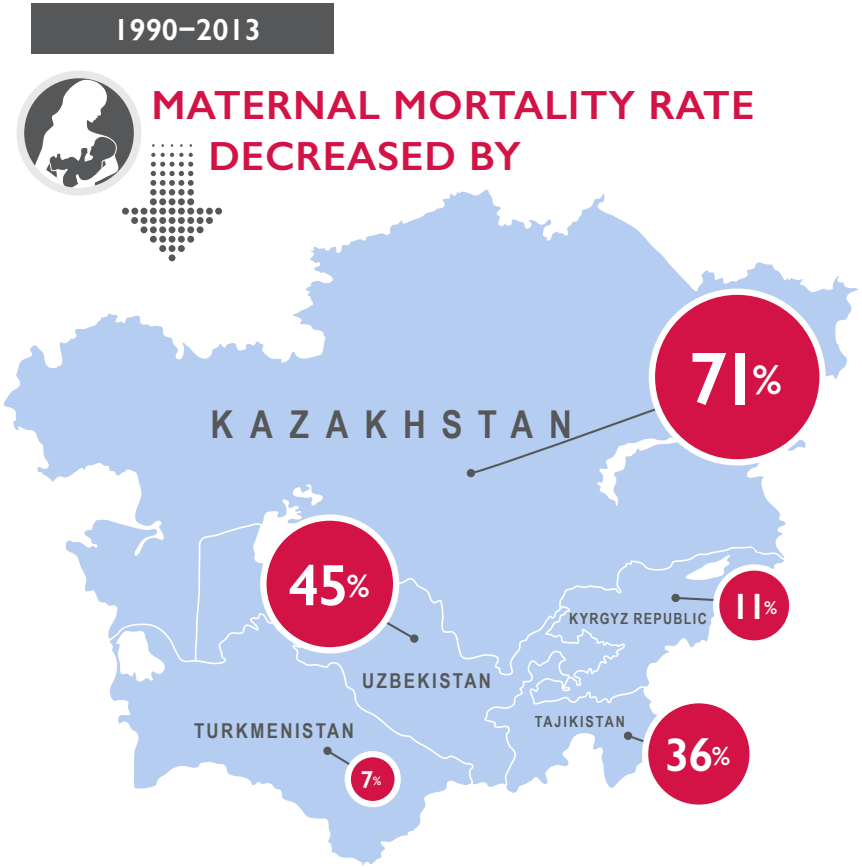
INTRODUCTION

The countries of Central Asia have seen dramatic improvements in health outcomes in recent years. Motherhood has become safer as maternal mortality rates have fallen. Regional health systems have worked to stop the growth of epidemics such as HIV and tuberculosis (TB). Children are better nourished. Cardiovascular diseases are better managed.

USAID has played an important role in helping the countries of Central Asia strengthen their health systems so that they can provide efficient, accessible, and quality care to their populations. For the past 20 years, USAID has cooperated closely with other multilateral and bilateral donors such as the World Bank, World Health Organization, United Nations agencies, and the development arms of the German, Swiss, and British governments. In the Kyrgyz Republic and later in Tajikistan, this cooperation was formalized through a sector-wide approach mechanism, which called for joint strategy development and planning of all technical assistance in the health sector.

This shared approach to improvement has helped Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan reorganize their health systems and financing structures while improving the quality of health service. Throughout its work in the region, USAID has supported country partners in a step-by-step strategic implementation approach (illustrated on page 13), aimed to ensure local ownership and sustainability.

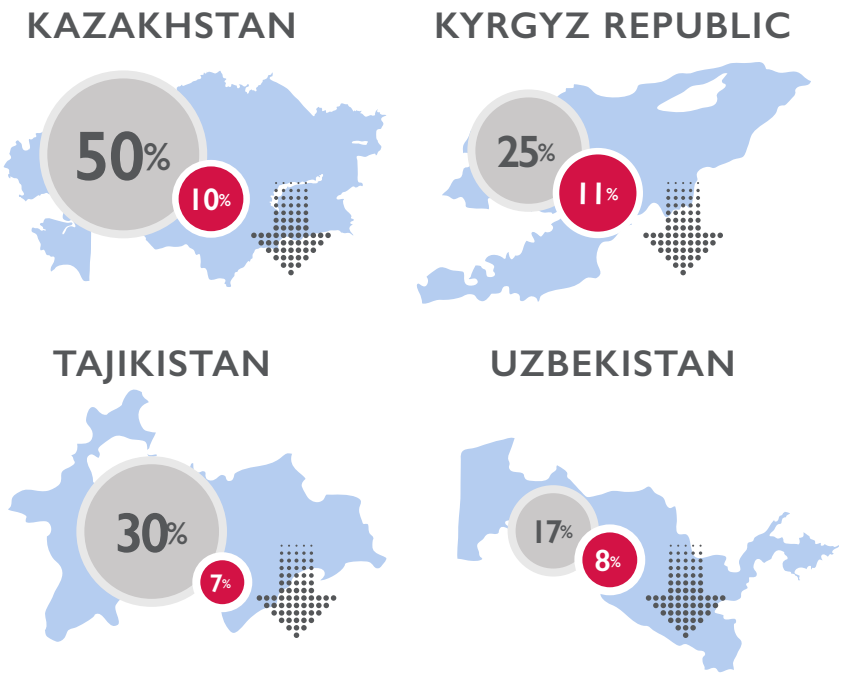
The stories that follow describe a sampling of the improvements in health care made by national partners, thanks in part to USAID's targeted, ongoing technical assistance. USAID has supported change through a comprehensive, integrated set of interventions. This document highlights the processes and impact of USAID's collaboration with Abt Associates, profiling the ways in which USAID has played a pivotal role in improving the quality of service delivery, access to care, and patient empowerment over the past two decades.



Source: World Health Organization Global Health Observatory.

1998–2013

TB MORTALITY DECREASED

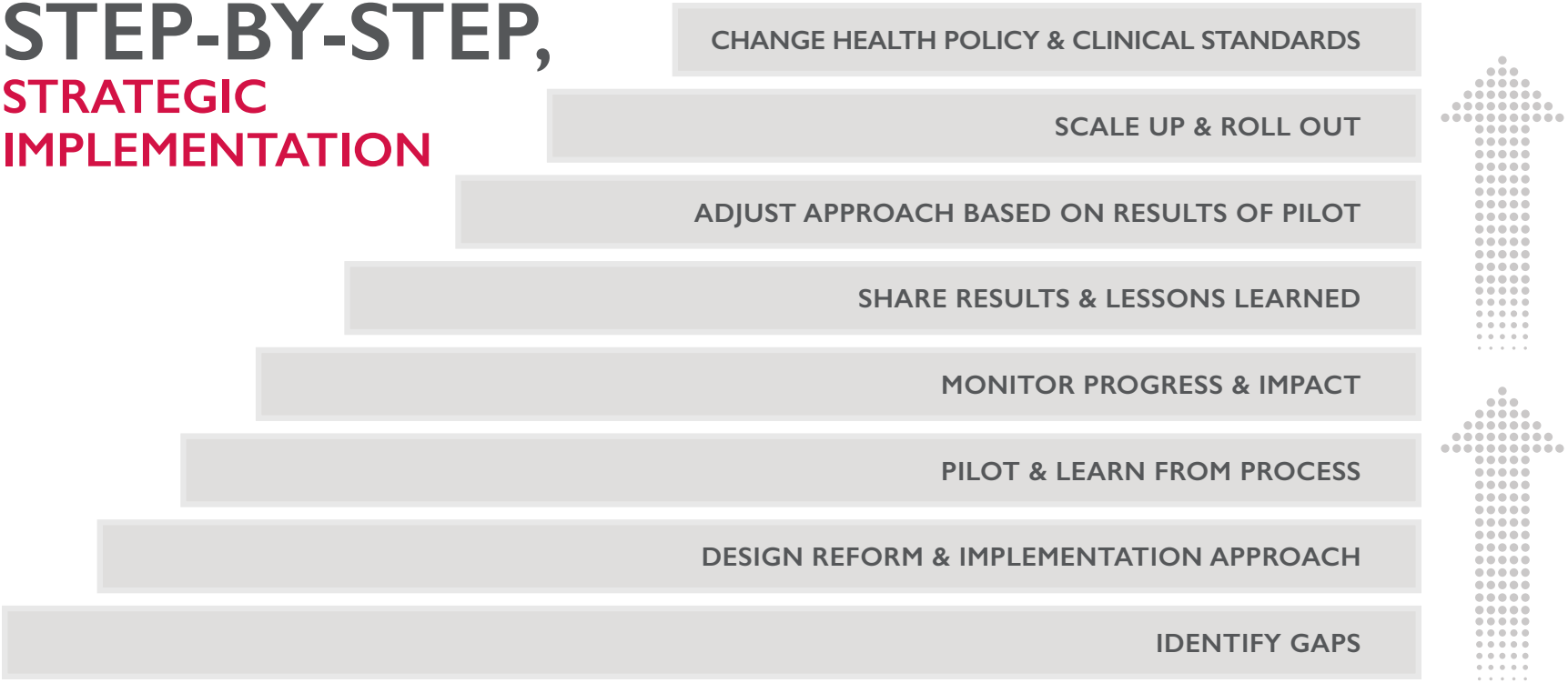


Source: http://www.who.int/tb/country/data/profiles/en/

TIMELINE: USAID'S CENTRAL ASIAN HEALTH SYSTEMS PROJECTS

- **1991** – Collapse of the Soviet Union; Central Asian countries become independent.
- **1992** – USAID establishes a Central Asian Mission based in Almaty, Kazakhstan.
- **1994** – Abt conducts exploratory consulting work in Russia and Central Asia through the global USAID Health Financing and Sustainability Project.
- **Late 1994-2000** – USAID ZdravReform Project implemented by Abt Associates; initially focused on Russia, Ukraine, Kazakhstan, and the Kyrgyz Republic. By 2000, evolves to focus on Central Asia only, including small programs in Uzbekistan and Turkmenistan. Focus is on health systems strengthening, including development of primary health care and activities to strengthen quality of services at the primary health care level. Specific service delivery focuses on improving outcomes for mothers and children.
- **2000-2005** – USAID ZdravPlus project implemented by Abt Associates. Builds off the work of the ZdravReform Project. Country focus expands to include Tajikistan.
- **2005-2009** – USAID ZdravPlus II project implemented by Abt Associates. Builds off the work of the earlier Zdrav Projects. Covers all five Central Asian countries.
- **2010-2015** – Abt implements the Quality Health Care Project. Project ultimately focuses on separate health components of HIV, TB, maternal and child health, family planning and reproductive health, and other public health threats. Covers all five Central Asian countries.

STEP-BY-STEP, STRATEGIC IMPLEMENTATION



STEP-BY-STEP, STRATEGIC IMPLEMENTATION underlies USAID's approach in the region. With support from local partners, new approaches based on WHO recommendations and evidence were first piloted in a limited geographic region.

RESULTS OF THE PILOT SITE HELPED DEMONSTRATE the validity of new approaches to national decision makers, informed adjustments or refinements based on implementation in preparation for scale up, and provided evidence for policy change. This approach helped to ensure local buy-in for the work. As a result, the improvements that USAID supported became part of the country system and will remain when assistance money comes to an end.

With USAID's assistance, over 700 standards, protocols, and guidelines have been adopted and are being utilized throughout the region.

COUNTRY SUMMARY: KAZAKHSTAN

FAST FACTS ABOUT KAZAKHSTAN

TOTAL POPULATION **17,037,500** (2013)

47% of population **LIVES IN RURAL AREAS** (2013)

GROSS NATIONAL INCOME per capita **$4,738** (2013)

Percentage of population **BELOW THE POVERTY LINE** **5%** (2011)

POPULATION PROPORTION between 0-14 years **24%** (2010)

LIFE EXPECTANCY at birth **F 73 / M 63** (2013)

BACKGROUND

Kazakhstan is the world's largest land-locked country. It has benefited greatly from its natural gas and oil wealth and is now considered an upper-middle income country by the World Bank. Kazakhstan has had a single president since independence. Its government is relatively outward looking and has fostered economic growth, supported public sector improvements, and been open to foreign technical assistance. In the initial years of USAID's involvement in the region, Kazakhstan experienced changes in government structure, including moving the national capital from Almaty to Astana, merging some oblasts and several ministries, and decentralizing authority from the national to the regional level. However, in more recent years, the country's policymaking environment has stabilized greatly. As its wealth has increased, the government has taken on an increasing share of responsibility for health care support.

STEPS FORWARD

UNDER-5 MORTALITY RATE DECREASED

1990 **53** → **16** 2013 PER 1,000 LIVE BIRTHS

Source: WHO statistical profile.

ABORTIONS DECREASED

1994 **854** → **251** 2012 PER 1,000 LIVE BIRTHS

Source: European Health for All database.

DEATHS DUE TO TB AMONG HIV-NEGATIVE PATIENTS DECREASED

2000 **33** → **10** 2013 PER 100,000 POPULATION

Source: WHO statistical profile.

COUNTRY SUMMARY: KYRGYZ REPUBLIC

FAST FACTS ABOUT THE KYRGYZ REPUBLIC

TOTAL POPULATION 5,719,500 (2013)

65% of population **LIVES IN RURAL AREAS** (2013)

GROSS NATIONAL INCOME per capita **$603** (2013)

Percentage of population **BELOW THE POVERTY LINE 34%** (2011)

POPULATION PROPORTION between 0-14 years **30%** (2010)

LIFE EXPECTANCY at birth **F 73 / M 66** (2013)

BACKGROUND

The Kyrgyz Republic is considered the most democratic of the republics in Central Asia, with a parliamentary government and strong protections for freedom of speech. The country has experienced periodic political overthrows, changes in government, and ethnic discord since independence.

Like many of the countries in Central Asia, the Kyrgyz Republic saw a dramatic decrease in the quality of its health care provision after independence. However, the country reacted quickly and decisively to turn around these outcomes. Perhaps because it was both poorer than Kazakhstan and Turkmenistan, but more open, the Kyrgyz Republic early on embraced many reforms to a greater extent than its neighbors, including market and health care restructuring. Still, the country faces serious health challenges, among them high rates of TB and an increasing incidence of HIV/AIDS.

STEPS FORWARD

FULL IMPLEMENTATION of the case-based and single payer systems and a basic health benefit package with an outpatient drug benefit. **REFORMS NOW REACH 100% OF THE POPULATION.**

Source: Ministry of Health data.

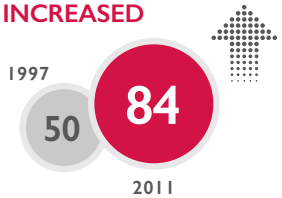
THE UNDER-5 MORTALITY RATE DECREASED

Source: WHO statistical profile.

ABORTIONS DECREASED

Source: European Health for All database.

THE TB TREATMENT SUCCESS RATE AMONG NEW TB CASES INCREASED



Source: WHO statistical profile.

