



ЗдравПлюс / ZdravPlus

ENSURING ACCESS TO QUALITY
HEALTH CARE IN CENTRAL ASIA

TRIP REPORT:

National Conference on the Institutionalization of Quality Improvement Activities in Kyrgyzstan

Authors:

Bruno Bouchet, Regional Quality of Care Director, ZdravPlus

Irina Stirbu, Senior Program Manager, ZdravPlus

May 13-27, 2003

Kyrgyzstan



FUNDED BY:
THE U.S. AGENCY FOR
INTERNATIONAL DEVELOPMENT



IMPLEMENTED BY:
ABT ASSOCIATES INC.
CONTRACT NO. 115-C-00-00-00011-00

TRIP REPORT:

**National Conference on the
Institutionalization of Quality
Improvement Activities in Kyrgyzstan**

Authors:

Bruno Bouchet, Regional Quality of Care Director, ZdravPlus

Irina Stirbu, Senior Program Manager, ZdravPlus

May 13-27, 2003

Kyrgyzstan

Table of Contents

I. Acknowledgements.....	1
II. Abstract.....	1
III. Executive Summary.....	2
IV. Background.....	3
V. Objectives	3
VI. Activities.....	3
VII. Main Results.....	4
A. Preparation of the Conference	4
B. National Conference on the Institutionalization of the Integrated Quality Improvement System.....	4
1. Goal, Objectives and Participants in the Conference	4
2. Overview of the Conference.....	5
3. Outcomes of the Conference and Next Steps.....	9
Roles and Responsibilities of the Key Stakeholders of the Healthcare System.....	10
VIII. Other Results.....	25
Participation in the World Bank Review Mission.....	25
IX. Annexes	25
Annex 1: Terms of Reference of the Mission	26
Annex 2: Program of the Mission	28
Annex 3: Conference Agenda.....	29
Annex 4: Conceptual Framework for the Design of an Integrated Quality Improvement System.....	34
Annex 5: Presentation at the Conference.....	37
Annex 6: List of Participants at the Conference.....	41
Annex 7: Contribution to the Aide Memoire.....	45
A. MEDICAL EDUCATION AND TRAINING	45
1. Undergraduate and Post-graduate Medical Education.....	45
2. Retraining and Continuous Medical Education of General Practitioners	45
B. PROFESSIONAL DEVELOPMENT.....	47
1. Support to Family Group Practice Association (FGPA).....	47
2. Support of the Hospital Associations (HA).....	48
3. Medical Accreditation Commission (MAC)	49
4. Promotion of Evidence Based Medicine (EBM)	49
C. PHARMACEUTICAL MANAGEMENT	51
1. Strengthening Quality Control of Drugs and Rational Drug Use.....	51
Annex 8: Acronyms and Abbreviations	54

I. Acknowledgements

The authors express their gratitude to all people met during this mission, and whose names are listed in Annex 3 of this report. We apologize for any incomplete or inaccurate statements that come only from the time constraints or incomplete notes. We are asking the readers to report to us any inaccuracy that they deem important¹. We also apologize for missing or misspelling the names of our counterparts due to defects in our own notes.

II. Abstract

This conference presented the conceptual framework for the institutionalization of an integrated quality improvement system and facilitated discussions between the working groups and plenary sessions. It also provided technical assistance to the organization committee to finalize the strategic recommendations and draft the work plan; and reviewed the progress achieved in the quality improvement component of the World Bank-funded Project, as part of a WB supervision team mission.

The authors met with a number of stakeholders involved in WB-funded “Manas” project with the objective to review the progress of work, clarify challenges, and provide assistance to resolve problems, expressed in a set of recommendations in the final Aid Memoir. A lecture was conducted at one of the management courses for healthcare leaders on Modern Quality Improvement methods and tools as part of the regular capacity building activities lead by World Bank team members during their missions.

¹Irina@zdravplus.uz, bruno.bouchet@zdravplus.uz

III. Executive Summary

This mission had four **objectives**:

1. Provide technical assistance for the final preparation of the conference;
2. Present the conceptual framework for the institutionalization of an integrated quality improvement system to the participants of the conference and facilitate the discussions of the working groups and plenary sessions during the conference;
3. Provide technical assistance to the organization committee to finalize the strategic recommendations and draft the work plan; and
4. Review the progress achieved in the quality improvement component of the World Bank-funded Project, as part of a WB supervision team mission.

We carried out the following main **activities**:

1. We had individual meetings with conference organizers: HIF, Ministry of Health (PIU), and AED to finalize preparation of the conference;
2. We conducted a pre-conference preparation meeting for the facilitators to ensure their understanding of the objectives and processes for the working group sessions;
3. During the conference, we presented the conceptual framework for the institutionalization of an integrated quality improvement system to the participants of the conference and assisted in the facilitation of the discussions of the working groups and plenary sessions;
4. We met with a number of stakeholders involved in WB-funded “Manas” project with the objective to review the progress of work, clarify challenges, and provide assistance to resolve problems, expressed in a set of recommendations in the final Aid Memoir; and
5. We conducted a lecture at one of the management courses for healthcare leaders on Modern Quality Improvement methods and tools as part of the regular capacity building activities lead by World Bank team members during their missions.

The following **results** were achieved:

1. The national conference on the institutionalization of quality improvement activities was successfully conducted during May 22-24, 2003, achieving its objectives; and
2. We developed a set of recommendations for more successful implementations of the WB-funded project.

We are suggesting the following **next steps**:

1. Conference organization committee, assisted by ZdravPlus, will follow up on the institutionalization plan developed during the conference. They will contact each stakeholder for the detailed plan of actions that will then be sent to all the partners;
2. ZdravPlus will prepare and conduct a small workshop for selected participants from professional associations (FGPA and HA) in Uzbekistan, followed by a visit to Ferghana Valley to observe QI activities; and
3. ZdravPlus will participate in the next WB review mission.

IV. Background

The Central Asia Quality Health Project – known as the ZdravPlus project – funded by the US Agency for International Development (USAID) is working with the governments of five Central Asian countries to improve the quality and efficiency of health services. The project works in selected areas of these countries to support health sector reform as well as technical assistance, training and limited provision of equipment.

Since the reforms are sufficiently evolved to allow the primary healthcare facilities both autonomy and increased capacity, ZdravPlus feels that FGPs are ready to work on improving the quality of care they provide and that the Ministry of Health is ready to institutionalize quality improvement mechanisms in the health sector.

A review of Quality Improvement activities in July 2002 concluded that Kyrgyzstan has reached a level of maturity in the reform that allows for the developing of an integrated quality improvement system within the health sector. It was agreed that this process would start with a national conference that will allow a structured discussion among all the stakeholders on the process of institutionalization of quality improvement activities in the country. In close collaboration with the WHO (EURO and Geneva), and the World Bank Project (Washington and Bishkek), ZdravPlus helped develop an agenda for the conference and a conceptual framework². A 15-member preparation committee was established with a specific work plan and technical documents were prepared: a questionnaire for a situation analysis that will be presented at the conference, and guidelines for working groups. This conference is a co-funded activity with AED.

V. Objectives

Specific objectives of the visit were:

1. Provide technical assistance for the final preparation of the conference;
2. Present the conceptual framework for the institutionalization of an integrated quality improvement system to the participants of the conference and facilitate the discussions of the working groups and plenary sessions during the conference;
3. Provide technical assistance to the organization committee to finalize the strategic recommendations and draft the work plan; and
4. Review the progress achieved in the quality improvement component of the World Bank-funded Project, as part of a WB supervision team mission.

Details of the scope of work can be found in ***Annex 1***.

VI. Activities

The major activities of this mission were:

1. We had individual meetings with conference organizers: HIF, Ministry of Health (PIU), and AED to finalize preparation of the conference;
2. We conducted a pre-conference preparation meeting for the facilitators to ensure their understanding of the objectives and process for the working group sessions;

² Preparation for the National Conference on the Institutionalization of Quality Improvement Activities in Kyrgyzstan. Bruno Bouchet. February 24-28, 2003. ZdravPlus Trip Report.

3. During the conference, we presented the conceptual framework for the institutionalization of an integrated quality improvement system to the participants of the conference and assisted in the facilitation of the discussions of the working groups and plenary sessions;
4. We met with a number of stakeholders involved in the WB-funded “Manas” project with the objective to review the progress of work, clarify challenges, and provide assistance to resolve problems as expressed in a set of recommendations in the final Aide Memoire; and
5. We conducted a lecture at one of the management courses for healthcare leaders on Modern Quality Improvement methods and tools as part of the regular capacity building activities lead by World Bank team members during their missions.

Details of the program can be found in *Annex 2*

The lecture on the integrated quality improvement framework is reproduced in *Annex 3*

VII. Main Results

A. Preparation of the Conference

During May 13-21, we focused on preparation activities for the conference. In particular, we assisted the organization committee in the following activities:

- ✓ Final review of the organizational preparation for the conference (in collaboration with AED), including venue, equipment, services, distribution materials;
- ✓ Review of the presentations and recommendations on the content and format;
- ✓ Assistance in the finalization of the list of participants for the conference and repartition of the participants by thematic working groups in accordance with the needs and objectives;
- ✓ Review of the questionnaires for the situation analysis and summary of the answers; and
- ✓ Discussion with the appointed facilitators regarding objectives and processes of the working groups.