COUNTRY SUMMARY: TAJIKISTAN

FAST FACTS ABOUT TAJIKISTAN

TOTAL POPULATION 8,208,000 (2013)

73% of population **LIVES IN RURAL AREAS** (2013)

GROSS NATIONAL INCOME per capita (2013) **$477**

Percentage of population **BELOW THE POVERTY LINE 36%** (2013)

POPULATION PROPORTION between 0-14 years **36%** (2010)

LIFE EXPECTANCY at birth **F 70 /M 68** (2013)

BACKGROUND

Tajikistan is one of the least accessible places in the world, with more than 90% of its territory covered in high mountains. The landlocked country also suffers from weak infrastructure, lack of natural resources, and extreme poverty. After independence, Tajikistan endured a civil war that lasted from 1992-97. The war killed approximately 50,000 people and displaced more than 10% of the population. The war caused $7 billion in damage and loss of more than 50% of GDP, hampering development and economic growth. During this period, many health care workers and professors of medicine emigrated, depriving the country of much of its health care expertise. When USAID began working in Tajikistan in 2000, the country was still emerging from this civil war and the country's health system was beginning to crumble. Since the late 1990s, the country has remained politically stable, with a single president, improved economic growth, and implemented steady health care reform. The poorest of the Soviet Republics, it remains the only lower income country in Central Asia, according to World Bank classifications. Perhaps in part because the system was so close to collapse due to the political and economic turmoil, Tajikistan has been quite open to new approaches and improvements in its health system and has embraced positive change, with significant improvements in health outcomes.

STEPS FORWARD

UNDER-5 MORTALITY RATE DECREASED

2000: 94
2013: 48
PER 1,000 LIVE BIRTHS

Source: WHO statistical profile.

ABORTIONS DECREASED

1994: 122
2012: 39
PER 1,000 LIVE BIRTHS

Source: European Health for All database.

TB MORTALITY DECREASED AMONGST HIV-NEGATIVE PATIENTS

2002: 17
2013: 7
PER 100,000 POPULATION

Source: WHO statistical profile.

70% OF HEALTH FACILITIES IN THE COUNTRY OFFER BIRTH PREPAREDNESS CLASSES

Source: Project data.

USAID
Quality Health Care Project

COUNTRY SUMMARY: TURKMENISTAN

FAST FACTS ABOUT TURKMENISTAN

TOTAL POPULATION 5,240,100 (2013)

51% of population **LIVES IN RURAL AREAS** (2013)

GROSS NATIONAL INCOME per capita (2006) **$1,767**

Percentage of population **BELOW THE POVERTY LINE 30%** (2004)

POPULATION PROPORTION between 0-14 years **39%** (2010)

LIFE EXPECTANCY at birth **F 68 / M 60** (2013)

BACKGROUND

Since independence, Turkmenistan's leaders have kept the country isolated from outside influence, with few civil society organizations and a tightly controlled economy. Like other countries in the region, Turkmenistan saw a dramatic decrease in the quality of health care after the fall of the Soviet Union. Since that time, the country has experienced improvements in health outcomes, thanks to continual efforts of both the government and international donors, and economic growth, as a result of natural gas and oil deposits. The World Bank now considers the country an upper-middle income country.

The government has quickly implemented technological solutions such as health information systems. The government also expanded the internationally-accepted DOTS system for TB treatment to the entire country in 2007 and extended it to include treatment of multiple-drug resistant forms of TB in 2014. Health care providers are actively involved in educating the population about key health care topics. Although the country has no official cases of HIV, it developed clinical protocols for HIV testing and treatment in line with WHO international standards.

STEPS FORWARD

UNDER-5 MORTALITY RATE DECREASED

1994 **90** → **55** 2013

PER 1,000 LIVE BIRTHS

Source: WHO statistical profile.

ABORTIONS DECREASED

1994 **238** → **116** 2012

PER 1,000 LIVE BIRTHS

Source: European Health for All database.

TB INCIDENCE DECREASED

2002 **206** → **72** 2013

PER 100,000 POPULATION

Source: WHO statistical profile.

COUNTRY SUMMARY: UZBEKISTAN

FAST FACTS ABOUT UZBEKISTAN

TOTAL POPULATION 30,241,100 (2013)

64% of population **LIVES IN RURAL AREAS** (2013)

GROSS NATIONAL INCOME per capita (2013) **$921**

Percentage of population **BELOW THE POVERTY LINE 17%** (2011)

POPULATION PROPORTION betwee 0-14 years **21%** (2010)

LIFE EXPECTANCY at birth **F 72 / M 67** (2013)

BACKGROUND

Uzbekistan is Central Asia's most populous country. It has been led since 1990 by President Islom Karimov. The country has significant mineral and petroleum deposits, but due to many characteristics of the command economy, foreign investment and economic development have been limited. In the first decade of independence, the country made great strides toward strengthening primary health care in the country through retraining medical workers.

Initially more open to foreign technical assistance in the 1990s, the government tightened control in the 2000s, closing the majority of its international projects. The NGO sector is limited, but a network of traditional mahalla (neighborhood) organizations spreads health information.

STEPS FORWARD

FINANCING AND MANAGEMENT REFORMS cover 3090 rural primary health care facilities **REACHING APPROXIMATELY 16 MILLION PEOPLE,** over half of the country's population.

Source: Ministry of Health data.

UNDER-5 MORTALITY RATE DECREASED

Source: World Bank Healthstats database.

TB INCIDENCE DECREASED

Source: WHO statistical profile.

TB MORTALITY DECREASED AMONGST HIV-NEGATIVE PATIENTS

Source: WHO statistical profile.

BUILDING PRIMARY HEALTH CARE

When health care financing drops from 6% to 2% of gross domestic product (GDP) — and to make matters worse, GDP shrinks by almost 90% — how can a country ensure quality health care for its population?

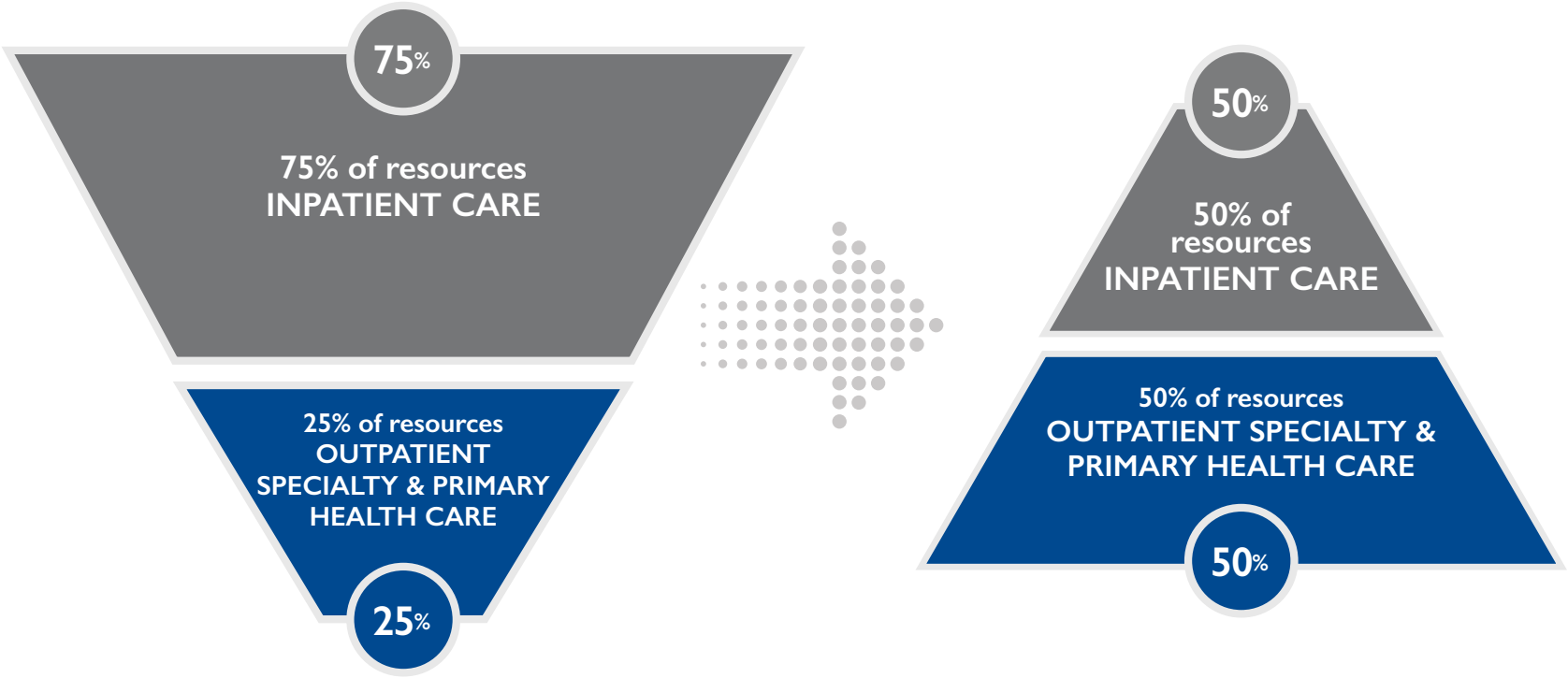
With the fall of the Soviet Union, its former republics faced just this situation: a stunning 97% drop in health care spending. Already poor health indicators were on the verge of a calamitous collapse. Only an international intervention, one that could preserve the strengths of Soviet universal coverage while correcting the systems' considerable defects, could prevent these nations from tumbling over a health precipice.

The health systems needed nothing less than a transformation. The countries' inefficient and top-heavy health care structures and systems were exacerbating the health financing problem. Expensive care from hospitals and outpatient specialists historically had been the priority, while primary health care was almost completely neglected. Staff at primary facilities tended to refer patients to specialists or hospitals for almost all conditions, major or minor. It was no wonder that this occurred: the primary care sector received only about 25% of all health care resources. It often lacked even simple antibiotics or medical equipment. Over-reliance on specialists and hospitalization created an expensive, inefficient, and ineffective system that desperately needed downsizing and restructuring. The countries needed to invert the pyramid (page 25) to emphasize more efficient and cost effective primary health care, especially preventive care, early treatment, and ongoing care for chronic conditions.

In 1994, USAID and its country partners began working to build a strong primary health care system to improve preventive care, treat common conditions, and address chronic ilnesses. USAID worked with national partners in all five countries to strengthen the capacity of providers and establish family medicine as the bedrock of the health care system. The percent of the budget dedicated to PHC in each country increased 31% on average for the region from 2005 to 2009. This indicates greater allocative efficiency for the health systems as it is presumably less expensive to prevent disease rather than treat it and to treat in PHC versus hospital settings.

As governments began to implement and institutionalize this change, patient outcomes began to improve while costs decreased. Primary care doctors are now able to manage the symptoms and ilnesses seen most frequently at the outpatient level, preventing worsening of conditions. They make significantly fewer referrals to expensive specialists. One indicator of these improvements is the reduction in emergency visits and hospitalizations. For example in the Kyrgyz Republic, the number of emergency cases per 100 asthma patients fell from 53 (2005) to 34 (2013). Across the region, patients are benefiting from a move toward this new form of patient-centered primary health care.

BUILDING PRIMARY HEALTH CARE



EXCESS CAPACITY IN THE SERVICE DELIVERY SYSTEM

SMALLER MORE EFFICIENT DELIVERY SYSTEM
many more patients receive primary health care

RESTRUCTURING AND DOWNSIZING OF HEALTH SYSTEMS:
Resources had to be moved out of the inpatient hospital system and into the PHC level. At the same time PHC services needed to expand to offer more services and treat more patients. The PHC sector is bigger than the hospital sector in the new model, but, because PHC care is cheaper and more effective, it uses fewer resources, creating overall savings for the system.

For more information, please see: Conceptual Foundations for Central Asian Republics Health Reform Model http://pdf.usaid.gov/pdf_docs/pnack456.pdf.

BUILDING A NEW SYSTEM TO HELP PATIENTS

I was working as a cardiologist when I heard that the Kyrgyz Republic Ministry of Health was soliciting applications to form a team within the Ministry to work with donor organization experts to restructure the health care system. It was not a good time to be a cardiologist. There was a shortage of medicines and supplies, and so I often could not help my patients, even though I knew what they needed. I frequently had to tell them to go buy the necessary medications themselves. By law, these drugs were supposed to be free, but our country's budget was in bad shape in the early 1990s. I knew that something had to be done to keep the system from falling apart completely, so I sent in my application to the Ministry to join the reform team.

As they say, the rest is history. In 1994, I joined the team working to develop and then implement our first national health care strategy called "Manas". I was sent abroad for training on health economics. I remember when I was asked the question, "If you had a limited amount of money, and it would be enough for either dialysis for two very sick patients, or for vaccinations for 1000 healthy children, what would you do?"

Back then, I was purely a clinician. I had never thought of health issues that way. I was horrified by the question, thought it was wrong to even ask it. However, I soon came to understand that our job was to do the best to allocate the resources we did have, in order to minimize these kinds of trade-offs, and truly provide the best basic package of care to our full population.

As part of the Manas team, we closed some hospitals and merged others, and built up primary health care. Soon, I had learned quite a bit about health economics and health systems through my joint work with the Manas team experts from both USAID and other donors. I became the first director of the government's Mandatory Health Insurance Fund. I spent a very busy year with our team, creating a national insurance system to provide a basic package of health services and drugs to the population. This new state health insurance system launched in June of 1997. Since then, the national Insurance Fund has served as a major pillar in keeping our country's health system functional and ensuring access to health care for the people of the Kyrgyz Republic.

I would like to note that the USAID ZdravReform Project implemented by Abt Associates played a key role in creating the single payer system and a state guaranteed benefits package of services for the population. ZdravReform supported the development of the Mandatory Health Insurance Fund as an institutional structure.

There have been ups and downs, of course. Our government has changed many times, and sometimes new leadership has wanted to go backwards on the reforms. However, our system is strong and has persevered. Here we are, 20 years later, with the Kyrgyz Republic as a real success for the region.

Dr. Ainura Ibraimova, former Deputy Minister of Health (2000-2008), Kyrgyz Republic

HEALTH FINANCING AND RESTRUCTURING

One of the major strengths of the Soviet health care system was that patients had access to universal health coverage, regardless of their ability to pay. However, the system was unwieldy and expensive, and at times, quality was poor. The health care system inherited by the Central Asian countries focused on inpatient treatment of disease, rather than outpatient disease prevention and management of chronic conditions.

Few resources were allocated to primary health care. The focus on in-patient care was closely tied to the health financing system, as hospitals, like hotels, got money by keeping beds full. Medical practice adapted accordingly. For example, pregnant women were routinely hospitalized for observation, and many procedures treated on an outpatient basis in the West required long hospital stays in Central Asia.

With the fall of the Soviet Union, government provision of drugs and supplies declined. Health care workers' salaries plunged. While health care was officially free for the post-Soviet population in the 1990s, patients found themselves having to pay unpredictable, unofficial fees to health care workers and often had to bring their own supplies with them to the hospital.

USAID helped the governments in Central Asia restructure their health financing systems to move resources away from hospitals and therefore discourage inpatient care. Funds were redirected toward primary health care, where care is not only less costly, but also more efficient in preventing disease and managing chronic conditions.

To enable this shift and improve allocative efficiency, USAID helped the governments restructure their health payment systems to provide money to clinics and hospitals based on the work they did (outputs), rather than on the resources, like beds and staff, that they required to do the work (inputs). At the same time, health care facilities were given more control over their budgets, to improve allocation of resources on the facility level.

SELECTED OUTCOMES

- KAZAKHSTAN and THE KYRGYZ REPUBLIC both pool budgets on the national level, allowing money to "follow the patient" so that they can access any hospital in the country. They have also **introduced a basic benefits package** including an outpatient drug benefit that every citizen in the country is eligible to receive.

- UZBEKISTAN rolled out rural primary health care financing and management reforms to all **3090 rural primary care facilities** in **161 rayons** in its **13 oblasts,** covering approximately **16 million people** or more than half of the country's population.

- TAJIKISTAN has introduced a basic benefits package in eight rayons, **reaching 20% of the country's total population**. Large hospitals and research institutions have introduced **official patient co-payments** for diagnostic and curative consultations.

- THE KYRGYZ REPUBLIC has achieved full implementation of the case-based hospital payment and per capita PHC payment systems, **covering 100% of the population.**

Source: Ministry of Health data.

"MY PENSION IS VERY SMALL AND THIS PROGRAM ALLOWS ME TO HAVE THE NECESSARY MEDICATIONS AT A REDUCED PRICE."

Kyrgyz patient describing prescription drug benefit

To maintain or reinstate universal health coverage to the extent possible given budgets, USAID supported the governments in determining which health services it would purchase and how it would purchase them. Financing changes were aimed at maintaining or reestablishing equity and access to care, while creating incentives for increased efficiency and improved quality.

The Kyrgyz Republic went the furthest in implementing a comprehensive set of health financing reforms in order to benefit the population, but all five countries took important steps in improving their health financing systems.

The first step was **pooling** or creating a single pot of money at the oblast or national level. A general principle of health insurance, pooling meant that the government could spread risk across a larger population of both sick (high cost) and healthy (low cost) citizens, across age groups, and across geographic areas. The Kyrgyz Republic established a new government institution, the Mandatory Health Insurance Fund, to administer the pooled funds and monitor use of the funds.

USAID also provided assistance to the Central Asian countries in determining what services the government would purchase for the population. USAID supported the government in defining a **basic benefits package** of services to be provided free to the population at the primary health care level.

Next, the government introduced **copayments** for select services, to encourage patient responsibility for care. Formalizing payments discouraged informal payments to providers and generated revenue that health care facilities could use to improve their services. The copayment system included exemptions for those with greater need, while imposing fees on those who could better afford to contribute to the cost of their own health care. Benefits packages and co-payment schedules were revised annually, with benefits and coverage expanded as health budgets allowed.

USAID supported establishment of a **per capita payment system** for primary health care through which the government pays a primary health care facility a given sum for each individual enrolled with or assigned to that facility. Rates varied by sex and age adjustors, to encourage service use by groups

INCLUDING SALARIES IN THE NEW PROVIDER PAYMENT SYSTEM

Health care worker salaries are by far the largest expense in Central Asia's health care systems. During the Soviet era, the national government's input-based budget payment system paid the salaries of health care workers no matter how many patients they treated or the quality of treatment the patients received. Facility staffing patterns were determined by national norms.

In contrast, the USAID-supported **output-based** provider payment systems for the state guaranteed benefits package included all costs except capital investment. Including salary costs in payment systems dramatically changed health purchasing and produced many positive impacts. Impacts included aligning all payments for a health service or output to avoid conflicting financial incentives, allowing health facility managers the autonomy to better align and manage their health workers, and increasing health worker productivity as facility managers were given leeway to provide incentive pay to motivate staff.

"I AM PLEASED WITH THE EXPERIENCE WITH [THE FORMAL COPAYMENT] POLICY TO DATE. IN PARTICULAR, I FEEL THAT THIS HAS DEMONSTRATED THAT WE CAN REDUCE CORRUPTION IN THE HEALTH SYSTEM AND ENABLE HEALTH WORKERS TO INCREASE THEIR SALARIES BY LEGAL MEANS. THIS SYSTEM HAS ALSO EMPOWERED PATIENTS BY GIVING THEM A GOOD UNDERSTANDING OF THEIR FINANCIAL RESPONSIBILITIES AS WELL AS THEIR RIGHTS."

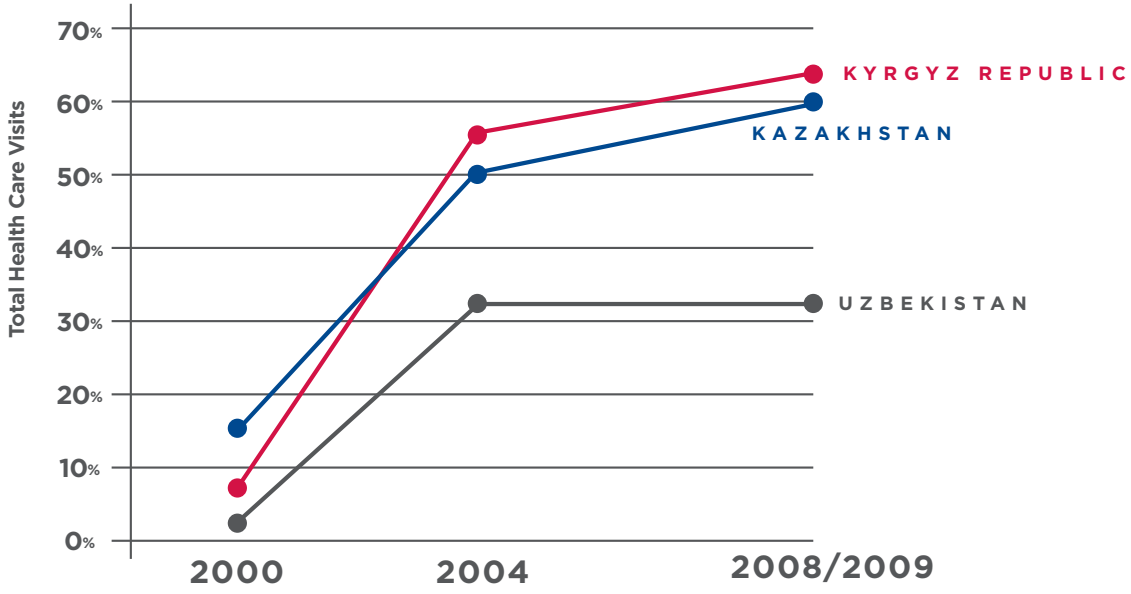
Dr. Tilek Meimanaliev, Former Minister of Health, Kyrgyz Republic

who tend to seek care less frequently (such as working-aged men) and to account for those groups who require more care on average, such as young children and women of reproductive age.

USAID supported government partners in establishment of a **case-based hospital payment system** based on diagnostic-related groups (DRGs). Payments were higher for those diagnoses which required significant inpatient care, and much lower for conditions that could be addressed with just a short inpatient stay. Through the DRG system, health conditions were grouped based on diagnosis, and a number of other factors, including age, sex, and the presence of complications. Then, weights were assigned to each group, based on the care required as per evidence-based practice. Through this system, a condition like a common cold might have a weight of zero, meaning that a hospital would not receive any money for treating someone with the condition, while something like appendicitis would have a much higher weight. Implementation of the new cost-based payment system led to decreased hospital stays throughout the region, and an accompanying reduction in budgets for hospitals. Accordingly, governments closed and merged some hospitals to decrease the overall number of beds and increase efficiency.

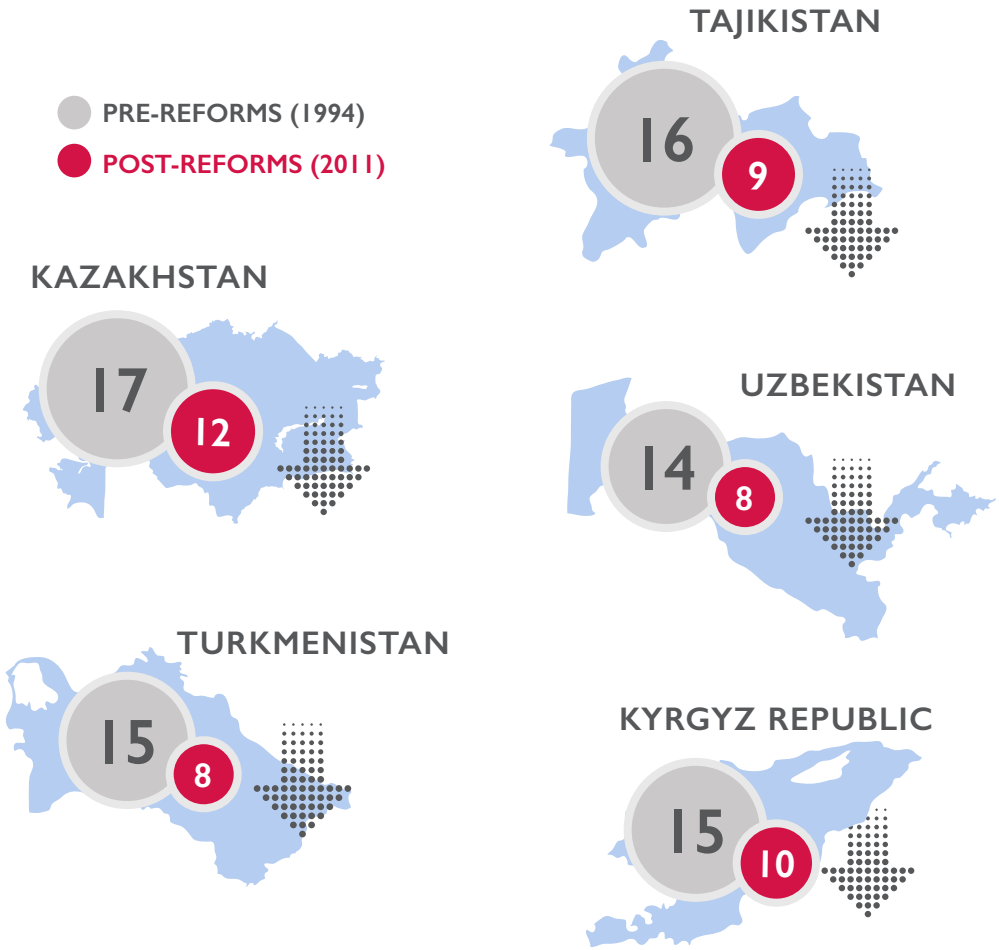
Outpatient drug benefits were added later, to ensure that patients could get the basic medications they needed for free or at subsidized prices at clinics and pharmacies, rather than only at hospitals, resulting in further use of primary health care services.

The new financing systems redirected resources from more costly hospital care to primary health care. This increased allocative efficiency, as indicated in the pyramid diagrams on page 25. Average length of hospital stay declined. For example, Uzbekistan saw reductions of 20% in hospital admissions and an average 25% increase in the use of primary care services. In USAID-assisted pilot rayons,



Source: Zdrav Project Performance Monitoring Plan, based on Ministry of Health data.

AVERAGE LENGTH OF HOSPITAL STAY (IN DAYS) DECREASED:



Source: World Health Organization, European Health for all database.

registration of pregnant women supervised by primary care doctors increased by up to 90% in the early period of pregnancy.

Basic benefit packages also helped make care more affordable for patients. The reforms had a rapid impact even in the early stages of USAID's work. For example, in Kyrgyzstan, of those who needed care but did not seek it in the previous 30 days, 11% in 2001 stated that care was "too expensive" or "too far." By 2006, the figure had dropped to 3%. Out-of-pocket expenditure as a percentage of total health expenditure dropped from 45% in 1995 to 36% in 2013. Data from a pilot rayon in Kyrgyzstan also showed that, following introduction of the outpatient drug benefit (from 2000 to 2001), visits to primary health care facilities increased by 6%, emergency cases decreased by 38%, and referrals to hospitals decreased 22% for conditions easily treated by primary care doctors such as asthma, hypertension, anemia, and ulcers.

And, as demonstrated throughout this document, the system changes together with health care financing interventions also contributed to improvements in health care outcomes.

INSTITUTIONAL STRUCTURE, ROLES, AND RELATIONSHIPS

As one key step in building strong and sustainable health care systems, USAID supported the Central Asian governments in defining the roles and inter-relationships of the country's health-related institutions. This meant defining their scopes of work, areas of responsibility, and lines of reporting. This focus was particularly important, given the inefficiencies, redundant institutions, and lack of strategic management that plagued the region in the early 1990s.

Toward this end, USAID supported creation of legal and regulatory mechanisms in each country to clarify which institution has which responsibility. This was necessary for establishment of payment systems, treatment algorithms, and quality monitoring.

Simultaneously, it helped national partners develop new institutions critical to quality improvements, including independent primary health care providers, policy departments within Ministries of Health, evidence-based medicine departments and centers, and independent organizations. New non-governmental organizations such as the Medical Accreditation Commission in the Kyrgyz Republic took on many regulatory and monitoring functions. Professional organizations such as the Kazakhstan Association of Family Physicians began to adopt many of the traditional functions of the Ministry of Health, such as professional development of health care providers, creation of clinical practice guidelines and protocols, and support for quality improvement and evidence-based medicine.

On the personnel level, USAID supported changes in human resources practices, including clarifying job responsibilities, shifting task responsibilities from one level to another, and ensuring that various job classifications fit together to avoid duplication of effort and ensure no bases were uncovered. Providers were given more autonomy. Patients were encouraged to exercise their rights and responsibilities. Ministries of Health began to take over many of the health purchasing functions traditionally handled by Ministries of Finance in the region.

With new roles and relationships, health care workers, policymakers, and citizens themselves have become vested in quality improvement and change.

REFORMING MEDICAL EDUCATION

To build a stronger primary health care sector, doctors needed to be trained in the skills of family medicine. USAID started by training a cadre of physicians to serve as family medicine trainers charged with training and 're-training' physicians throughout the region. With an eye to the future, USAID and partners also established residency programs in family medicine for recent medical school graduates along with a system for continuing medical education for current doctors.

USAID worked with university rectors, professors, and administrators to update and unify the content of medical curricula in line with international standards and to place greater emphasis on clinical teaching. This approach enabled students to observe doctors working and interact directly with patients rather than learning only from books and lectures. Evidence-based medicine was introduced to students, and they were taught to develop and use clinical practice guidelines and continuous quality improvement systems to improve service delivery. Uzbekistan was a leader in improving undergraduate medical education. USAID support to medical institutes in Tashkent and Samarkand focused on training faculty in principles of EBM, adult-learning techniques, and problem-based learning.

USAID also supported the restructuring of continuing medical education programs across Central Asia. More than 22,000 doctors, nurses, and rural health workers participated in these restructured courses between 2005 and 2008 alone. In the Kyrgyz Republic, Turkmenistan, and Tajikistan, USAID helped develop distance learning initiatives to train primary care providers from the convenience of their villages or towns. Thanks in part to the capacity building efforts of USAID and partner PACTEC, the Kyrgyz State Medical Institute for Retraining and Continuous Education is now independently able to operate the country's distance learning courses without donor support.

USAID's continuous focus on improving medical education throughout the region means that today health care providers are better prepared than ever to give their patients the high-quality, evidence-based treatment they need.

INTEGRATING SERVICES

During the Soviet era, the government established a number of individual health institutions to manage certain diseases. The result by the 1990s was separate administrative structures, high overhead costs, and redundant sets of personnel, both inpatient and outpatient, for TB, sexually-transmitted infections, obstetrics/gynecology, psychiatry, HIV, drug abuse, and oncology in nearly every oblast. A patient with multiple conditions, even if related, would have to visit several facilities to receive care. Men, women and children were served in separate policlinics. Patients often repeated tests and exams at different levels of the health care system and in different types of facilities.

USAID responded to requests from the national governments in Central Asia to help the countries reduce costs and improve patient outcomes by supporting plans to merge superfluous facilities and integrate care into general hospitals and the primary care level. This would limit specialized care to complex cases.

In most of the Central Asian countries, prenatal care, gynecological services, and treatment for sexually transmitted infections have been integrated into primary health care. TB, HIV, and drug addiction treatment have been partially integrated to differing degrees in different countries. At the current time, mental health and cancer continue to be treated through separate facilities. As national partners, with USAID's assistance, downsized their oversized health care systems to reflect the needs of the population, USAID supported changes in internal management systems to improve effectiveness and efficiency. USAID also worked with the Ministries of Health and Finance to encourage reinvestment of the savings from downsizing back into the health sector.