B. National Conference on the Institutionalization of the Integrated Quality Improvement System

The National Conference on the Institutionalization of the Integrated Quality Improvement System took place during May 22-24, 2003 in the “Kyrgyzskoe Vzmorie” resort area in Issyk Kul, Kyrgyzstan.

1. Goal, Objectives and Participants in the Conference

Goal: To develop a Strategic Plan for the Establishment of an Integrated Quality Improvement System (IQIS)

Objectives:

1. To clarify definitions of quality of care and concepts for a quality improvement system;
2. To develop a strategy for establishing an integrated quality improvement system; and
3. To start a coordinated quality movement in health care in Kyrgyzstan.

Participants:

Over 100 people participated in the conference. Participants included representatives from major stakeholders such as the Ministry of Health (including all of its main departments), Health Insurance

Fund, “Manas” health reform unit, providers from different levels of the system, professional associations of providers (FGP Association and Hospital Association), patients and patient groups, medical education institutions, NGOs and various international organizations operating in the country (USAID, WHO, JICA, WB, Swiss Red Cross, and others). It is important to note that for the first time, patients have been invited to discuss health care issues with health providers and health managers in the country.

2. Overview of the Conference³

To achieve its objectives, the conference followed a structured sequence of steps developed during its preparation. The main events are described here:

Analysis of the Current Situation in Kyrgyzstan and International Perspectives on the Quality Movement

The conference started with the description of the strategic directions of the reforms in the Kyrgyz Republic. Dr. Meimanaliev, Deputy Minister of Health, pointed out that every health system in the world is confronted with the challenge of constantly adapting its structure and the health care services it delivers in order to ensure that quality of clinical care is consistent with current scientific medical knowledge. He also stressed that in Kyrgyzstan, quality of care is a priority issue because, as elsewhere, it is a direct determinant of the health status and the mandate of the Ministry of Health is “to preserve and improve the health status of the population⁴.”

Dr. Siem Tiam, from WHO/Geneva, presented a global view on governance and quality movement in the world.

In order to understand the current situation and plan any future activities, a questionnaire was developed before the conference to map stakeholders’ current roles and responsibilities in Kyrgyzstan. The questionnaire was organized under the four categories of stakeholders identified in the national conceptual framework for the reforms: the regulator (who makes the rules), the provider (who delivers the care), the patient (who benefits from the care), and the payer (who manages the costs of care). Other organizations that contribute to an integrated quality improvement system, but not included in any of these categories, were regarded as others. This was not a traditional survey where the sample size matters and the number of respondents would increase the precision of any results. Instead, we were aiming at describing the situation by finding out which organizations are in the best position to provide answers to the specific questions. The following key results were presented to the participants:

- Most aspects of QI are taught at the postgraduate level to physicians. None or very little are taught at the undergraduate level. Physicians have more opportunities to be trained in QI than nurses. Physicians access new information mostly through newspapers, meetings or professional journals;
- Quality performance is not always used as a criterion to motivate physicians. Financial incentives are rarely used. Poor performance is always punished through administrative and financial sanctions. Criteria for assessment of performance are not clear: providers cited mostly outcomes criteria (such as mortality or morbidity rates), but no process indicators were mentioned. In contrast to hospital providers, more PHC providers mentioned compliance with standards as criteria for providing incentives. There is a clear understanding that quality is compliance with standards. Among people who assess quality of work are HIF experts, health facility administration, and special committees. Frequency of assessments varies from daily to yearly;

³ For the detailed Agenda of the Conference please refer to Annex 3

⁴ Health Care in Kyrgyzstan in the 21st Century. Ministry of Health of the Kyrgyz Republic.

- Every physician is required to improve quality, as mentioned in the job description. Many facilities participate in the QI programs. However, it often means just having a contract with the HIF and being regularly controlled by them for quality indicators. There is no special budget allocated for QI activities. Technical assistance on QI to providers is mostly provided from HIF, MAC, and often providers mention no access to much needed technical assistance in this regard;
- Quality control is mostly performed by HIF (payer) using quality indicators based on nationally approved protocols; and
- Overall healthcare providers (especially from PHC level) were much more responsive to the answers than patients or regulators.

Following the situation analysis, each type of stakeholder described their current roles and responsibilities in quality improvement efforts, including MOH, MHIF, Hospital and FGP Associations (representing the providers' side) and Village Health Committee (representing the patients' view).

Building an Integrated Quality Improvement System (IQIS)⁵

Irina Stirbu presented a description of the concept of an integrated quality improvement system on behalf of Bruno Bouchet⁶. The main points are listed here:

Improving the quality of care is the indisputable objective. Achieving this objective has proven to be extremely complex in every health care system due to two main reasons: the many determinants of quality and the unpredictable effect of single or combined interventions on each one of those determinants. In addition, there is not a unified definition of the term *Quality*. For the conference, quality was defined as the match between the two following characteristics:

- The care that patients receive (reflective of the performance of the system); and
- The care that we know is most appropriate in specific health conditions (the science of medicine).

Lessons learned from other countries identify the following essential characteristics of an **Integrated Quality Improvement System (IQIS)**:

1. The implementation of pilot quality improvement projects provides an opportunity to learn about the system changes and interventions that lead to improvement and the successful way to implement them. But the **sustainability** of the gains in quality requires that improvement processes be **integrated** in the daily work of all stakeholders of the health system and be supported by specific mechanisms that sustain an improvement dynamic. For example, health care providers must also spend some time working through the steps of an improvement project, besides seeing patients, and this time must be built into their regular working hours.
2. Because many factors affect the quality of care, a quality improvement strategy cannot rely on a single intervention. The **comprehensiveness** of an improvement strategy increases the likelihood of success because the combined effect of multiple interventions is more than just the sum of its parts. For example, the implementation of the IMCI guidelines requires that specific equipment and drugs are available. Training health providers in IMCI must therefore be accompanied by changes in the list of essential drugs and provisions of equipment consistent with the new guidelines.
3. Many stakeholders are involved in the healthcare delivery system, contributing to its complex nature. Their **coordination** is a condition for getting the benefits of the interventions in an

⁵ The conceptual framework for the Integrated Quality Improvement System is described in Annex 4

⁶ Dr. Bruno Bouchet, Regional Quality of Care Director, had to shorten his mission in Kyrgyzstan due to a family emergency.

improvement effort and ensures consistency. For example, the monitoring of quality of care through external “inspectors” requires that checklists be developed against explicit criteria. If several organizations are involved in the measurement, they need to collaborate to avoid duplication of work or inconsistency in the standards, which could be detrimental to the work of health providers.

Specific mechanisms are known to contribute, directly or not, to improving quality of care. Among those mechanisms are technical activities such as developing standards, monitoring quality, and implementing improvement projects using continuous quality improvement (CQI) techniques.

Working Groups on IQIS

Two types of working group sessions allowed for planning the development of the IQIS:

Session one focused on discussing the components of the conceptual framework (the factors that influence the quality of care) to identify issues and suggest changes/solutions. Eight thematic working groups were formed, with a mix of all key stakeholders (providers, payers, regulators, patients and medical educational institutions) in each group:

- ✓ *Provider competency in evidence-based medicine and improvement skills.* This system encompasses undergraduate training in medical and nursing care, postgraduate training, continuous medical education and also training in quality improvement and knowledge management. The main issue is **how** this system contributes to the effective communication of evidence-based care and implementation of evidence-based practices.
- ✓ *Provider motivation for quality and human resource management.* This system encompasses the recruitment, management, career plan, evaluation, benefits and motivation of the healthcare providers. The main issue is **how** this system contributes to improving the performance of health providers in the delivery of care according to evidence-based standards.
- ✓ *Provider and patient access to resources and information.* This system encompasses the identification of resources needed, the decision to allocate them, their distribution, their maintenance and their replacement. The main issue is **how** this system contributes to making available the resources needed to deliver care according to the standards, at the place where they are needed.
- ✓ *Patient demand for and rights to improved quality of care.* This system encompasses the health education of the population, information on patients’ rights and the communication of messages on the appropriate ways to use the health system. The main issue is **how** this system contributes to raising patients’ demand for evidence-based care.
- ✓ *Development of evidence-based medical standards and job-aids.* This system encompasses the use of evidence-based medicine (EBM) as a method to develop guidelines and protocols, and their effective communication to health providers. The main issue is **how** the development of guidelines and protocols contribute to the delivery of evidence-based care.
- ✓ *Quality measurement: monitoring and assessment.* This system encompasses the development of indicators that reflect providers’ and system’s compliance with evidence-based standards, and the establishment of a monitoring system. The main issue is **how** the measurement of quality contributes to the delivery of evidence-based care.
- ✓ *Continuous Quality Improvement & quality improvement projects.* This system encompasses the use of continuous quality improvement concepts and principles to achieve a specific quality improvement objective. The main issue is **how** quality improvement projects

contribute to the delivery, replication and sustainability of evidence-based care and medical practices.