As downsizing and integration progressed, governments quickly saw how savings from greater efficiency could improve health care. The Kyrgyz hospital sector reduced the square footage of the hospital sector by 40% and the number of buildings by 47% between 2000 and 2005. That significantly reduced utility costs. These reductions in infrastructure and personnel costs allowed an increase in expenditures allocated to direct patient treatment from 20% in 2004 to 33% in 2007.* These dramatic improvements created momentum for further changes. The number of inpatient facilities has steadily gone down in the region, with resources redirected to outpatient care.

This streamlining has created steady improvements in the quality and convenience of the care that patients receive. These days, prenatal care, which was previously handled only within specialized maternity facilities, is available to patients through their primary care provider. TB patients can now receive their daily medication from their local primary care provider instead of traveling to the TB regional facility or undergoing long-term hospitalization. Through the new, smaller integrated health systems, patients have easier access to holistic care. That ultimately encourages better health outcomes.

* Ministry of Health and Mandatory Health Insurance Fund data.

A TRUE SYSTEMS APPROACH

In the health sector, people who were trained working side-by-side with USAID project specialists have both a good vision and the skills necessary to understand and implement new procedures that meet the challenges of our changing world. Although the primary USAID projects—the "Zdrav" Projects—finished several years ago, health financing, health management, and information system ideas continue to develop and progress in the Central Asian countries. This ongoing progress is in response to the groundwork laid by USAID as well as through the vision and continuing hard work of our Central Asian people who learned through these projects. The strength of these earlier Zdrav Projects was their health systems strengthening approach.

I have worked with USAID Projects since almost the very beginning, as the Director of the Kazakhstan Association of Family Physicians. Through the cooperation with the many USAID projects implemented by Abt Associates, our Association, all of the practitioners in our countries and myself personally have come to understand evidence-based medicine, clinical practice guidelines, family medicine, safe motherhood practices, infection control, TB and HIV/AIDS care, and skills for communicating with patients. Social workers and psychologists are now a part of primary and secondary care. When these new approaches were introduced, they were revolutionary for our countries, and many health care workers were skeptical and angry about these new approaches. Today, no one working in the health care system would argue against any of these things.

Dr. Damilya Nugmanova, Director of the Kazakhstan Association of Family Physicians

BETTER HEALTH THROUGH DATA

As the countries of Central Asia began developing new structures and practices in their health care systems, antiquated forms and processes undermined some of their work. During the Soviet era, data was collected according to strict instructions and the facility level analyzed neither trends nor results. As a result, upon independence, administrators had little training or experience in how to use or analyze data, even if they had access to it.

To help the countries of Central Asia use data for decision-making, USAID introduced computerized management information systems (MIS). The MIS support each country's new health payment systems and provide policymakers and administrators with up-to-date data to help them improve services and outcomes. To date, more than nine million hospital cases have been recorded in the Kyrgyz Republic Mandatory Health Insurance Fund database, and Kazakhstan has nearly double that number.

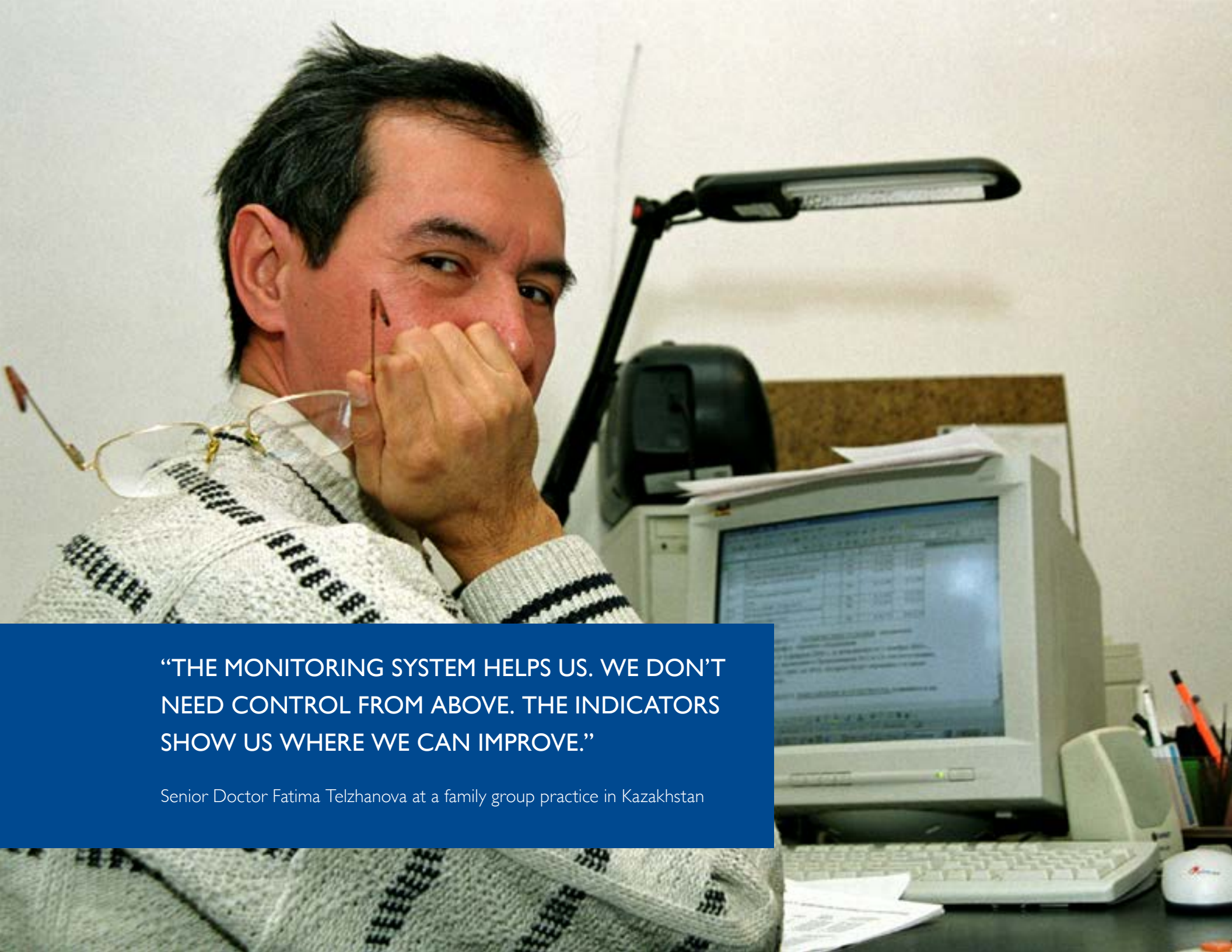
These electronic information systems, which supported the new health financing mechanisms, allowed for the implementation of clinical practice changes. For example, the reduced hospitalization stays that were part of the Safe Motherhood program would not have been possible if doctors had lost money by implementing them. Shifting to payment per hospital case allowed matching of payment to priority services and populations as well as retention of savings and reinvestment in Safe Motherhood and improving maternal care.

Health care workers and administrators appreciated the new MIS systems since they reduced the time to complete many routine data collection and monitoring tasks. As time passed, health care providers also observed trends and used them to improve patient outcomes. Reacting to these obvious improvements, ministries promoted and expanded information systems on their own.

The Ministry of Health of Turkmenistan, for example, used national resources to expand the health information system USAID introduced beyond the initial 14 hospitals to the rest of the country. In Kazakhstan, the government supported the creation of a national electronic quality assurance system for maternal and child health care, family planning, and reproductive health.

Through almost all of its activities, USAID promoted an understanding of data collection and use among national partners. At the policymaking level, USAID helped officials analyze data and use it to create policies for health care improvements. This approach influenced the content of more than 700 new national health care policies, which include evidence-based and WHO-supported standards for treating patients.

At the facility level, USAID helped individual providers review outcome indicators from their work with patients to determine and address possible reasons for above or below average performance and to target quality improvement efforts. In Kazakhstan, a monitoring system collected and analyzed data around 15 PHC indicators, which a number of facilities reviewed and discussed. That created productive competition that improved everyone's performance. The data also revealed facility-



"THE MONITORING SYSTEM HELPS US. WE DON'T NEED CONTROL FROM ABOVE. THE INDICATORS SHOW US WHERE WE CAN IMPROVE."

Senior Doctor Fatima Telzhanova at a family group practice in Kazakhstan

level and system-level barriers to improving quality that were addressed by the oblast health department.

Across Central Asia, better data collection systems and health care providers who are empowered to use them have created an environment in which quality improvement is part of the day-to-day work of everyone in the system, from policymakers and administrators to doctors and nurses.

USING EVIDENCE AND BEST PRACTICE TO IMPROVE CARE

Despite the fact that Central Asia had an extensive network of hospitals and specialists, patient outcomes in the early 1990s were poor. Clinics and hospitals were inadequately equipped, and doctors' and nurses' university training had been largely theoretical. Doctors followed outdated, codified clinical practices, many of which had been developed in Moscow decades earlier. In response, USAID introduced evidence-based medicine to update and upgrade medical practices. Evidence-based medicine advocates that, to the greatest extent possible, health workers base their practice on the results of rigorous research.

USAID worked with partners to establish evidence-based medicine centers in Kazakhstan, the Kyrgyz Republic, Tajikistan, and Uzbekistan. These centers began working with thought leaders who would be vital in influencing the development of evidence-based health care policies while providing training and serving as a resource for health care workers.

Throughout the region policymakers were so persuaded of the value of evidence-based medicine that they made significant changes to policy.

- In the Kyrgyz Republic, Tajikistan, and Uzbekistan, evidence-based medicine is now a required part of pre-service curricula at national medical schools.
- Kazakhstan used national funds to create further evidence-based medicine centers at each of its medical universities and at its Republican Health Development Center.
- Ministries of Health in the Kyrgyz Republic, Tajikistan, and Kazakhstan have adopted national methodologies that call for evidence-based precepts to be used in the development of all treatment guidelines that doctors use.
- In just the past five years, policymakers have written and put into practice more than 110 of these evidence-based guidelines and protocols for physicians, helping ensure that doctors use treatment practices that result in improved health outcomes for patients.

While policy changes are vital to improvements in medical practice, national governments recognized that they might not be sufficient to affect changes in provider practice. Therefore, USAID also supported partners at the facility level to introduce health care workers to a system called continuous quality improvement (CQI). A methodology that originated in the manufacturing industry, CQI focuses on a cycle of identifying problems, finding their causes, and pinpointing interventions to improve outcomes, which are tracked by measurable indicators.

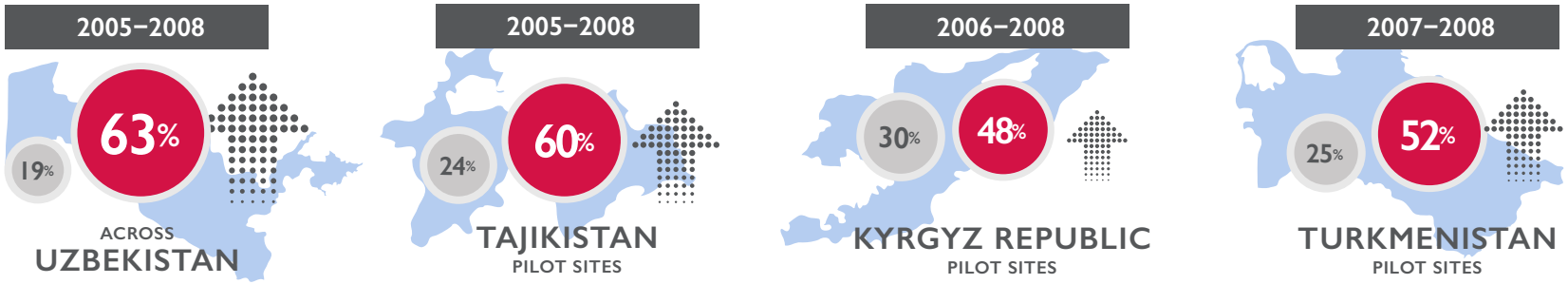
"WE AREN'T LIVING IN 1995. WE AREN'T EVEN LIVING IN 2000. NOW, WHATEVER WE DO, WE NEED TO USE EVIDENCE-BASED PRINCIPLES."

Dr. Alamkhon Akhmedov, Director of Tajikistan's Post Graduate Medical Institute

"QUALITY IMPROVEMENT HAS A VERY POSITIVE EFFECT ON THE CLINICAL LEVEL BY HELPING US SHOW THE IMPACT OF OUR INTERVENTIONS AND BY HELPING US TO REACH THE GOALS WE ARE ALL STRIVING FOR IN IMPLEMENTING EVIDENCE-BASED PRACTICES."

Dr. Svetlana Zoy, Deputy Chief of the Tashkent Oblast Health Department

THE PERCENTAGE OF HEALTH CARE WORKERS ADHERING TO EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES (CPGS) FOR DELIVERIES:



Source: USAID Project Monitoring data.

While CQI was used across the region to address a wide variety of diseases, partners early on wanted to focus on high blood pressure because Central Asia has one of the highest cardiovascular disease burdens in the world. Results from this work show the power of evidence-based medicine combined with CQI.

- In Uzbek pilot sites, accurate diagnosis of arterial hypertension rose to 100% in pilot facilities, compared with around 68% in non-pilots.
- In Kyrgyz pilot sites, the percentage of patients with diagnosed hypertension whose blood pressure was in the target range during their most recent primary care visit increased from 12% to 53% due to improved management of the condition.
- In Kazakh pilot sites, the percentage of patients with hypertension requiring emergency treatment fell from 14% in 2006 to 4% in 2011.

These kinds of outcomes were seen all over the region. As a result, governments expanded their use of evidence-based guidelines through CQI approaches from rayons to entire oblasts and almost entire countries.

- The Kyrgyz government adopted a National Quality Improvement policy, and as a result about half of family medicine practices nationally use CQI approaches.
- In Tajikistan, all 36 USAID-supported pilot facilities use CQI approaches.
- In Uzbekistan, a USAID-designed CQI training program was integrated into the general practice retraining program. The percentage of facilities using quality improvement approaches grew from two in 2005 to 38 in 2008.

"BEFORE I FELT BAD WHEN I COULDN'T DIAGNOSE A CONDITION AND HAD TO REFER MY PATIENTS TO ANOTHER SPECIALIST. NOW I FEEL LIKE I CAN TREAT THE WHOLE PATIENT AND IT MAKES ME FEEL PROUD OF MY WORK AND OF COURSE MAKES THE LIVES OF MY PATIENTS MUCH EASIER."

Dr. Mukadas Madaminova, a family doctor trained by USAID in Dushanbe, Tajikistan

"WHEN I GO TO RURAL HOSPITALS TO DO MONITORING, I SEE HOW EFFECTIVE THE TRAININGS WERE. IT HAS A GREAT IMPACT. WHEN I FIRST SAW THIS, I COULDN'T SLEEP. I JUST THOUGHT ALL DAY AND NIGHT ABOUT HOW I COULD SHARE THIS INFORMATION!"

Dr. Ulya Kurmanalieva, Head of the Children's Ward at the Koch Kor Hospital and National IMCI Trainer, Kyrgyz Republic

- Thanks to the introduction of CQI at a pilot site in Kazakhstan, the Ministry of Health saw primary care providers could provide family planning services previously only available from gynecologists and changed the law to allow them to do so nationally.

With this degree of institutionalization at both the policy and facility level, more and more doctors are using evidence-based guidelines to treat their patients, which will improve health outcomes in Central Asia for years to come.

IMPROVED DIAGNOSTICS

In the Soviet system of specialized clinics, each separate clinic had its own labs. The many different specialists one patient might see for one simple ailment at times led to duplication of laboratory tests by different doctors at different facilities. This redundancy and bureaucracy led to the type of waste that the newly independent Central Asian republics could ill afford. The quality of lab equipment and availability of supplies and reagents decreased with the declining health budgets in the early 1990s. At the same time, conditions such as TB and HIV were becoming more prevalent in Central Asia, requiring new testing methods and tools.

To help address these issues, USAID worked with other development partner such as the World Bank, the Asian Development Bank, WHO, the United Nations Development Program (UNDP), the Centers for Disease Control and Prevention (CDC), Doctors without Borders, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). Together they helped the countries of Central Asia develop a network of effective, efficient laboratories at the primary care level and develop greater capacity in the region's TB laboratories.

USAID introduced WHO-recommended methods for assuring the quality of sputum microscopy testing for tuberculosis, including blind rechecking of representative test slides by a higher-level lab. Any discrepancies in slide results are addressed with support from the national lab system. USAID supported national rollout of EQA in Kyrgyzstan and Tajikistan, and limited rollout in Kazakhstan (one oblast) and Uzbekistan (covering 40% of the countries TB labs). Further, USAID introduced Quality Management Systems (QMS) for labs doing TB testing in selected geographical areas in all five countries. QMS covers all aspects of laboratory operations—such as infection control, equipment maintenance, and supply management. Thanks to these changes, patients now can receive quick, convenient diagnostics for a large number of conditions.

585
GOOD FRIEND

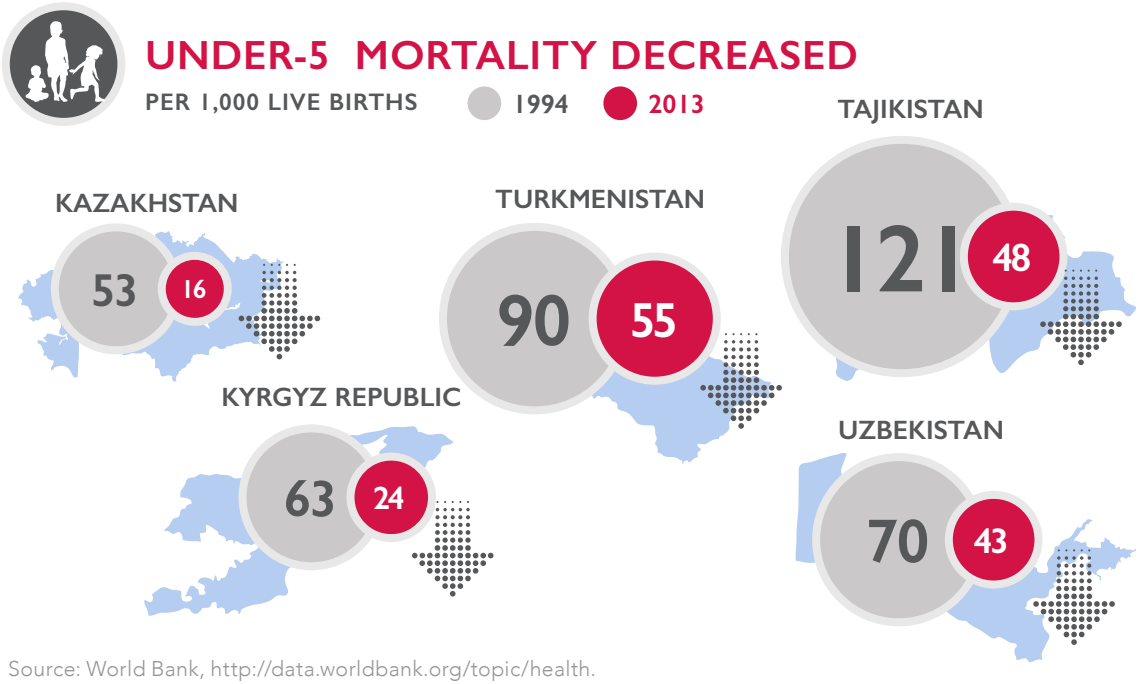
KEEPING CHILDREN HEALTHY

To give all children in Central Asia the opportunity to grow up to be healthy, successful adults, USAID has worked with governments and communities to implement a series of evidence-based interventions that improve the knowledge and skills of health care workers who care for children and parents.

As with all of USAID's health work in Central Asia, activities to improve maternal and child health center on close partnership with national organizations to ensure local ownership by government and local organizations from the start. USAID cooperated with the Kyrgyz Republic State Medical Institute for Retraining and Continuous Education, the Kazakhstan Mother and Child Center, the Turkmenistan Mother and Child Health Institute, the Tajikistan Institute of Pediatrics, the United Nations Children's Fund (UNICEF), the WHO, and the World Bank.

Together, they supported the training of thousands of primary care doctors, nurses, physicians' assistants, medical students, and community health workers in the WHO's Integrated Management of Childhood Illness (IMCI) program. IMCI teaches health care workers to recognize and treat common illnesses and to counsel parents on proper child development, disease prevention, and nutrition. These efforts had effects across the region with national passage of IMCI-related policies.

- In Turkmenistan, the Ministry of Health and Medical Industry mandated inclusion of IMCI in the curriculum of the country's six major medical schools. The government has included an IMCI strategy in each of the national maternal and child health plans since 2008.
- Likewise, both Kazakhstan and Tajikistan have adopted IMCI as an integrated national policy.
- In the Kyrgyz Republic and Tajikistan, IMCI is now a part of medical education at all levels.



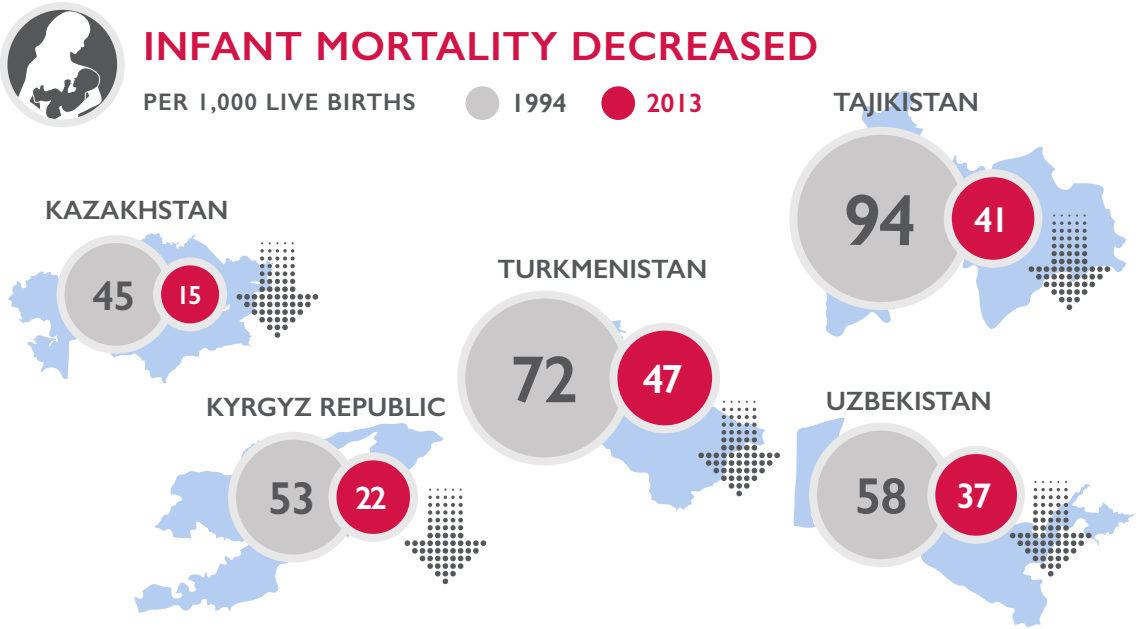
Source: World Bank, http://data.worldbank.org/topic/health.

USAID also worked with partners to train community health providers, parents, children, and community members in healthy practices. In the Kyrgyz Republic, USAID brought evidence-based health information to children and their families by supporting the Ministry of Education's introduction of the groundbreaking Healthy Schools Program in 956 mostly rural schools. That represented more than 40% of the country's schools.

In Turkmenistan, USAID supported TV, radio, and live "infotainment," including puppet shows and street festivals, to get out the messages. Afterward, average residents demonstrated improved knowledge about potentially lifesaving practices, such as hand washing, treatment of childhood diarrhea, and breastfeeding. For example, a national survey in 2000 showed that 62% of the population of Turkmenistan thought a child with diarrhea should receive much less food than usual—a dangerous practice.* After USAID's work in the town of Farab, Turkmenistan, near the Uzbek border, only 11% felt that a child with diarrhea should be fed less than normal. Since poor sanitation makes childhood diarrhea quite common in much of Central Asia, this cultural change will have enormous consequences for children's health.

USAID-supported interventions contributed to dramatic improvements in quality of care and health outcomes for Central Asian children and infants: Stunting prevalence across the region fell from 35% to 14% between 1995 and 2015.

- Every country in the region saw dramatic decreases in child mortality rates across age groups, as illustrated on the right.
- In the Kyrgyz Republic, children under five with diarrhea receiving oral rehydration therapy—an evidence-based inexpensive mix-at-home powder similar to Pedialyte—increased more than 200% between 2006 and 2012; in Tajikistan where usage was already higher, an increase in use of the powder rose 25% between 2005 and 2012.
- The number of newborns receiving unnecessary vitamin infusions in the Kyrgyz Republic dropped from 40% before implementation of Effective Perinatal Care interventions, to 1% in 2014.



Source: World Bank, http://data.worldbank.org/topic/health.

* Turkmenistan DHS Survey, 2000.

SAFER MOTHERHOOD

Upon independence, the Central Asian Republics had the highest maternal mortality of all of the former Soviet Union countries. In several of the new countries, these rates rose even further as health systems began to crumble. In Tajikistan, the maternal mortality rate spiked from 94 per 100,000 live births at independence in 1990 to 160 per 100,000 in 1995. In the same period, the trend rate rose from 73 to 98 in the Kyrgyz Republic and from 82 to 94 in Turkmenistan. By comparison, in 2013 Norway's maternal mortality rate was 6 per 100,000 and Afghanistan's was 400 per 100,000.*

To change these outcomes, USAID worked with partners to implement evidence-based, patient-centered standards of practice for safe deliveries and emergency obstetric care.

The first major maternal health program implemented by USAID in Central Asia was the WHO effective perinatal care (EPC) program, focused primarily on de-medicalizing deliveries, while providing evidence-based, woman-centered care. The EPC program helps reduce the chances of infection and prepares teams of health providers to address potentially life-threatening medical conditions such as pre-eclampsia, postpartum hemorrhage, and perinatal asphyxia, which require specialized emergency care. EPC teaches providers how to reduce the number of unnecessary lab tests, lengthy hospitalizations, and caesarian deliveries.

USAID used the EPC program to introduce simple, low-cost approaches. To further improve care during pregnancy, USAID introduced an antenatal care (ANC) program for midwives,

* World Health Organization Global Health Observatory.

"WITH IMPLEMENTATION OF EFFECTIVE PERINATAL CARE TECHNOLOGIES, PATIENT SATISFACTION HAS INCREASED: WOMEN EXPRESS THEIR GRATITUDE THAT THEY CAN BE ACCOMPANIED BY THEIR PARTNER DURING THE BIRTH, THAT THEY ARE ABLE TO MAKE AN INFORMED CHOICE ABOUT THEIR BIRTHING POSITION, THAT THEY CAN RECEIVE NON-MEDICAL PAIN RELIEF DURING LABOR, AND FOR THE COUNSELING ON BREASTFEEDING THAT WE PROVIDE."

Dr. Damira Seksenbaeva, Obstetrician-Gynecologist at the Bishkek Perinatal Center, Kyrgyz Republic

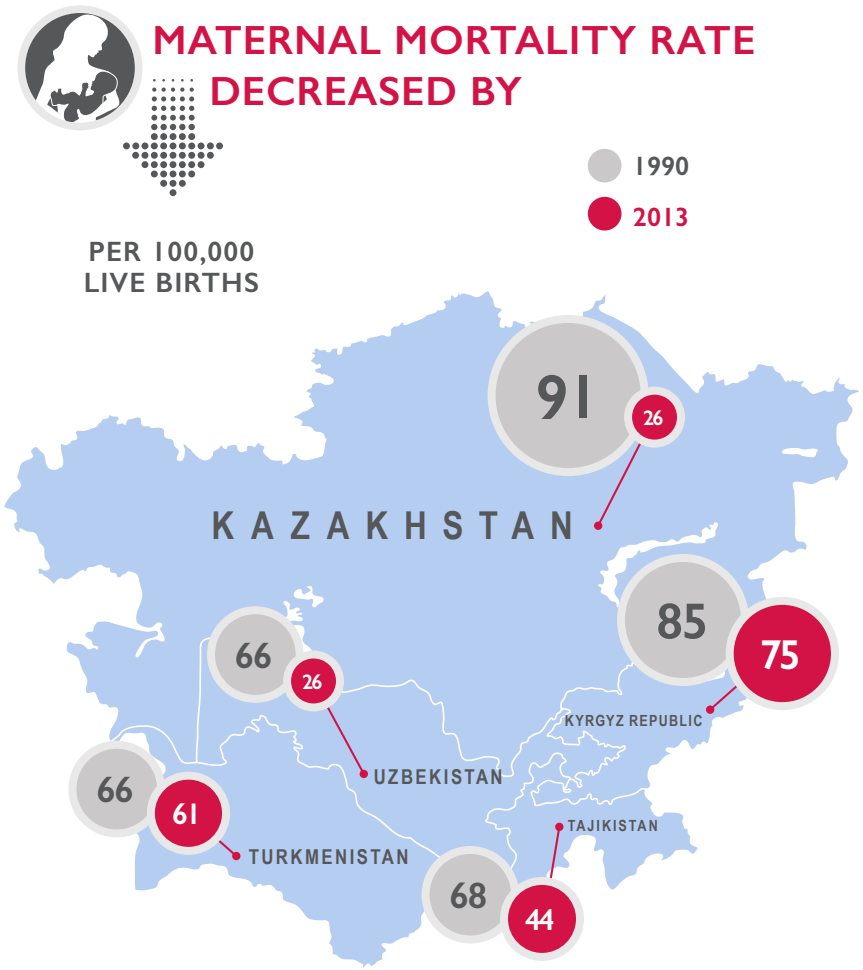
obstetricians, and family doctors. Region-wide, USAID worked in close collaboration with the United Nations Population Fund (UNFPA) and other agencies to maximize geographic coverage of these programs.

To prepare expectant mothers and fathers for the birthing process and what comes after it, USAID supported 20 birth preparedness schools in Kazakhstan, the Kyrgyz Republic, Tajikistan, and Turkmenistan. The schools educate and empower pregnant women and involve their partners in preparing for labor, delivery, and infant care.

These interventions have had a huge impact on providers and practices, with dramatic increases in areas such as the percentage of women prescribed folic acid and number of partner-assisted deliveries.

- In six focus regions of Tajikistan, the percentage of women screened for pre-eclampsia rose from 25% to 88%.
- The percentage of deliveries in which the health care worker used active management of the third stage of labor increased from 46% to 99% in those regions. The technique can significantly reduce the likelihood of postpartum hemorrhage.
- In nine target regions in the Kyrgyz Republic, there was an increase from 28% to 98% in the percentage of pregnant women receiving counseling in the first five months of their pregnancy to ensure they knew danger signs that would require medical assistance.

Altogether, these types of improvements have contributed to regional reductions in birthing complications and maternal mortality. The result is many happier, healthy mothers and babies across Central Asia.