- ✓ *Regulations, especially licensing, certification and accreditation.* This system encompasses the licensing of medical professionals, the certification of specialists and the accreditation of health facilities. The main issue is **how** these regulations contribute to the delivery of evidence-based care.

A balanced representation of the stakeholders in each group allowed different opinions to be expressed regarding the same issue. Some of the facts were new to the audience, for example, the opinions of the patients on how the system should be organized or what functions of the health system they would like to be strengthened. As a result of the discussion, groups presented recommendations on what solutions/interventions must be implemented to address the issues within this component⁷.

Session two focused on defining the roles and responsibilities of the key stakeholders in designing and/or implementing the IQIS. Four stakeholder working groups were formed, each one representing a specific category of stakeholder/institution:

- ✓ The regulator and payer
- ✓ The provider
- ✓ The patient
- ✓ The academic institutions: trainers and researchers

During this session, groups discussed the recommendations on who would be involved in implementing the interventions identified earlier (roles and responsibilities of each of the stakeholders), and how institutions would have to coordinate their activities and develop functional links. A four point grading system was developed to help stakeholders evaluate their involvement in the implementation of the identified interventions:

- An institution that is completely *in charge* of a specific task was assigned *grade one* for this task
- An institution that is *leading* a specific task in cooperation with other organizations was assigned *grade two* for this task
- An institution that is *contributing* to a specific task under the leadership of another organization was assigned *grade three* for this task
- An institution that is *not involved* in implementation of a specific task was assigned *grade four* for this task

In addition to grading (which defined their roles), stakeholders described their specific responsibilities in the implementation of interventions. They also listed the institutions they would like to cooperate with in implementing these interventions.

All the results were compiled in one matrix (reproduced below) and presented to the audience in a plenary session. Such a summary allowed the participants to identify and address gaps and balance the efforts since it became visible that some of the activities lacked some leadership, whereas for others there was some confusion regarding coordination and roles.

⁷ The results of Session one are reproduced below in column 2 of the table

3. Outcomes of the Conference and Next Steps

This is the first time in the history of health reforms in Kyrgyzstan that a national event was devoted to develop a quality improvement strategy. This fact in and of itself is one of the main achievements. In addition, the conference has accomplished the following results:

- Stakeholders have a better idea of their roles, responsibilities and links with other organizations in an integrated quality improvement system;
- Stakeholders reached a consensus on the quality improvement mechanisms to be established, strengthened and sustained; and
- Stakeholders committed to work in a coordinated fashion to build the capacities they need, along with their partners.

Patient – provider partnerships were significantly strengthened during the conference. For the first time, patients were invited and actively participated in the process of developing strategies to improve quality of care. Patient organizations felt responsible for the final product and did their best to contribute. They were also pleased that their opinion was requested, valued and taken into account. Providers, at the same time, realized that patients are able and are willing to contribute to improving quality of care.

By nature, the development of an integrated quality improvement system is a long-term objective and the conference is not an end in itself but the beginning of the work. Although some of the gaps/overlaps were addressed during the conference, an actual plan of activities in implementation of the interventions is yet to be developed. It was agreed that the conference organizers, which represent a mix of key stakeholders in Kyrgyzstan, would develop a strategic plan that describes concrete actions. The following are the next steps:

- Strategic plan approval
- Development of the national quality policy document
- Development of the implementation plan, including:
 - Specific operational plans to build stakeholders’ capacity in one or several aspects of quality improvement, and to establish the mechanisms for coordinating their work with others;
 - Support from international development agencies in implementing the operational plans; and
 - Follow-up evaluation.

The following table presents the results of the working group discussions. Many of the interventions that are supposed to build the components of an IQIS need more work in terms of defining more precisely the content and the expected product/impact. ZdravPlus will help the stakeholders move forward with this “roadmap”:

Roles and Responsibilities of the Key Stakeholders of the Healthcare System

Explanatory notes:

1 - Completely in charge of the task

2 - Leading the work but working with other organizations/departments/structures

3 - Contributing under the leadership of another organization

4 - Not involved at all

Macro Level: decision-makers at the Republican level, in charge of designing or approving policies

Micro Level: implementing organizations

	Strategy	Regulators/Payers	Academia	Providers	Patients
Providers' competency	Improve the quality of pre-service medical education by upgrading training curriculum in order to meet international standards	<ul style="list-style-type: none"> 2 (macro level) 	2	3	4
		<ul style="list-style-type: none"> Ministry of education and culture (MOEC); medical educational facilities 	MOH, MOEC	KSMA, CCME, Medical Nursing College	
		<ul style="list-style-type: none"> Initiate the process of development of medical training programs according to international standards Introduce changes in the regulations for training Adapt, modify and approve the programs Control the implementation 	<ul style="list-style-type: none"> Develop the training curriculum Implement the training according to standards 	<ul style="list-style-type: none"> Suggest changes 	
	Review national regulations for	2	3	4	4
		MOEC; medical educational facilities	MOH, MOEC		

medical education	<ul style="list-style-type: none"> Develop joint orders (prikazes) between Ministry of Health and Ministry of Education 	<ul style="list-style-type: none"> Suggest changes 		
Develop a system for licensing and certification of health providers	2	3	3	4
	Association, Professional medical organizations, educational facilities, Clinical Protocols Coordination Committee	MOH, Association, Professional medical organizations	MOH, Association, Professional medical organizations	
	<ul style="list-style-type: none"> Develop regulations Issue the orders 	<ul style="list-style-type: none"> Develop and implement the OSCE method to test physicians' skills Participate in certification commissions 	<ul style="list-style-type: none"> Tertiary level develops the certification system Secondary and Primary levels suggest changes in the system 	
Improve the continuous medical education system	2	2	3	4
	MOEC, medical educational institutions	MOH, MOEC	KSMA, CCME, Medical Nursing College, Research Institutes, affiliates	
	<ul style="list-style-type: none"> Develop a clinical residency program for specialists Develop a system to manage the CME program by linking training needs with human resources database 	<ul style="list-style-type: none"> Design the CME program Make suggestions for orders 	<ul style="list-style-type: none"> Suggest changes 	

	To train health care managers	3	2	3	4
		MOEC, medical educational institutions	MOH, Health care reform department, research institutes, school of public health and management	KSMA, CCME, Medical Nursing College	
		<ul style="list-style-type: none"> Develop and approve the functions, roles and responsibilities of the manager at the facility level 	<ul style="list-style-type: none"> Develop a training program for managers 	<ul style="list-style-type: none"> Suggest changes 	
Providers' motivation	Develop regulations on the social protection of medical staff	2	3	3	3
		MF, Alliance of health workers, Ministry of Labor and Social Protection, MOEC, NGOs	MOH, Ministry of Labor and Social Protection, FGPA	HA, FGPA	MOH, KR government, Associations, health facilities, local self governments
		<ul style="list-style-type: none"> Create a working group to revise current regulations and develop draft law on "medical and pharmaceutical worker" 	<ul style="list-style-type: none"> Suggest changes 	<ul style="list-style-type: none"> Suggest changes to draft regulations 	<ul style="list-style-type: none"> Lobbying for social protection of medical staff through proposals, claims, petitions, and mass media
	Introduce	2 (macro)	3	2 (micro)	3

rational management of resources	Local self governing organs, health facilities, public organizations, Associations	MOH, HF, Medical Associations	FGPA, HA, Health Reform Department	MOH, HF, HIF
	<ul style="list-style-type: none"> • Redistribute functions and staff according to needs, • Improve training programs, plans, and programs on rational management 	<ul style="list-style-type: none"> • Organize and conduct trainings; • Prepare training materials; • Submit proposals on assignments of graduates 	<ul style="list-style-type: none"> • Participate in training seminars 	<ul style="list-style-type: none"> • Carry out opinions survey, develop suggestions and undertake relevant activities
Improve human resource management	3	3	2	3
	Interested ministries and agencies	MOH	HA, FGPA, Health Reform Department	MOH, HF
	<ul style="list-style-type: none"> • Implement a system for rational management of human resources 	<ul style="list-style-type: none"> • Train and retrain staff 	<ul style="list-style-type: none"> • Participate in the rational management of human resources 	<ul style="list-style-type: none"> • Promote patient initiatives through mass media
Develop new mechanisms for providers' motivation	3	3	2	3
	Interested ministries and agencies	MOH, self governments	HIF, local self governments	MOH, HIF, HF, aiyl okmotu and local self governments