Source: World Health Organization Global Health Observatory.

IMPROVING INFECTION CONTROL PRACTICES

As budgets declined after the fall of the Soviet Union, the infrastructure began to crumble. In some rural areas, hospitals found themselves without running water. It became harder to ensure that visitors to health care facilities didn't catch infections from other patients. Further complicating matters, government bodies responsible for infection control often used outdated protocols—sometimes over-sanitizing and sometimes neglecting simple steps that prevent infection. As facilities sat without money for repairs, infectious TB patients were hospitalized next to non-infectious TB patients.

To address these issues, USAID worked with national partners to create up-to-date infection control plans, policies, and clinical practice guidelines, including policies and guidelines for TB and maternal and child health. In the Kyrgyz Republic, USAID worked with the Sanitary Epidemiological Service (SES) to change financing policies to ensure that these agencies, which monitor all infection prevention and control practices, had adequate funding to fulfill their role. SES was previously funded through fee-for-services and fines, a system that discouraged medical facilities from using their services to save money and to hide problems and risks to avoid fines.

At the same time that financial systems were updated, USAID trained SES workers in new guidelines and practices and helped them move away from past policies of strict oversight to more supportive supervision. Health care workers at facilities throughout Central Asia were also trained and mentored in new practices. USAID encouraged simple administrative changes to improve infection control—such as having facilities install sinks and purchase soap and towels for every room. USAID also emphasized facility-level management improvement and continuous quality improvement.

To increase adherence to infection control practices by healthcare providers, USAID encouraged undergraduate medical institutes to include the new infection control guidelines and training modules in their curricula. Family medicine trainers helped rapidly disseminate the new infection control guidelines to nurses and doctors throughout the region.

These efforts have had a major effect on infection control practices. For example, TB infection control surveillance conducted in TB laboratories in Chui Oblast in the Kyrgyz Republic by SES and the national Center for Infection Control reported that among eight rayons and one city, all but two were assessed at over 70% compliance with recommended TB infection control measures.

MOVING TB TREATMENT CLOSER TO HOME

Most TB sanatoriums in the West closed down in the 1950s as antibiotics became available to treat TB, and treatment could take place on an outpatient basis. But in the Soviet Union, TB patients continued to be hospitalized for their full course of treatment—often for more than a year. This was an enormous and unnecessary cost burden for the system and the patient. In the late 1990s, USAID and other donors supported the introduction of the WHO-recommended Directly Observed Treatment (DOT) process.

"Directly observed"means that as patients take a course of several antibiotics, someone else, generally a health care worker, observes them swallow the medication. Thanks to DOT's introduction, patients are able to leave the hospital mid-way through treatment and continue their treatment on an outpatient basis.

Beginning 2011-12, the Governments of Tajikistan and the Kyrgyz Republic asked USAID to help them implement WHO recommendations that TB be treated

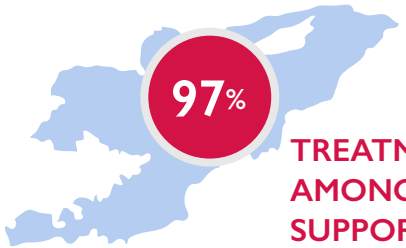
completely in outpatient settings to improve patient quality of life and treatment outcomes and reduce costs associated with hospitalization. Under this internationally accepted approach, hospitalization is reserved for patients whose clinical condition is severe enough to require inpatient care or for those requiring services not offered in outpatient settings.

In 2012, both the Kyrgyz Republic and Tajikistan began to introduce fully outpatient TB treatment. With significant support from the German Development Bank (KFW), Tajikistan has already reduced the number of TB beds in the country by 40%. As USAID and partners began implementing outpatient treatment, a technological breakthrough helped them solve the major challenge of diagnosing the growing number of patients with forms of TB that cannot be treated with the normal medications. These hard to treat forms of TB are called drug resistant or multi-drug resistant (MDR) TB.

USAID purchased this new technology, called GeneXpert, for facilities in Tajikistan and the Kyrgyz Republic and provided training to laboratory technicians in Turkmenistan. The introduction of this new tool enables doctors to know whether a patient has active TB disease and whether the TB is drug-resistant within a matter of hours rather than months.

GeneXpert use in the first year demonstrated the effectiveness of this method of rapid diagnosis for TB/MDR-TB diagnosis, with 143% more TB cases identified using GeneXpert, compared with smear microscopy at the Kyrgyz Republic's Issyk-Ata rayon pilot site. Ninety-six percent of patients treated fully outpatient in this rayon over a one year period successfully completed their treatment. The government saved money by not having to hospitalize as many people. The patients were able to

KYRGYZ REPUBLIC



TREATMENT SUCCESS RATE AMONG OVER 500 PATIENT SUPPORT GROUP ATTENDEES

continue their daily lives during treatment. And the treatment success rates were much higher than seen in other areas of the country where hospitalization remained the standard.

In large part thanks to policy dialogue and demonstrated results from USAID, the Government of the Kyrgyz Republic has included the move to full outpatient TB treatment in its national plans. With support from USAID and other donors, the country will have a GeneXpert machine in each of its eight oblasts by the end of 2015. Tajikistan also plans to roll-out the new technology nationwide, ensuring that easier, faster, more effective TB tests are available to more patients. As a result, cases will be caught and treated early, reducing further spread of the disease.

ЭМЧЕК ЭМИЗҮҮНҮН ПАЙДАЛАРЫ
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IMPROVING ACCESS TO FAMILY PLANNING

Enabling couples to determine whether, when, and how often to have children is vital to safe motherhood and healthy families. Increasing access to reproductive health services, including voluntary family planning, has profound health, economic, and social benefits for families and communities. Worldwide, USAID works to help countries address the unmet need for modern contraceptive methods by providing access to reliable family planning methods for women who express interest in delaying a first pregnancy, in spacing births, or who do not want more children.

In Central Asia, UNFPA, the United Nations Population Fund, took the first steps to address access to effective family planning and reduce abortions. USAID worked in concert with UNFPA and other donors to address the particular family planning challenges that affected the region.

In Central Asia at independence, access to and choice of modern family planning methods were limited. As elsewhere in the former Soviet Union, abortion was quite commonly used as a family planning method. In some areas of the region, it was not uncommon for IUDs to be inserted post-partum without a woman's permission. At the same time, women in rural areas who did want an IUD might have to travel to the city to obtain modern contraceptives at a facility with a gynecologist on staff, while others could not afford to take the trip.

To provide all Central Asian couples with high-quality counseling and their preferred form of family planning, USAID has worked to integrate family planning services into the primary health care system and to improve access to both contraceptives themselves and to accurate information about modern contraceptive methods.

USAID taught family medicine trainers about family planning and trained more than 200 rural midwives to expand family planning services to women who least frequently received them. Maternity hospital doctors and nurses were instructed on post-abortion and post-partum family planning counseling. USAID provided limited quantities of contraceptives and worked with partners such as the UNFPA to ensure that reproductive health commodities were available to patients throughout the region.

At the same time, USAID focused on ensuring that evidence-based national protocols and policies on modern family planning methods were in place in all of the Central Asian countries. USAID also ensured that national family planning trainers in each country could conduct training and follow-up mentoring and monitoring on family planning

All of these interventions have played a role in creating positive changes for women in the region.

- The Kyrgyz Republic saw an impressive increase in postpartum family planning counseling from 57% in 2006 to 88% in 2008.
- Also in the Kyrgyz Republic, the percentage of rural rayons without gynecologists where family planning services are now available thanks to USAID training rose from 8% to 69% between 2005 and 2008.
- Abortion rates have also decreased across the region, as illustrated on page 55.

"NOW I CAN INSERT AND REMOVE IUDS AND DISPENSE BIRTH CONTROL PILLS, CONDOMS, AND GOOD ADVICE."

Dogunbubu, midwife, Kyrgyz Republic

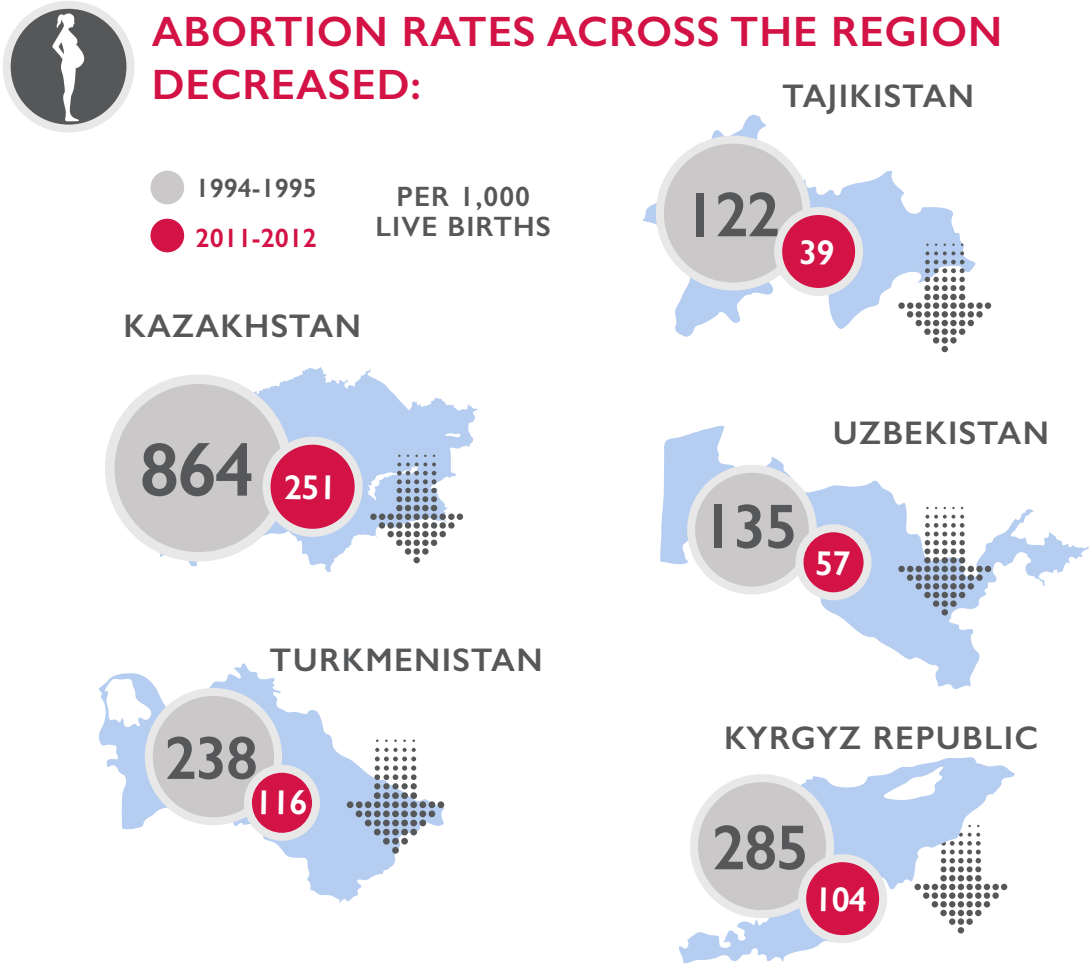
"WOMEN COME TO ME AND SAY, 'WHY COULDN'T YOU DO THIS BEFORE? GIVE THANKS TO THOSE WHO TAUGHT YOU HOW TO DO ALL THIS. IT IS CHEAPER FOR US THAN TRAVELING TO THE CITY."

Chinara, midwife, Kyrgyz Republic

Despite these increases in access to and use of services, many challenges remain. Family planning still has not been fully integrated into the primary health care system, and there is a lack of coordination between specialists and general practitioners. Training programs for future doctors and nurses need to be improved to help resolve this issue.

Members of vulnerable groups, such as migrants, youth, and the poor, still face challenges in accessing contraceptives, and in some cases, even understanding the concept of modern family planning. Some progress has been made, particularly in Turkmenistan and the Kyrgyz Republic. But in most Central Asian countries, low-cost or free contraceptives are available under state programs only through donations from international organizations. As a result of these barriers, and perhaps also the return to traditionally larger families in Central Asia, the percentage of women of reproductive age who use modern contraceptives is still low, as evidenced by the most recent Demographic Health Surveys in the Kyrgyz Republic and Tajikistan.

Still, as USAID's family planning and reproductive health programming leaves the region, it leaves behind policies, guidelines, and many trained instructors and practitioners. That legacy will help Central Asia continue down a path that enables all women to choose the best means to maintain their reproductive health.



DRAMATIC DECREASES IN ABORTION RATES HAVE COINCIDED WITH INCREASED ACCESS TO FAMILY PLANNING

Source: European Health for All Database.

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FASTER, EASIER HIV TESTING

Though significant investments had been made in Central Asia to scale up HIV testing and counseling, testing rates among key populations at higher risk accounted for less than 2% of all HIV testing in all Central Asian countries. Health care workers across the region reported that many individuals diagnosed with HIV came to the health care system in the later stages of the disease, when they already had AIDS-defining illnesses.

Because studies have shown that the most effective way to reach more key populations is to make testing community-based and accessible outside of brick-and-mortar health care institutions, USAID intervened to help partners provide rapid HIV testing at Kyrgyz non-governmental organizations (NGOs) and Tajik primary care facilities that already served key populations. In Tajikistan, USAID also worked with Global Fund medical mobile outreach units to expand their services to include rapid testing. As a result, more individuals at higher risk are being tested in the two countries.

In the Kyrgyz Republic, 19 NGOs in 10 cities began offering rapid testing, providing nearly 11,000 tests to key populations between November 2012 and March 2015. An assessment conducted in 2013 showed the following:*

- These NGOs saw the greatest increase in testing among men who have sex with men, with the number of tests among this group rising from the pre-intervention annual average of 30 individuals to 185 in the first five months of the pilot.
- Provision of rapid testing by NGOs had improved NGO and AIDS Center collaboration at the vast majority of sites where the pilot program was introduced. It also found that the program had increased the ability of service providers to bring patients who had previously left the health care system back into care and treatment.
- Key populations also reported high satisfaction with the services they received at the NGOs, stating that the ability to receive testing from people they trust at known NGOs made them more comfortable receiving their tests and results.

NOTHING FOR US WITHOUT US

With USAID support, people living with HIV and individuals receiving medication-assisted therapy for drug addiction in Central Asia have formed Community Advisory Boards (CABs). The CABs are groups of clients with similar needs who work hand-in-hand with the management of the health care facility that serves them to make care more patient-friendly.

The efforts of these groups make it more likely that patients seek care and keep coming back to the facility. CABs can help those most at risk of contracting or transmitting HIV who nevertheless avoid health care facilities for fear they will be judged, or who do not stick with care because it does not take their unique needs into account.

A total of 12 CABs have been created in the region. Each one has begun resolving long-standing issues affecting their constituents' quality of

* Bolotbaeva, Aisuluu. 2013. Mid-term review of pilot NGO-based voluntary counseling and rapid testing for HIV program in Kyrgyz Republic. United Nations Development Programme Grant Implementation Unit, Bishkek, Kyrgyzstan. [Unpublished draft]

USAID'S APPROACH TO FIGHTING HIV IN CENTRAL ASIA

The combined efforts of a large group of international and local entities, including the Global Fund, PEPFAR, USAID, CDC, regional governments, and other donors, have kept HIV transmission in Central Asia from spreading widely through the general population. Today, HIV is primarily concentrated among "key populations," including men who have sex with men, people who inject drugs, sex workers, and transgender persons. To respond to the needs of these populations in a way that helps them seek out and stay in treatment, USAID has worked consistently with National AIDS Centers across Central Asia to create an HIV system that is more patient-centered and welcoming. These efforts have contributed to the strengthening of referral systems that enable civil society and government agencies to work together to make sure that patients seek out and receive the services that they need. At the same time, USAID's efforts have focused on strengthening the communities of key populations so that they are more empowered and able to advocate effectively for their needs.

In early years, USAID's national-level work supported research into the issues that affected HIV patients and the systems that treated them. USAID also contributed to the development of monitoring and evaluation systems, including the creation of a unified surveillance system that can be used by all government entities to target HIV interventions. As national policymakers adapted treatment protocols and care standards, USAID provided technical guidance and support. To implement these new standards and improve diagnosis and treatment at the facility level, USAID provided training and mentoring of health personnel. In cooperation with the CDC SUPPORT Project, USAID provided focused assistance to increase the historically low levels of HIV testing among key populations in Central Asia.

More recently, USAID has worked with partners to implement national policies that define a comprehensive package of services that should be available for each key population to prevent, diagnose, treat, and provide supportive care for HIV. These comprehensive packages follow guidance created by WHO, the United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Response on HIV/AIDS (UNAIDS). As part of the development process, USAID conducted workshops with the NGO community in each country to determine how civil society could help provide each service in the comprehensive package.

This development of a formal, policy-based role for civil society is a novel idea in Central Asia's HIV programming and signals a commitment to a more patient-centered response. Three sets of comprehensive packages were developed in Kazakhstan, the Kyrgyz Republic, and Tajikistan, one designed to support people who inject drugs, one for sex workers, and one for men who have sex with men.

While the full impact of these policy changes remains to be seen, Central Asia is now a global leader in developing plans and policies for full implementation of comprehensive packages of services for key populations. With the full weight of these comprehensive packages behind them, any person who injects drugs, engages in sex work, or identifies as a man who has sex with other men can receive a full range of services to prevent, diagnose, treat, and care for HIV infection—all provided by law. From the perspective of the individual, USAID's work in this area has supported access to health as a human right. From an epidemiological perspective, USAID has strengthened national HIV responses by taking one more step toward unencumbered access to health care services for key populations.

For more information, please see: USAID Quality Health Care Project- KAZAKHSTAN HIV Closeout Video 2015 https://youtu.be/3FYcG_YUBME.

care. In Almaty, Kazakhstan, the City AIDS Center CAB was able to convince the Center to use existing funds to purchase new clinical monitoring equipment, enabling accurate monitoring of T-4 cell count. T-4 cells, also known as CD4+ cells, are a type of white blood cell that helps protect a person from viral infection; a decrease in T-4 count means that the immune system is not functioning as it should. Since introduction of the new machine in Almaty City in 2014, 5,000 people have received test results.

A CAB in Dushanbe, Tajikistan, for those receiving medication-assisted therapy for drug addiction worked with a clinic liaison to end police harassment. In both countries, CAB members have reported that their efforts have resulted in increased availability of medication for HIV patients.

Thanks to the CABs, these at-risk and marginalized communities have come to have their opinions respected and taken into account by their health care providers as the providers work to increase accessible, high-quality care for their patients.

SAFE, EFFECTIVE, AND ACCESSIBLE MEDICINES

As the countries of Central Asia transitioned to market-based economies, thousands of new, often unregulated drugs were introduced, making it difficult for both doctors and patients to select safe and effective pharmaceuticals. USAID stepped in with a series of interventions to improve the availability, quality, control, and use of medication in the region. USAID had plenty of help, including partners such as the Medicines Transparency Alliance, Pharmacists Sans Frontières, WHO, the Asian Development Bank, and the International Center for AIDS Care and Treatment Programs (ICAP)/CDC.

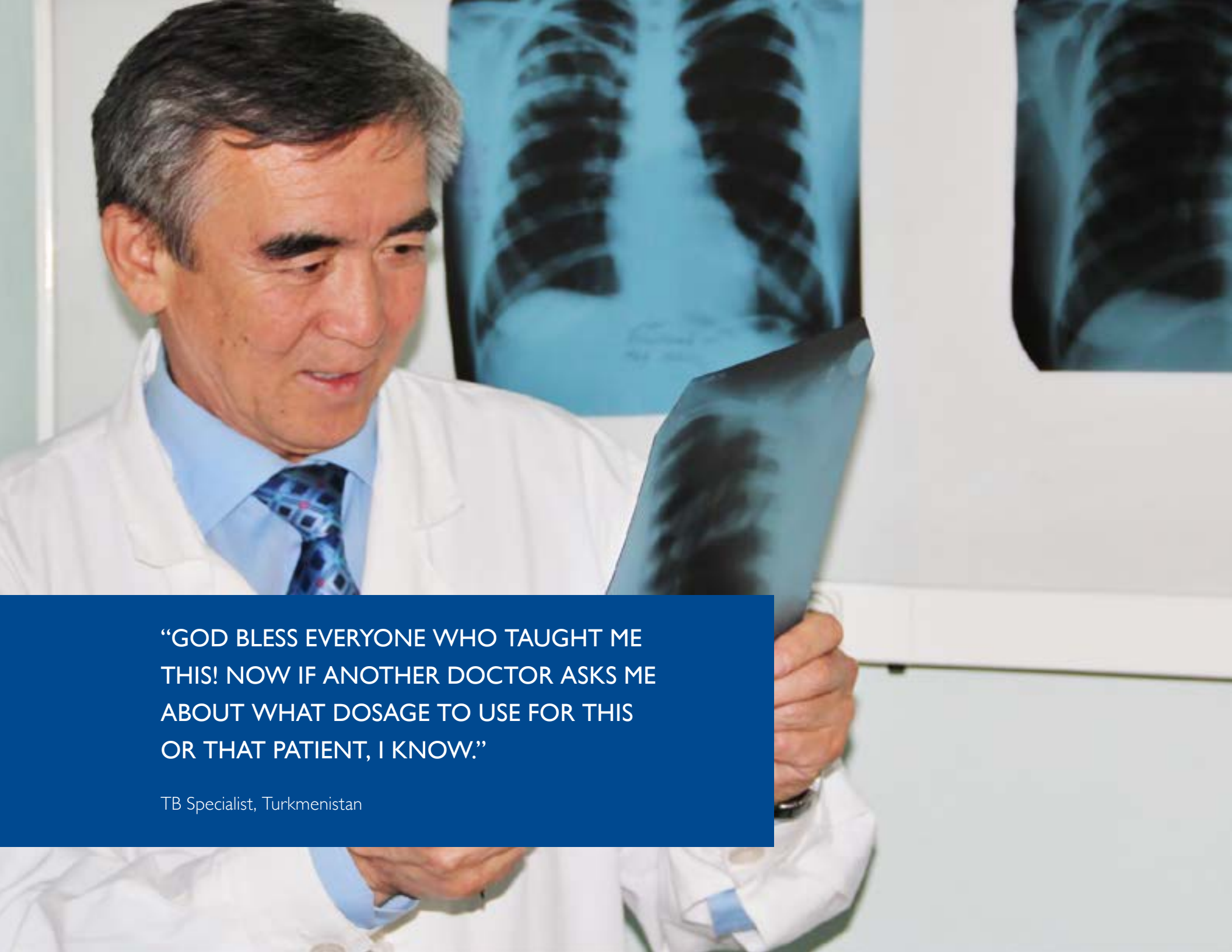
USAID and partners supported the creation of drug information centers in Kazakhstan, Tajikistan, and Uzbekistan to research, develop, and provide health care workers and consumers with appropriate treatment guidelines. These centers worked with USAID experts to create and promote essential drug lists for every Central Asian country to help reduce widespread use of non-evidence based pharmaceuticals.

USAID also worked with national partners to increase the availability of the medications that appear on these lists and to bring down their cost by improving planning and management capacity for inventory control and ordering practices, often by building computerized systems. Since introducing such a system for HIV medications in Tajikistan. The number of HIV patients receiving medication rose from 1,082 in 2011 to 2,167 in mid-2015.*

USAID also worked at the facility level to improve doctors' prescribing practices. One such effort was the promotion of rational use of antibiotics by health providers and patients. USAID implemented antibiotic work with partners from Drug Information Centers, the Kazakhstan Association of Family Physicians, the Kyrgyz Family Group Practice and Nurses' Association, the Hospital Association of the Kyrgyz Republic, and national trainers in Turkmenistan and Tajikistan. Regional results were immediately impressive, showing reduced rates of unjustified prescriptions of antibiotics.

One leading stroke expert in the Kyrgyz Republic reported to his USAID partners the incredible results of their combined work. After discontinuing use of all non-evidence based

* Ministry of Health data.



"GOD BLESS EVERYONE WHO TAUGHT ME THIS! NOW IF ANOTHER DOCTOR ASKS ME ABOUT WHAT DOSAGE TO USE FOR THIS OR THAT PATIENT, I KNOW."

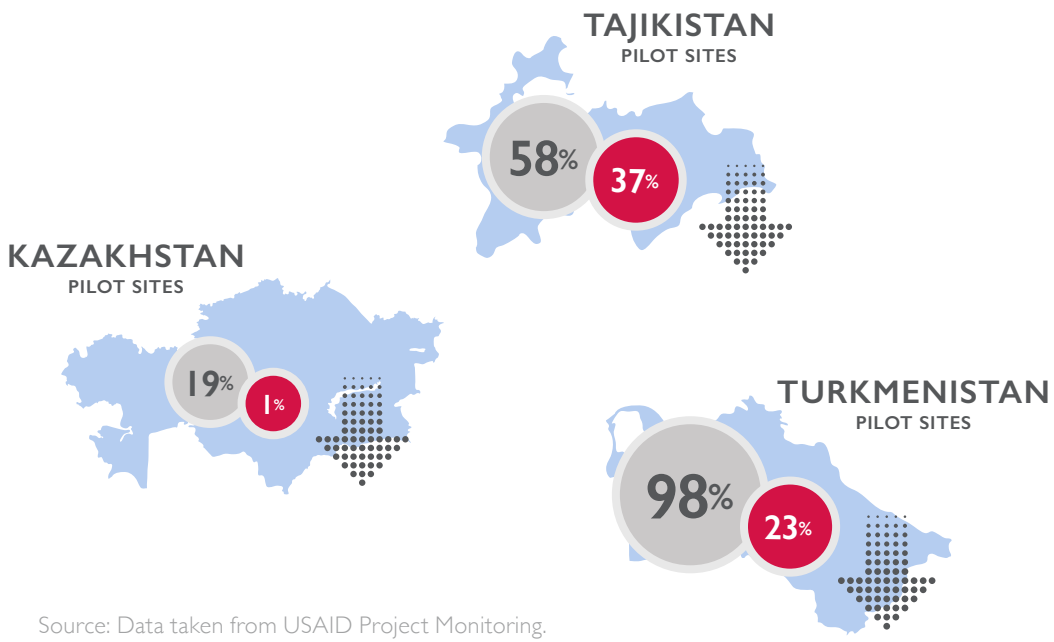
TB Specialist, Turkmenistan

medications for stroke patients as described in a new national guideline, costs decreased from $1875 per patient to $625 per patient without worsening outcomes. Most of that cost represented patient out-of-pocket expenses. These are the kinds of changes that improve the lives of patients everyday throughout Central Asia, thanks to the investments of USAID and its national partners.

ANTIBIOTICS ARE NOW RARELY BEING PRESCRIBED FOR THE COMMON COLD:

BEFORE USAID educational interventions under the Quality Project

AFTER USAID educational interventions under the Quality Project



Source: Data taken from USAID Project Monitoring. Work carried out in 2013-2014.

PUBLIC- PRIVATE PARTNERSHIPS FOR HEALTH

Throughout the years, USAID has used private sector resources to further US government funding for health care in Kazakhstan. Since 2004, USAID has used private sector resources by cooperating with ExxonMobil and the Kazakhstan Association of Family Physicians to support the Kazakh Ministry of Health's efforts to improve the quality of care for its citizens. The partners worked together to train health care providers on managing common upper respiratory disease and diarrhea in children and to educate the population on the related rational use of antibiotics. This cooperation has enabled USAID to reach more people with its interventions. It has also fostered the development of a working relationship between the local professional association and this key private sector partner to allow for further collaboration beyond the scope of USAID's activities in the region.

"THE TRAINING CONDUCTED BY THE QUALITY PROJECT INCREASED MY KNOWLEDGE AND SKILLS RELATED TO SOCIAL STATE FUNDING AND ASSISTED IN IMPROVING COLLABORATION BETWEEN NGO AND GOVERNMENTAL STRUCTURES."

Elena Bilokon Head of NGO "Moi Dom" and of the Kazakhstan Network of Women Living with HIV

GROWING CIVIL SOCIETY

The newly independent countries of Central Asia had weak civil society sectors. There were no grassroots organizations pushing for better access, lobbying for improved working conditions for health care workers, or reaching out to groups in society that might not be willing to go to their neighborhood health care facility. USAID saw that civil society needed development if overall political and system changes were to take root in the region.

Worldwide, non-profits and civil society organizations play a significant role in raising awareness of health issues. They advocate for changes in laws or service delivery to improve access to drugs or services. And they serve as a link between marginalized populations and health care workers. To empower these groups to improve the policies and practices that most affect them, USAID supported health policy and patient support NGOs through sustained training and capacity building.

In the early 2000s, USAID and the Soros Foundation implemented the Healthy Communities Grants Program. It provided grant funding and technical assistance to small NGOs to help them carry out community health work in all five countries, reaching 296 organizations by the end of the program. More recently, USAID supported the organizational and technical capacity of NGOs working with key populations.

In Kazakhstan, where HIV NGOs faced potential loss of funding due to the country's ineligibility to receive further Global Fund grants, USAID and national partners provided training and technical assistance to help them obtain government contracts through a long-standing Kazakh government social contracting program. Social contracting provides non-governmental service providers the opportunity to apply for contracts to undertake work in the public's interest on behalf of the government.

USAID worked with the NGO Zholdas to provide basic training for other NGOs and to facilitate NGO-government roundtables to increase the number of social contracts available and awarded for HIV prevention. As a result, 10 NGOs received funding for HIV prevention activities in 2013, and this success

KAZAKHSTAN:

STATE SECTOR FUNDING

NGOs
(NON-GOVERNMENTAL ORGANIZATIONS)

2013-2014

18 NGOs RECEIVED $1.3 MILLION FROM THE GOVERNMENT TO IMPLEMENT HIV PROJECTS FOR KEY POPULATIONS

"RESIDENTS OF ISSYK-KUL OBLAST ARE THANKFUL TO USAID BECAUSE WITH ITS HELP VILLAGE HEALTH COMMITTEES WERE CREATED IN THE OBLAST….THANKS TO USAID IT HAS GOTTEN EASIER FOR US TO ADDRESS HEALTH ISSUES IN OUR OWN COMMUNITY."

Anora Abdrazakova, a Health Promotion Specialist working in Issyk-Kul Oblast, Kyrgyz Republic

has continued. In the most recent round of grants (2013-2014), 18 NGOs trained by USAID and Zholdas received $1.3 million from the government to implement HIV-related projects for key populations.

USAID has also supported several non-profit organizations, including the Kazakhstan Association of Family Physicians, the Family Group Practice and Nursing Association (Kyrgyz Republic), and the Hospital Association (Kyrgyz Republic), to step up into the role of true professional associations as representatives and supporters of their constituents. All three of these organizations represent the interests of their constituents, work to improve the functioning of the health sector through training and monitoring, and provide policy inputs to the Ministry of Health.

Today, all kinds of NGOs take an active role in health promotion and support throughout much of Central Asia. Together, NGOs, their clients, and their new government allies are working together to improve health care services available for all.