		<ul style="list-style-type: none"> Develop a set of motivation factors (moral, financial and social incentives) 	<ul style="list-style-type: none"> Participate in certification of health personnel; Prepare and implement changes 	<ul style="list-style-type: none"> Develop a set of motivation factors (moral, financial and social incentives) 	<ul style="list-style-type: none"> Promote the participation of local communities in the budget preparation and provision of social benefits and privileges
<i>Access of providers and patients to resources and information</i>	Increase of health share in GDP	2	4	3	3
		MF, KR government, Jogorky Kenesh, oblast state administrations, oblast Kenesh		HA, FGPA	KR government, Parliament, local self governments, MOH, aiyl okmotu
		<ul style="list-style-type: none"> Submit proposals on the budget 		<ul style="list-style-type: none"> Advocate the providers' interests 	<ul style="list-style-type: none"> Organize round-table discussions; Participate in Parliamentary sessions; Advocate the providers' interests
	Complete the new financing system (case	2	4	3 (micro level)	3
		Local self governments			MOH, HIF, government

based/per capita payments and co-payments) across the country	<ul style="list-style-type: none"> • Develop joint agreements and resolutions 		<ul style="list-style-type: none"> • Implement new provider payment system 	<ul style="list-style-type: none"> • Undertake a survey in social sector on new payment system • Educate public on new payment system • Control of resources by the population and public entities
Improve rational management and planning of resources based on clinical guidelines	<p style="text-align: center;">2 (macro level)</p> <p>Drug Departments, Health reform department, Human resource department, educational institutions, MHIF</p>	<p style="text-align: center;">3</p> <p>MOH, Health reform department, MHIF</p>	<p style="text-align: center;">1 (micro)</p>	<p style="text-align: center;">3</p> <p>HF, MOH, MHIF, Community based organizations</p>
	<ul style="list-style-type: none"> • Approve regulations • Develop profile of medical institutions in terms of medical equipment • Develop mechanisms on how to supply health facilities in remote outreach places with basic medical equipment • Document the results of pilot EHTP project and make decisions on its further utilization 	<ul style="list-style-type: none"> • Conduct trainings 	<ul style="list-style-type: none"> • Plan capital renovation, human resources, reallocation of financial resources 	<ul style="list-style-type: none"> • Train citizens through education clubs, associations
Creation of	<p style="text-align: center;">2 (macro)</p>	<p style="text-align: center;">4</p>	<p style="text-align: center;">1 (micro)</p>	<p style="text-align: center;">3</p>

	system of incentives that will provide rational distribution of human resources	Human resource department, educational institutions, local governments			Local self governments, KR government, MOH, MHIF
		<ul style="list-style-type: none"> • Develop regulations to stimulate rational distribution of human resources • Introduce additional coefficients for bonuses for remote and difficult to access areas • Develop mechanisms of incentives to assure long term stay of medical staff in remote areas (decrease turnover) 		<ul style="list-style-type: none"> • Develop regulation on incentives • Develop criteria and funds 	<ul style="list-style-type: none"> • Mobilize the population for material and moral incentives • Submit proposals to different agencies
	Strengthen partnership between patients and providers	3	3	2	2
	Communities, Health Committees, international organizations	HF	Local self governments, mass media, communities	MHIF, MOH, HF, public entities	
	<ul style="list-style-type: none"> • Improve the activities of the Advisory Committee 	<ul style="list-style-type: none"> • Conduct training on interpersonal communication 	<ul style="list-style-type: none"> • Create a health purchasers' right advocacy unit, with hotline • Support the creation of health committees 	<ul style="list-style-type: none"> • Social partnership development; • Accountability of health providers; • Assist health providers 	
Improve access	2	3	3	3	

	to medical information (modern medical literature, clinical guidelines, drug formularies, internet and email, National Library, etc)	FGPA, HA, Health reform department, Health Promotion Center, Press Center, Drug Department, educational institutions	MOH, Health Center, Health reform department, MOEC, internet-providers	Associations (HA, FGPA), Professional organizations	Local self governments, aiyl okmotu
		<ul style="list-style-type: none"> • Creation of a resource center including EBM center for interested people • Publish changes in the health care regulatory basis 	<ul style="list-style-type: none"> • Create a resource center • Develop and implement distance education 	<ul style="list-style-type: none"> • Strengthen resource centers at the health facility level 	<ul style="list-style-type: none"> • Develop projects and write grant applications • Publish information sheets for citizens, libraries
Patients demands and rights	Provide access to patients of their health care rights	3	4	2	3
		Community based organizations, MOEC, communities, aiyl okmotu		Mass media, public entities	MOH, public organizations, MHIF, FGPA, HA
		<ul style="list-style-type: none"> • Disseminate information through mass media, hot line 		<ul style="list-style-type: none"> • Develop information boards, meetings, discussions, village meetings 	<ul style="list-style-type: none"> • Carryout public awareness campaign • Inform population of its rights
	Increase interest and responsibilities of the	3	4	2	2
		Local communities, associations, organizations, MOEC			Public entities, MOH, MHIF, HA, FGPA

	population for their own health	<ul style="list-style-type: none"> Develop health promotion concept 		<ul style="list-style-type: none"> Create health committees 	<ul style="list-style-type: none"> Create specific clubs for diseases Establish health promotion, sanitation education materials, self control, training programs
	Strengthen the role of community based organizations and local communities in meeting the patient's rights	3	4	4	2
		Local communities			Local self governments, MOH, MHIF, HA, FGPA
		<ul style="list-style-type: none"> MOH meetings with citizens, cooperation with public entities, conferences on patients' rights 			<ul style="list-style-type: none"> Train on patients' rights, information dissemination, round tables, patients claims consideration
5. Use of EBM in quality improvements	Improve the methods of development and revision of clinical EBM guidelines	2	3	3	4
		Associations, providers, research institutes, health education institutions, SPH, HIF	MOH, Health reform department, school of public health		
		<ul style="list-style-type: none"> Improve the Coordination Council activity in development, approval of clinical guidelines Training of working groups 	<ul style="list-style-type: none"> Participate in development and revision of clinical guidelines 	<ul style="list-style-type: none"> Participate in development of CPG (tertiary level only) 	

Introduce EBM into training programs		3	2	3	4
	MOEC, educational institutions, associations, public entities		MOH, MOEC, MHIF	Tertiary level (Research institutes), Medical Academy, Drug Department and MOL&SP (computer center)	
	<ul style="list-style-type: none"> Draft order on introduction of EBM as a part of training curriculum 	<ul style="list-style-type: none"> Develop and implement training programs Train trainers on methods of knowledge management 	<ul style="list-style-type: none"> Implement EBM through training programs 		
Introduce clinical standards in certification system		2	3	3	4
	EBM center, Coordination Council on development of clinical guidelines, Associations, scientific ad hoc societies		Medical Associations by profile, entities	Educational institutions	
	<ul style="list-style-type: none"> Approve regulation on certification of health personnel 	<ul style="list-style-type: none"> Develop the clinical part of certification based on approved CG 	<ul style="list-style-type: none"> Develop the clinical part of certification based on approved CG 		
Provide access		2	3	3	3

	to information on EBM	Educational institutions, Associations, international organizations	Medical Associations, MHIF, HF	Together with other Resource Centers on the macro level (Information center of Drug department, Medical Academy)	MOH, MHIF, FGPA, HA, local communities, public entities
		<ul style="list-style-type: none"> • Publish materials, EBM information dissemination; • Publish and distribute clinical guidelines; • Create a clinical guidelines center • Implement the rational use of pharmaceuticals 	<ul style="list-style-type: none"> • Create information resource centers, data collection & processing 	<ul style="list-style-type: none"> • Create and strengthen health facilities' resource centers • Conduct trainings • Improve drug committees' activities ensuring access to information 	<ul style="list-style-type: none"> • Publish the bill of patients' rights, information dissemination
	Introduction of the rational drug use concept	2	3	3	3
		Educational institutions, Associations, international organizations	Medical Associations, MOH, MHIF	Drug department, information center	Drug department, MOH, MHIF
		<ul style="list-style-type: none"> • Publish and distribute EBM and clinical guidelines, evidence based center creation, introduction of concept on rational use of pharmaceuticals 	<ul style="list-style-type: none"> • Conduct trainings 	<ul style="list-style-type: none"> • Participate in development of CG • Strengthen the activity of Drug Committees 	<ul style="list-style-type: none"> • Public awareness campaigns, mass media, trainings
Role of	Create a	2	3	3	3

monitoring and evaluation in quality improvement	uniform national system for monitoring and evaluation	National Statistics Committee, MHIF, health facilities, Associations, MAC, MOL&SP	MOH, Health reform department, Republican medical information center, MHIF		MOH, MHIF, FGPA, HA, public entities
		<ul style="list-style-type: none"> • Introduce a joint health information system concept • Improve quality indicators 	<ul style="list-style-type: none"> • Participate in indicators development 	<ul style="list-style-type: none"> • Participate in working groups 	<ul style="list-style-type: none"> • Population survey, research • Submit proposals
	Provide access to the results of M&E	2 (macro)	3	2 (micro)	3
		National Statistics Committee, MHIF, health facilities, Associations, MAC, MOL&SP	RMIC, MOH	oblast medical information center, providers	MOH, MHIF, FGPA, HA, public entities
		<ul style="list-style-type: none"> • Develop mechanisms for provision of users' access to information 	<ul style="list-style-type: none"> • Place information on web sites 	<ul style="list-style-type: none"> • Inform relevant medical staff and health facilities of monitoring results • Promote providers' positive experience exchange 	<ul style="list-style-type: none"> • Disseminate the results of monitoring amongst population and mass media
	Use of results of monitoring in continuous quality improvement	2 (macro)	3	1 (micro)	3
		MHIF, educational institutions, associations, MAC, MOL&SP	MOH, RMIC		MOH, MHIF, public entities

		<ul style="list-style-type: none"> • Conduct training for users for rational use of the monitoring results as a decision making tool • Determine priorities in quality improvement 	<ul style="list-style-type: none"> • Revise and improve training programs 	<ul style="list-style-type: none"> • Develop health providers' quality improvement activities based on the monitoring results. 	<ul style="list-style-type: none"> • Feedback with providers, assist health facilities
Continuous quality improvement	Train and retrain qualified specialists in QI methods	3	2	4	4
		Educational institutions, associations	MOH, donor organizations, medical associations		
		<ul style="list-style-type: none"> • Control implementation 	<ul style="list-style-type: none"> • Develop QI module • Train trainers on QI • Train specialists on QI methods 		
Use of CQI to improve the quality of care at the health facility level		3 (macro)	3	2 (micro)	3
		Medical associations, FGPA, HA	MOH, FGPA, Chubakov Institute, donor organizations	MHIF, MOH, associations, public entities	HF
		<ul style="list-style-type: none"> • Monitor QI system implementation • Search main quality problems with provision of health services 	<ul style="list-style-type: none"> • Develop training programs • Conduct training, monitoring 	<ul style="list-style-type: none"> • Develop QI drafts • Roll out Issyk-Kul QI experience 	<ul style="list-style-type: none"> • Undertake research • Participate in problem solving

Regulations for Quality Improvement	Human Resource Management	2 (macro)	3	3 (micro)	3 (micro)
		Health workers Trade Union, Associations	MOH	Association	MOH, aiyl okmotu, public entities
		<ul style="list-style-type: none"> Develop and approve medical staff's work load from senior level to janitors; Develop regulations for assignment of health personnel in remote regions; Improve qualification upgrading system 	<ul style="list-style-type: none"> Draft legal normative acts on training Submit suggestions 	<ul style="list-style-type: none"> Submit changes 	<ul style="list-style-type: none"> Submit suggestions on incentives or sanction/punishment of medical staff
	Improve licensing and accreditation	2	3	3	3
		Kyrgyz standard (National accreditation center)	MOH, MAC, Health reform department	Associations	MOH, associations, public entities
		<ul style="list-style-type: none"> Improve licensing standards, approve and register with MOJ if required; Improve accreditation standards; Ensure licensing and accreditation transparency 	<ul style="list-style-type: none"> Develop & submit proposals Participate in licensing & accreditation 	<ul style="list-style-type: none"> Participate through associations 	<ul style="list-style-type: none"> Appeal to relevant institutions to recall back accreditation certificate
	Develop regulations for QI issues	2	3	3	3
		All interested parties	MOH, Health reform department	MOH, HIF	MOH, MHIF government

		<ul style="list-style-type: none"> • Give legal explanation of the following terms: <ul style="list-style-type: none"> -health facilities accreditation -health services quality -health standards -quality standards of health services • Develop and approve the Concept of quality management • Develop and approve quality standards for health services • Develop and approve mechanisms of monitoring and private health accountability • Develop regulations on relations between private and state health care • Create legal base that regulates the issues of insurance, providers' accountability • Develop and approve mechanisms of patients' rights advocacy • Develop and approve mechanisms of coordination between health facilities, MOH and local authorities. • Develop legal framework for health providers' activities • Develop and motivate private health services to create healthy competitive environment 	<ul style="list-style-type: none"> • Develop and submit proposals 	<ul style="list-style-type: none"> • Participation through Associations 	<ul style="list-style-type: none"> • Public entities' legislative activities, advocating patients' rights
--	--	--	--	--	--

VIII. Other Results

Participation in the World Bank Review Mission

During May 18, 19, 26-29 we participated in the World Bank mission. The results are reproduced in Annex 7.

IX. Annexes

Annex 1: Terms of Reference of the Mission

Annex 2: Program of the Mission

Annex 3: Conference Agenda

Annex 4: Conceptual Framework for the Design of an Integrated Quality Improvement System Overview

Annex 5: Presentation at the Conference on Quality

Annex 6: List of Participants at the Conference

Annex 7: Contribution to the WB Aide-Memoire

Annex 8: Acronyms and Abbreviations

Annex 1: Terms of Reference of the Mission

CONSULTANT NAME:	Dr. Bruno Bouchet, Regional Quality of Care Director and Dr. Irina Stirbu, Senior Program Manager
NATURE OF ASSIGNMENT:	Technical Assistance to the Ministry of Health Lead the Institutionalization Conference on Quality Improvement Joint ZdravPlus/World Bank review of Quality Improvement activities in Kyrgyzstan
WORKPLAN ACTIVITY:	Institutionalization of Quality Improvement Activities
DATES:	Bruno Bouchet: May 18 – 29, 2003 Irina Stirbu: May 13 – 27, 2003
ACTIVITY MANAGERS:	MOH/Partners: Ninel Kadyrova, Ainura Ibraimova USAID: Mary Skarie, Damira Bibonusova ZdravPlus: Marat Turgunbaev

Background:

The ZdravPlus project, funded by the US Agency for International Development (USAID), is working with the governments of five Central Asian countries to improve the quality and efficiency of health services.

Initial emphasis was on achieving better structural efficiency through reforming the health care financing system, restructuring of the health system, equipping and training. Stakeholders of the reform in Kyrgyzstan agree that the focus should now shift to the reforms that have more direct impact on the quality of care that patients receive. ZdravPlus, in a July 2002 mission, proposed its technical assistance to institutionalize quality improvement mechanisms. In February 2003, ZdravPlus regional director for quality of care worked with a group of individuals and institutions to organize a National Conference on the development of an integrated quality improvement system (IQIS).

In close collaboration with the WHO (EURO and Geneva), and the World Bank Project and office (Washington and Bishkek), ZdravPlus helped develop an agenda for the conference and a conceptual framework. A 15-member preparation committee was established with a specific work plan, a date was set, and technical documents were prepared: a questionnaire for a situation analysis that will be presented at the Conference, and guidelines for working groups. This conference is co-funded with AED.

Specific objectives of the conference are:

1. To clarify definitions of quality of care and concepts for a quality improvement system;
2. To develop a strategy for establishing an integrated quality improvement system; and
3. To start a coordinated quality movement in health care in Kyrgyzstan.

Expected outcomes of the Conference are:

1. Stakeholders will have a clear idea of their roles and responsibilities in an integrated quality improvement system, whose description in a conceptual framework makes their links explicit;

2. Stakeholders will get a consensus on the quality improvement mechanisms to establish, strengthen and sustain; and
3. Stakeholders will commit to work in a coordinated fashion to build the capacities they need, along with their partners.

Purpose of this mission:

The purpose of this mission is to provide technical assistance to the National Conference on Quality Improvement and review the status of quality improvement activities jointly with the World Bank.

Specific tasks:

Bruno Bouchet, Regional Quality of Care Director, will:

1. Present the conceptual framework for the institutionalization of an integrated quality improvement system to the participants at the Conference;
2. Facilitate the discussions of the working groups;
3. Facilitate the discussion during plenary sessions;
4. Provide technical assistance to the organization committee to finalize the strategic recommendations and draft the work plan; and
5. Review the progress achieved in the quality improvement component of the World Bank-funded Project, as part of an 11-member WB team mission.

Irina Stirbu, Senior Program Manager, will:

1. Provide technical assistance with the last-minute organizational issues, such as reviewing the presentations, coordinating activities with AED, and finalizing technical documents to guide the work of the groups, based on inputs from our partners;
2. Facilitate the discussions of the working groups;
3. Facilitate the discussion during plenary sessions; and
4. Provide technical assistance to the organization committee to finalize the strategic recommendations and draft the work plan.

Expected Outputs of this Mission:

The most concrete output of this consultancy will be a trip report describing:

1. The strategic recommendations made by participants to the National Conference on the establishment of an integrated quality improvement system: its components, roles and responsibilities of institutions and a draft work plan to build the needed capacities;
2. A description of the assistance that would be rendered by the main partners of the Kyrgyzstan Ministry of Health, including ZdravPlus Project;
3. A description of the situation of QI activities and components in Kyrgyzstan, from the results of the survey and the review of activities funded under the World Bank loan; and
4. Any other relevant information.