EMPOWERING PATIENTS

Twenty years ago when USAID first came to Central Asia, patients often were skeptical of the quality of care they received and sometimes felt like victims of unresponsive health systems. To help patients feel that they had a stake in their own care, USAID introduced a variety of mechanisms to promote advocacy, choice, and better service and educate the public about their health.

At the policy level, USAID helped governments implement open enrollment systems that enable patients to use state funding to visit any provider they want to see. Under the Soviet system, patients were restricted to visiting doctors assigned to them based on where they lived or worked. The new freedom that citizens received through the open enrollment campaigns in Kazakhstan and the Kyrgyz Republic was immediately popular, with citizens flocking to register.

In cooperation with national agencies in each country, USAID worked through providers and non-profit and community groups to communicate information about exclusive breastfeeding and introduction of complementary foods, nutrition for pregnant women, and HIV prevention. USAID supported numerous interventions to raise population understanding of key health information. This included symptoms requiring medical attention, from danger signs in pregnancy or early childhood illness to potential TB symptoms.

In Uzbekistan, for example, 60% of children and women of reproductive age were shown to have an anemia. USAID supported a public education campaign against anemia in the Ferghana Valley region.* The campaign centered around a three-part, 70-minute TV soap opera, "Simple Truth." This custom-written soap opera tells the story of a typical Uzbek family and how anemia and a doctor's recommendations for curing it lead to family crises.

After many twists and turns in a plot involving suspicions of amorous encounters and family rifts, the local primary health care doctor convinces the mother-in-law that her family's anemia must be cured and persuades her to take responsibility for ensuring that the family is treated and eats right from now on. The

* Uzbekistan DHS Survey, 1996.

mother-in-law's influence not only changes the family's nutrition habits but also brings the family back together.

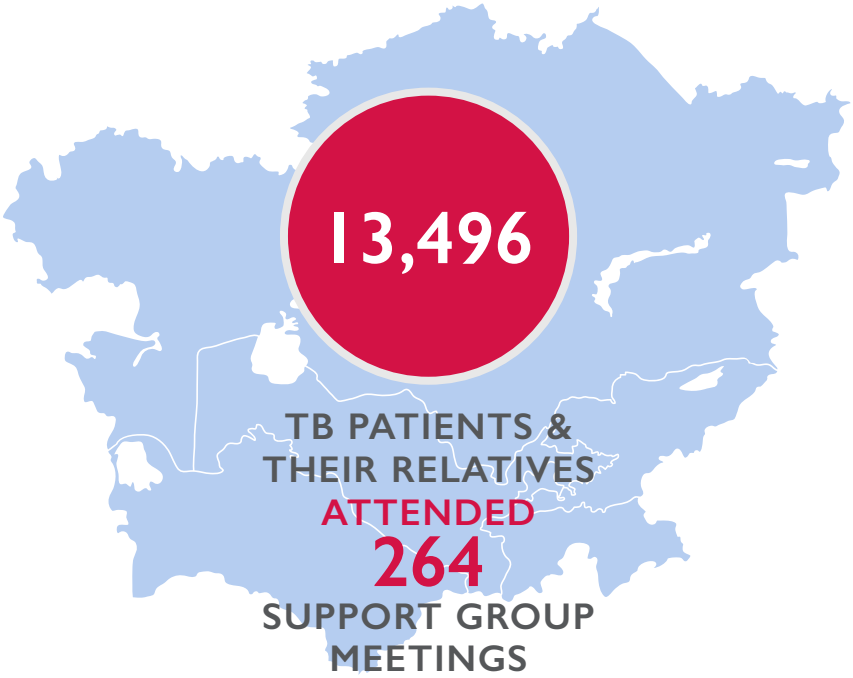
USAID also helped support the formation of patient support groups. Seeing the efficacy of these groups in improving patients' treatment outcomes, both Uzbekistan and Tajikistan passed laws supporting establishment of these groups in all of their TB facilities. USAID also helped promote village health committees, which enable citizens to plan and coordinate initiatives to improve health outcomes where they live. These activities have had huge impacts throughout Central Asia.

- Sixty percent of villages, or about two million people, have been reached by these committees' health education work in the Kyrgyz Republic.
- In Uzbekistan, the work of these committees has been taken on and is now supported by the Republican Institute of Health and Medical Statistics, the Republican DOTS Center, the Republican Women's Committee, and the Youth Movement Kamolot. These groups use their hundreds of countrywide branches to carry out community mobilization activities to encourage people with TB symptoms to get tested for TB and reduce stigma against TB patients.
- In Tajikistan, USAID worked closely with religious and community leaders and female activists. In just one illustrative quarter, these groups conducted 369 information sessions contributing to a doubling in the number of TB patients diagnosed in USAID pilot sites.

EMPOWERING PATIENTS:

DURING THE LIFE OF THE USAID QUALITY HEALTH CARE PROJECT (2010–2015):

ACROSS THE REGION

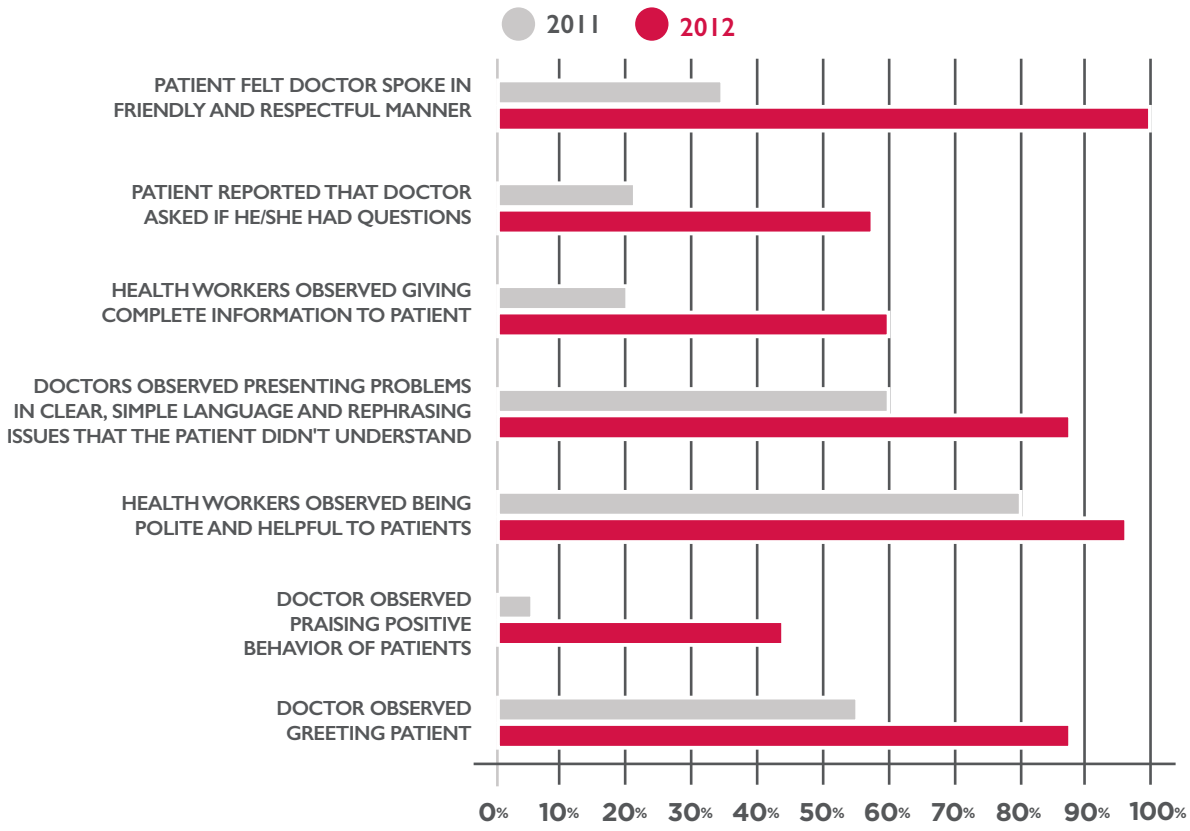


- In Turkmenistan, where there are greater restrictions on community organizing, USAID worked with national partners to create and support four community drop-in centers where sex workers, men who have sex with men, and injection drug users could come for HIV-prevention education, counseling, and job training. These centers served almost 1,000 individuals between 2010 and 2014.

Finally, to ensure that health care workers can effectively educate patients to monitor their own conditions, USAID created a network of trainers in interpersonal communication skills throughout Central Asia, reaching more than 10,000 health care workers between 2003 and 2015.

These results were seen throughout Central Asia wherever interpersonal communication skills were taught. As a result, patients are more comfortable with their health care providers and are more likely to seek them out. All together, these interventions have ensured that Central Asians now respect and are willing to connect with their health care systems. That in turn enables citizens across the region to be strong forces for positive change.

IMPROVEMENTS IN HEALTH CARE WORKER INTERPERSONAL SKILLS IN THE KYRGYZ REPUBLIC



ADDRESSING GENDER ISSUES

Gender equity in accessing health care services in Central Asia had a different character than that of many other parts of the world. Early studies conducted by USAID project staff indicated that women were 3-5 times more likely to use primary health care than men. Given the high levels of cardiovascular disease in the country, and the large gap in life expectancy—with men living much shorter lives than women— sex and age adjustors were a necessary part of the state health financing system, designed to encourage providers to get men into primary health care facilities. Sex and age adjustors were also used to account for the greater health care utilization/need amongst women of reproductive age as well as children.

Through its health projects in Central Asia, USAID has empowered women working in the Ministry of Health by providing them with evidence-based tools to make health care policy decisions, and by helping to implement new health financing systems that allowed the MOH to direct financing to health care priorities. Over the years, USAID has also trained women in health management positions, prepared women to be trainers, strengthened women's roles as health care providers, and galvanized women in rural areas to become community leaders and mobilizers.

Health education efforts targeting the population in the region have aimed to involve both men and women as appropriate. While women have access to health care, family dynamics often restrict young women from making certain decisions regarding their own health and that of their children. If, for example, more costly foods are in short supply in the family, priority often goes to elders and then to younger men.

Additionally, young mothers often find themselves unable to make decisions on breastfeeding, the introduction of solid foods, birth spacing, and medical care for common childhood illnesses, with the mother-in-law weighing in strongly on these issues. At the same time, a wife may be able to influence her husband or her parents to get a much-needed blood pressure check, or to follow the doctor's orders. In response to these dynamics, USAID has sought to educate entire households in order to ensure improved health outcomes for the population.

For more information, please see: The Gender Gap in Primary Health Care Resource Utilization in Central Asia http://pdf.usaid.gov/pdf_docs/pnadg935.pdf.

SHARED KNOWLEDGE FOR BETTER RESULTS

USAID's work in our country has changed the way we understand medicine. Before, all of our knowledge was based on information that was given to us by our professors. Through USAID assistance, now we have greater insight into science and how it is used to diagnose and treat diseases.

With our new understanding of evidence-based medicine, we can now better diagnose conditions. The population of our country gets better health care and treatment. And in many cases, because correct treatment is given early, not only do we get well sooner, but we save money. And we cannot forget the importance of the introduction of evidence-based approaches to maternal and child health. As a result of USAID support, many fewer mothers are dying during childbirth.

From working hand-in-hand with USAID's technical experts, I now understand that sharing knowledge is the most important thing that you can give to anyone. Some donors spend lots of money on buildings and equipment which is good for a little while, but eventually infrastructure breaks down and you can't use it any more. But the things that we have learned have helped us to be better doctors and these skills will always stay with us.

Thank you to USAID and all the Abt projects. We would not be where we are now if it were not for your help.

Professor Shavkiya Pachadzhanova, Head of the Evidence Based Medicine Centre, Tajik State Medicine University

ANATOMY OF HEALTH CARE TRANSFORMATION

CONCLUSION AND LESSONS LEARNED

CONCLUSION AND LESSONS LEARNED

The efforts of USAID and its partners over the past 20 years have led to both measurable and intangible improvements in the lives of the citizens of Central Asia. Through strategic planning with national partners, implementation on the pilot level followed by scale up, and sustained work on the policy and population levels, USAID was able to support comprehensive health systems strengthening in this new and complex environment. The insights gained through these many years of experience, can be useful for future health systems strengthening work.

1. HEALTH SYSTEMS STRENGTHENING MUST BE COMPREHENSIVE AND ADDRESS ALL ASPECTS OF THE HEALTH CARE SYSTEM.

Financing reforms alone cannot bring about the necessary changes in the delivery of health care services. In the case of Central Asia, USAID and country counterparts saw the need to reorient and rebuild the health system foundation while introducing family medicine and integrating separate systems such as infectious diseases and reproductive health into primary health care. A comprehensive health care systems strengthening vision shared by donors and country counterparts led to greater impact.

2. CHANGES MUST BE IMPLEMENTED IN AN INTEGRATED MANNER WITH ATTENTION TO TIMING.

As changes were implemented in one area and changes began to occur, other parts of the health care system were affected, making it clear that steps must be carefully coordinated to ensure some elements do not progress too far ahead of others and that implementation does not get ahead of capacity.

3. STEP-BY-STEP IMPLEMENTATION ALLOWS FOR SUCCESS BY BREAKING LONG-TERM GOALS—WHICH CAN SEEM OVERWHELMING – INTO MANAGEABLE PIECES.

Accomplishment of each piece of the change allows for small successes which garner local support and gain momentum for more sweeping changes.

4. LOCAL PARTNERS MUST BE INVOLVED IN SOME WAY IN ALL ASPECTS OF THE DESIGN AND START UP.

This is crucial even though they usually do not have time to devote their full attention to health systems strengthening activities. Capacity building grows in part from day-to-day implementation of system interventions.

5. KEY POPULATIONS MUST HAVE A STRUCTURED AND UNDERSTOOD ROLE IN THEIR OWN HEALTH CARE.

The needs of beneficiaries of donor-funded projects often get pushed aside in favor of donor or implementer priorities. Key population representatives must be enabled to conduct their own advocacy and, where possible, participate in the provision of their own services.

6. GOVERNMENT-NGO COLLABORATION IS CENTRAL TO THE SUCCESS OF ANY PROGRAMMING THAT TARGETS KEY POPULATIONS.

The complexity of the government-NGO relationship should not be overlooked. USAID had significant success in improving relationships by training state health care workers and NGO staff together and by creating platforms for regular meetings between clinic and NGO leaders.

7. IN COUNTRIES WHERE NGOS ARE LESS STRONG OR NON-EXISTENT, IT IS IMPORTANT TO WORK WITH A VARIETY OF LOCAL PARTNERS TO INVOLVE THE POPULATION IN HEALTH CARE OUTCOMES.

Thanks to cooperation with religious leaders and organizations such as youth and women's committees, USAID was able to cover wider areas and reach more patients.

Health care challenges remain in Central Asia, as in most of the world. However, thanks to the joint efforts of USAID, country counterparts, and other donors in setting the path for improved health systems over the past 20 years, the Central Asian countries now have a clear path to follow to continue strengthening health systems to benefit their populations. The sustainable, integrated changes in place from rural villages to big cities mean that as their institutions grow stronger, Central Asians will have better health care and fuller, more productive lives in the years to come.

SOURCES:

Where not otherwise indicated, data included in this document comes from monitoring conducted by staff on the USAID projects in the region, as part of routine project monitoring.

Data in the Country Summaries is taken from the World Health Organization Global Health Observatory Data Depository http://apps.who.int/gho/en/; WHO European Health for All Database http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db; and World Bank http://data.worldbank.org/.

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USAID | CENTRAL ASIA
FROM THE AMERICAN PEOPLE