Annex 2: Program of the Mission

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
	May 13 Irina Departs from Tashkent (17:00) <i>Night in Bishkek</i>	14 - Meeting with Marat Turgunbaev - Meeting with HIF <i>Night in Bishkek</i>	15 - Analysis of the data from the Situation Analysis questionnaire and discussion with HIF <i>Night in Bishkek</i>	16 - Meeting with AED - Meeting with Ainura Kadyralieva - Meeting with the team of conference organizers and facilitators <i>Night in Bishkek</i>	17 - Review of conference materials <i>Night in Bishkek</i>	18 Bruno Departs from Tashkent (7:00) - Meeting with the WB team <i>Night in Bishkek</i>
19 - Meeting with Ainura Kadyralieva, WB - General WB team meeting <i>Night in Bishkek</i>	20 - Meeting with FGPA - Meeting with HA - General WB team meeting <i>Night in Bishkek</i>	21 Bruno Returns to Tashkent (9:00) - Preparation of the conference <i>Night in Issyk Kul</i>	22 - Participation at the conference <i>Night in Issyk Kul</i>	23 - Participation at the conference <i>Night in Issyk Kul</i>	24 - Participation at the conference <i>Night in Issyk Kul</i>	25 - Participation at the conference <i>Night in Bishkek</i>
26 - Meeting with MAC - Meeting with David Burns, Marat and Sheila - Meeting EBM center - Lecture at the Management training course <i>Night in Bishkek</i>	27 - Meeting with Drug Department - Meeting with Drug Information Center <i>Night in Bishkek</i>	28 - Meeting with the Deputy Minister of Health - General WB team meeting <i>Night in Bishkek</i>	29 Irina Returns to Tashkent (14:00)			

Annex 3: Conference Agenda

Institutionalization of the Healthcare Quality Management System Conference in the Kyrgyz Republic May 22-25, 2003

May 21: Participants arrive to “Kyrgyzskoe Vzmorie” Resort

DAY 1: Thursday, May 22

8:00 – 9:00 Registration

PLENARY SESSION 1:

Introduction

Chairperson: Professor M. Mamytov

- | | |
|-------------|--|
| 9:00-9:10 | Opening and general overview of the conference
<i>Professor M. Mamytov, Minister of Health</i> |
| 9:10-9:50 | Quality improvement as one of the important components of health care system reform in the Kyrgyz Republic
<i>Professor T. Meimanaliev, Deputy Minister of Health</i> |
| 9:50-10:10 | Quality improvement policy in the health care systems
<i>Dr. F. Siem Tiam, Health Program Officer, WHO, Geneva</i> |
| 10:10-10:30 | Results of the research on quality improvement mechanisms
<i>Dr. A. Ibraimova, Deputy Minister, MHIF Director</i> |
| 10:30-11:00 | Quality improvement concepts
<i>Dr. B. Bouchet, Regional Director on Quality of Care, ZdravPlus/USAID</i> |

11:00–11:30 Coffee break

PLENARY SESSION 2:

Stakeholders perspectives and conceptual structure

Chairperson: M. Mamytov

-
- 11:30 – 11:40 Stakeholders' views on quality
K. Mambetov, Head of the Curative Department, Ministry of Health
- 11:40 – 11:50 N. Kadyrova, Deputy Director, MHIF
- 11:50 – 12:00 K. Jemuratov, Executive Director of the Hospital Association
- 12:00 – 12:10 A. Isakov, Executive Director of the Family Group Practices Association
- 12:10 – 12:20 T. Mutalipov, Chairman of the Health Committee of Kyzyl Jyldyz village from Jungal Rayon of Naryn Oblast
- 12:20 – 12:30 Questions and answers

12:30–13:30 Lunch

13:30-15:00

GROUP WORK 1:

Thematic discussion on the components of the Integrated Quality Improvement System

Group 1: Competence of providers as a factor that affects quality of health

Group 2: Motivation of providers as a factor that affects quality of health

Group 3: Access to resources and information for patients and providers as a factor that affects quality of health

Group 4: Patient rights implementation and demand for health care services as factors that affect quality of health care services

Group 5: Use of evidence-based health care for health care quality improvement

Group 6: Role of monitoring & evaluation in health care quality improvement

Group 7: Quality improvement methods

Group 8: Health care quality regulations

15:00–15:30 Coffee Break

- 15:30-16:00 Development of the presentations on the components of the integrated quality improvement system by each working group
-

16:00-17:00

PLENARY SESSION 3:

Working groups presentations at the Plenary Session

Presentations of groups 1 and 2: 30 minutes each

(Presentation –15 min., Discussion – 15 min.)

Chairperson: M. Mamytov

DAY 2: Friday, May 23

9:00-10:30

PLENARY SESSION 4:

Working group presentations

Presentations of groups 3, 4 and 5: 30 minutes each

(Presentation –15 min., Discussion – 15 min)

Chairman: T. Meimanaliev

10:30–11:00 Coffee break

11:00-12:30

PLENARY SESSION 5:

Work group presentations

Presentations of groups 6, 7 and 8: 30 minutes each

(Presentation –15 min., Discussion – 15 min)

Chairman: T. Meimanaliev

12:30–13:30 Lunch

13:30-15:00

SECTION 3:

Working group discussion of the roles/functions of the stakeholders, their contribution to the integrated health care quality improvement system and coordination with other participants of the quality improvement system

Group 1: Patients

Group 2: Health care providers

Group 3: Financing body

Group 4: Regulating and executive bodies

Group 5: Education institutions

15:00–15:15 Coffee Break

15:15-17:00

PLENARY SESSION 6:

Presentations of the working groups on the roles/functions and coordination of the stakeholders

(Presentations of five groups – 15 minutes each)

Chairman: T. Meimanaliev

DAY 3: Saturday, May 24

9:00-10:30

PLENARY SESSION 7:

Presentation of the Draft Plan on establishing the Integrated Quality Improvement System

Chairperson: A. Ibraimova

-
-
1. Working group presents the general strategic plan based on the recommendations
 2. Discussion of the plan

10:30–11:00 Coffee break

11:00-12:30

PLENARY SESSION 8:

**Next steps, implementation actions & closure
Chairperson: A. Ibraimova**

1. Action Plan development
2. Development of implementation mechanisms
3. Official closure

12:30–13:30 Lunch

16:00 Departure of the participants to Bishkek

May 25: Working Group amends the action plan in compliance with the recommendations collected and forms the conference materials to be distributed to the participants.

Annex 4: Conceptual Framework for the Design of an Integrated Quality Improvement System

Conceptual frameworks are useful tools to help a group define a common vision, have a comprehensive view of a complex system, and think about issues and improvement interventions. Conceptual frameworks shape our thinking by identifying components and making explicit their links and interactions. The graphic representation of a system allows for a better way to comprehend its complexity reflected in a narrative.

The implementation of an integrated quality improvement system is a complex topic. It requires developing a vision of a rather abstract concept and using it to decide upon an operational strategy to achieve this vision. This is why a conceptual framework could be useful in the institutionalization of quality improvement mechanisms in the Kyrgyz healthcare system.

This paper presents the conceptual framework developed for Kyrgyzstan. The development of the framework follows a three-step logic:

1. **The definition of quality** that we use focuses on the care that is delivered through an interaction between a patient (who has a demand) and a health system (which is supposed to respond to needs). Improving quality of care means delivering care that is more effective (patients benefit from it), more efficient⁸ (no overuse of ineffective services, leading to waste and risks) and safer (care is delivered in a way that meets standards and does not have harmful side-effects for the patients). This dynamic definition of quality (improvement over time) contrasts with the static view that care is of quality or not (all or nothing), and refers to science-based evidence (the standards tell us what is more effective, efficient and safe).
2. **The main factors that affect the quality of care** (as defined above) must be identified. There is probably a long list of factors that influence the care that patients receive. For Kyrgyzstan, we decided to focus on six main factors:
 - **Providers' competency.** The care delivered is in direct relationship with the knowledge and skills of the health provider. Less competent providers might not make the appropriate diagnosis, give the right counseling, and prescribe the right treatment.
 - **Providers' motivation.** Unmotivated or discouraged providers have fewer incentives to follow procedures, work harder or better and have less genuine concern for the well being of their patients. They might also be at a higher risk of making mistakes.
 - **Access to resources, including information.** Both patients and providers must have access to resources and the knowledge of how to access them. A provider must have the resources to examine his patient, record his findings, get complementary exams and treat. A patient must know how to access the resources needed to follow and complete the treatment. When resources are not available at the facility level, both providers and patients need to know where and how to access them.
 - **Patients' demands and rights.** Decisions taken for the case-management of any health condition must involve the patient. Not only should it be a patient's right to be involved but it is also the shared responsibility of patients and providers to decide on the best course of action, because patient involvement is a condition for better adherence to standards.

⁸ It must be noted here that the concept of efficiency has different meanings. Economic efficiency, from the reform perspective, has to do with rationalizing the structure of the health system to make it more "affordable." From a quality perspective, it is more the rational use of existing services and facilities as well as drugs and equipment, so that care is not "wasted."

- ***Specific quality improvement activities.*** The development of evidence-based standards (and the tools that help providers comply with them), the monitoring of quality, and the use of continuous quality improvement techniques, are all factors that influence the quality of care. Providers need to know the results of these activities, even if they are not carried out at the facility level, because they make standards explicit, provide information on their achievement and contribute to improvement.
 - ***Regulations.*** Quality of care is influenced by the standards for licensing and certification of providers, as well as the standards used for the accreditation of health facilities, because the right to practice or operate a facility is in direct relationship with the care delivered.
3. **The systems involved in producing the factors that affect the quality of care.** It is important to understand what produces competent providers, what motivates them, how resources are allocated, why patients demand for specific care, how specific improvement activities are carried out, and what are the standards to regulate medical practices, among other aspects. Behind every factor, there is a set of interrelated components (sub-systems) that are all part of the bigger health care system. These smaller “systems” need to be identified and analyzed because they are the ones that need to be improved and redesigned. Some of these systems are listed in the framework and their diversity shows how integrated the quality improvement system needs to be in the “bigger” health care system. This is why some strategies that could influence the factors that affect quality are listed as examples of interventions for the institutionalization of QI.

The graphic representation of the conceptual framework is provided on the next page and the relationships between subsystems are explained briefly in the following pages.

This framework remains a work in progress and will evolve as the health system in Kyrgyzstan is implementing an integrated quality improvement system. Because it highlights the way different sub-systems contribute to improving quality of care, it allows the stakeholders to:

- Better define their roles and responsibilities by taking part in the different sub-systems described;
- Identify the sub-systems that do not exist yet and need to be established;
- Identify the efficacy issues with the current sub-systems and how they affect quality of care;
- Identify the sustainability issues with the current sub-systems;
- Identify what functional links need to be created between stakeholders to address the issues; and
- What duplication exists and what coordination mechanisms are needed.

Conceptual Framework for the Institutionalization of an Integrated Quality Improvement System

Expected Outcomes	Factors influencing the quality of health care services	Systems Involved	Strategies to Institutionalize
Quality of Care <ul style="list-style-type: none"> • Effectiveness • Efficiency • Safety 	Competent Provider (Knowledge and skills to implement evidence-based practices, access to clinical information)	Clinical Education (undergraduate, postgraduate, continuous) Knowledge Management	Link curriculum with evidence-based CPGs/Teach the use of EBM Train students in quality improvement
	Motivated Provider (Willingness to implement guidelines, real concern for patient care, involvement in improvement activities, professional attitude)	Human Resources Management Provider payment mechanisms Incentives/disincentives Professional regulations	Modernize human resource management Link payment with accountability Establish performance-based incentives Develop code of ethics & mechanisms to enforce
	Providers' and Patients' Access to Resources and Information (That are necessary to implement, or receive care according to evidence-based guidelines and protocols)	Allocation of resources Drug supply and regulations Health finance mechanisms Comprehensive knowledge of the health care system	Link resource allocation to needs Standardize medical equipment Rationalize supply and use of drugs
	Patients' Demand and Rights (Demand for specific care, capacity to express dissatisfaction, rights to care, participation in improvement activities)	Population information Population education Patients counseling and education Recourse mechanisms Patients rights	Educate population on healthier lifestyles and better use of health care services Establish litigation mechanisms Develop a patients' bill of rights
	Specific Quality Improvement Activities (Development of evidence-based standards, Quality monitoring & Continuous quality improvement)	Use of evidence-based medicine Monitoring and Evaluation Health Information System Training in quality improvement	Establish an EBM center Develop a single rayon-based quality monitoring system Implement quality improvement projects
	Regulations (Licensing of providers, certification of specialists, accreditation of facilities)	Licensing Certification Accreditation	Establish performance-based regulations Link regulations with improvement

Annex 5: Presentation at the Conference

Developing an Integrated Quality Improvement System in Kyrgyzstan

Dr. Bruno Bouchet
Regional Quality of Care Director

Slide 2

Outline

- Step-by-step health sector reform
- The focus on quality of care
- Modern quality improvement dynamic
- Conceptual framework for a quality improvement system
- Use of the framework at the conference
- After the conference

Slide 3

The Health Sector Reform Journey

- Changes in the 3 main functions of a health sector: regulatory, payment and provision of care
- Changes involve 4 main stakeholders: regulator, payer, provider, patient
- A step by step reform has a logical starting point
- Focus of the reform shifts as previous changes are sustained
- From structural efficiency to improving quality of care
- The new health system achieves its initial objectives (efficiency, access, equity, quality, etc.)

Time to Focus on Quality

- **Quality of care is achieved when the following match each other:**
 - the care patients receive (reflective of the performance of the system), and
 - the care that we know is most appropriate in specific health conditions (the science of medicine)
- **Issues to address if one wants to improve quality:**
 - Increase the use of evidence-based practices
 - Decrease the use of non evidence-based practices
 - Reduce the risks of harm to patients

Quality Improvement : A New Paradigm

- *New way*: Quality Improvement as a dynamic way to reach the next level of system performance
- *New mentality*: We will improve quality by using modern management methods to address system deficiencies
- *New Vision*: A health providers' responsibility is to deliver care according to scientific evidence AND to contribute to continuous improvement of the healthcare system

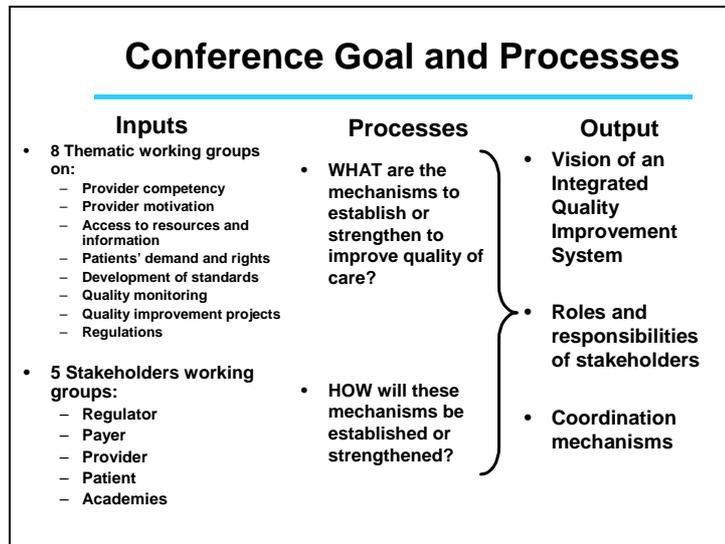
Quality Improvement Dynamic

- **Quality improves by design, not by chance**
- **Mechanisms are in place that contribute to improving the quality of care**
- **These mechanisms have 4 features:**
 - Part of day-to-day work (integrated)
 - Continuously operate and maintain results (sustained)
 - Combine several interventions (comprehensive)
 - Involve all stakeholders (coordinated)

Such mechanisms represent an Integrated Quality Improvement System (IQIS)

A Conceptual Framework to Design an IQIS

Factors Affecting Quality of Care	Systems producing or influencing the factors	Institutions & Stakeholders involved in the systems
<ul style="list-style-type: none"> •Competent provider •Motivated provider •Access to resources & information •Patients' demands and rights •Specific quality improvement activities •Regulations 	<ul style="list-style-type: none"> •Clinical education •HR management •Health financing •Population education •Development of standards •Monitoring & evaluation •Quality improvement projects •Licensing, certification & accreditation 	<ul style="list-style-type: none"> •Training institutions •Human resources office •Insurance fund •Institute of health •Professionals associations •Statistics department •Health facilities •LAC •Patients' associations



The Mechanisms

Mechanisms' Components	# 1	# 2	# 3
Provider Competency	Teach EBM skills to students	Train providers in team-based quality improvement	Teach providers how to use job-aids
Provider motivation			

Roles and Responsibilities			
Components	Mechanisms	Stakeholders Roles & Responsibilities	
		Academic	Providers
Provider Competency	Teach EBM skills to students	(1) Establishes an EBM center and trains students	(4) None
	Train providers in team-based quality improvement	(2) Integrate a 2-week QI module in continuous education FMTC, KGMA, LAC	(2) The FMTC develops the material FGPA
	Teach providers how to use job-aids	(2) FMTC teaches the use of job-aids FGPA	(3) FGPA reinforces the use of EB job-aids during their visits
Provider motivation			

- ### **Outputs of the Conference**
-
- **List of mechanisms/interventions**
 - **Consensus on an IQIS**
 - **Roles and responsibilities of stakeholders**
 - **Explicit links for coordination, to address duplications and gaps**
 - **Agenda for action/action plan**

- ### **Next Steps**
-
- **Finalize an action plan and coordination mechanism**
 - **Follow-up mechanism**
 - **Needs for policy and approval process assessed**
 - **The conference is just the beginning**
 - **No recipe/cookbook...that's how pioneers start**

Annex 6: List of Participants at the Conference

1	Mamytov M.M.	Minister of Health
2	Meimanaliev T.S.	First Deputy Minister of Health
3	Ibraimova A.S.	Director General of Health Insurance Fund - Deputy Minister
4	Madybaev M.J.	Office of Ministry of Health, Manager
5	Suyunbaeva P.U.	Deputy Chief of УКП иОП
6	Mambetov K.B.	Central Treatment Department, Chief
7	Djakipova R.S.	Central Treatment Department, Chief of Specialized and In-patient Care Department
8	Sagynbaeva D.Z.	Central Treatment Department, Chief of PHC Department
9	Toimatov S.Sh.	Central Treatment Department, Specialized and In-patient Care Department, Chief Specialist
10	Djumabaev A.B.	Central Treatment Department, Chief of License Department
11	Mambetov M.A.	MANAS Project, Chief
12	Seitalieva Ch.T.	MANAS Project, Technical Coordination Department, Director
13	Kadyralieva A.A.	MANAS Project, Coordinator of "Quality Improvement of Health Care Service" Component
14	Abdraimova A.B.	MANAS Project, Consultant for "Quality Improvement of Health Care Service" Component
15	Kadyrova N.A.	HIF, Deputy Director
16	Komarevskaya L.A.	HIF, Chief of Analysis and Perspective Development Department
17	Adnaeva N.M.	HIF, Chief of Community Involvement and Health Facility (HF) Department
18	Baiborieva A.A.	HIF, Chief of Finances and Economics Department
19	Jankorozova M.K.	HIF, Chief of Drugs Supply Department
20	Aldasheva D.B.	HIF, Analysis and Perspective Development Department, Chief Specialist
21	Salamatova G.J.	HIF, Drugs Supply Department, Chief Specialist
22	Keshikbaeva A.A.	HIF, Analysis and Perspective Development Department, Chief Specialist
23	Shimarova M.S.	HIF, Analysis and Perspective Development Department, Specialist of 1-

		st Category
24	Turdueva T.T.	HIF, Analysis and Perspective Development Department, Leading Specialist
25	Davydova Z.J.	Health Department of Bishkek City and HIF, Deputy Director
26	Abdullaeva A.A.	Director of HIF Osh Territorial Department (TD)
27	Kylychev M.A.	HIF Batken TD, Chief of Community Involvement and Health Facility (HF) Department
28	Kadyrova B.D.	HIF Issyk-Kul TD, Chief Specialist of Community Involvement and HF Department
29	Bochevskaya L.I.	HIF Chui TD, Chief of Community Involvement and HF Department
30	Akmoldoeva K.Sh.	HIF Talas TD, Chief of Community Involvement and HF Department
31	Shameeva Z.A.	HIF Naryn TD, Chief of Community Involvement and HD Department
32	Abdyganiev A.A.	HIF Jalal-Abad TD, Chief of Community Involvement and HD Department
33	Murzakarimova L.K.	Director of Republican Medical Informational Center
34	Urkunbaev Sh.D.	Drugs Department, General Director
35	Aidaraliev A.T.	Drugs Department, Chief Specialist of Pharmacology Department
36	Abdikarimov S.T.	Sanitary Epidemiological Supervision Department, Director General
37	Djemuratov K.A.	Hospital Association (HA), Administrative Director
38	Nasirova S.A.	HA, Specialist of Hospital Development
39	Niyazov Sh.N.	HA, Chairman of Board
40	Isakova A.U.	Family Group Practice Association (FGPA), Administrative Director
41	Tekenova A.Sh.	FGPA Osh Division, Administrative Director
42	Orunbaeva Z.Ch.	FGPA Jalal-Abad Division, Administrative Director
43	Sultanmuratov M.T.	Medical Accreditation Commission (MAC), Chairman
44	Azamatov Yu.M.	MAC, Senior Expert
45	Bayaliev S.A.	Kyrgyzstan State Medical Academy (KSMA), KГМА, Treatment Center
46	Mirdjalilov V.M.	KSMA, Manager of Methodology Department
47	Alekseev V.P.	KSMA, Director of Post-Graduate Training Center
48	Uzakov O.J.	KSMA, Director of Treatment Center

49	Batirkanov Sh.T.	KSMA, Chief of Propaedeutic Pediatrics Chair, Dean of Pediatrics Faculty
50	Orozbekova G.S.	Manager of Joint Family Medicine Centers (JFMC) of Issyk-Kul Oblast, Assistant of Family Medicine Chair
51	Jumaev D.J.	Director of Naryn JFMC
52	Teshebaeva N.T.	Deputy Director on Treatment of Jalal-Abad Oblast Hospital
53	Asylbekov E.A.	Director of Sokuluk FMC
54	Shorokhova T.O.	Deputy Director on Treatment of Batken Oblast Hospital
55	Mambetaliev K.M.	At-Bashi Territorial Hospital, Director
56	Kulanbaev M.A.	Director of Issyk-Kul JFMC
57	Bayalinova E.K.	Press-Center of MH, Manager
58	Jyrgalbaev M.U.	Press-Center of MH, Operator
59	Agibetov K.A.	MH, "Main Medical Technologies Package" Project
60	Karymbaeva S.T.	Informational Center on Drugs, Director
61	Karataev M.M.	Kyrgyzstan State Medical Institute of Advance Training (KSMIAT), Pro-rector of Scientific Effort
62	Ybykeeva E.O.	KSMIAT, Dean of Faculty
63	Mamasaidov A.T.	KSMIAT, Director of Osh Branch
64	Djumalieva G.A.	NGO "Preventive Medicine" - Head of Laboratory
65	Nurmakhanbetov A.	HIF, Informational Department, Leading Specialist
66	Tursunbekov M.	HIF, Informational Department, Specialist of 1-st category
67	Mambetaliev M.K.	Social and Cultural and Health Care Development Department of Prime-Minister's Office, Reviewer
68	Ryskeldieva E.F.	Kyrgyzstan Club of Hypertensive Patients
69	Korchakov V.P.	Diabetics Association of Kyrgyzstan
70	Dulatova A.B.	"Beitap" City Association of Invalids
71	Ismailova S.	"Alai Ata-Jurt" Public Association
72	Bakashova A.S.	NGO "Alga" Public Association of Rural Women
73	Polkovnikova I.S.	Republican Association of Invalids

74	Fomova L.M.	Chairman of OOC3H of the Republic of Kyrgyzstan
75	Abdrakhmanov J.	Chairman of OOC3H of Naryn Oblast
76	Ishkov I.P.	Chairman of OOC3H of Jalal-Abad Oblast
77	Avramenko A.M.	Vice-President of Kyrgyzstan Asthma Center
78	Mutalitov T.	Chairman of Health Committee of Jungal Rayon, Kyzyl-Jyldyz village
79	Sultangazieva G.	Chairman of Health Committee of Jungal Rayon, Tugol-Sai village
80	Djoldosheva Dinara	WB
81	Jo Kutzin	WHO
82	Ferdinand Siem-Tjam	WHO
83	Sheila O'Dougherty	ZdravPlus
84	Irina Stirbu	ZdravPlus
85	Jan Bultman	World Bank
86	David Burns	STLI
87	Roza Mukhamediyarova	ZdravPlus
88	Liza Myglina	ZdravPlus
89	Natalya Khe	ZdravPlus
90	Madjuga	"Den Saulyk", Kazakhstan
91	Tobias Shut	Swiss Red Cross
92	Damira Biybosunova	USAID

Annex 7: Contribution to the Aide Memoire

Quality Component

May 19-20 & 26-29, 2003

Bruno Bouchet and Irina Stirbu

A. MEDICAL EDUCATION AND TRAINING

1. Undergraduate and Post-graduate Medical Education

As part of the mission, the consultant met with the deputy rector for educational process and director of the postgraduate GP department of the Kyrgyz State Medical Academy (KSMA). The equipment for the printing office was supplied and installed. Staff was trained on the use of the new equipment. The Academy started producing printing materials for its own needs only. The administration plans to sustain the recurrent costs through offering this center on a fee-for-service basis. It is expected that costs for other institutions of the healthcare system will have lower prices. The printing office will have a separate mandate and bank account to avoid pooling of the income into the general fund that will be difficult to extract to cover recurrent costs.

Medical equipment was also supplied and installed with no delays. It is being used for the family medicine residency program clinical basis. Residency program implementation moves forward, using both family medicine trainers and specialists.

Recommendations:

1. *After developing price lists for the printing services, it is recommended for KSMA to notify different institutions of the health care system of the new printing opportunities (at different meetings, seminars, etc);*
2. *It would be valuable to receive a report on the residency program including the mix of training from family medicine trainers and specialists.*

2. Retraining and Continuous Medical Education of General Practitioners

The retraining process goes as scheduled. By the end of April, 1,654 physicians and 1,830 nurses were already retrained. An additional 568 physicians and 176 nurses are being re-trained now. In the future, 387 physicians and 2,311 nurses remain to be retrained. A new training department branch in Batken Oblast was renovated and opened in the fall of 2002. Equipment was received and installed. Although retraining of physicians from Chui, Bishkek and Issyk-Kul has been finalized in the previous project, about 100 staff members are being trained at the state budget expense due to turnover of staff.

Training Issues:

- ✓ Many training centers are located in the premises of the FM centers or other hosts, who bear the utility costs. Faced with limited resources, a request was voiced that training departments should cover part of the costs for utility and rent of space. The problem was addressed through the MOH that issued an order prohibiting such payments;
- ✓ Due to irregular dispatch of the counterpart's money, trainers are not paid on time and refuse to conduct trainings;
- ✓ According to the new order, trainees that live within a radius of 25km from the training location should not be paid per diems. However, due to the fact that the transportation system (especially in the rural areas) is poorly developed, daily commute is impossible. There were a few refusals in being retrained from the physicians and more are expected;

- ✓ Transfer of money through the bank branches to cover training expenses is often impossible and trainers (or accountants) have to take large sums of cash to be transported from Bishkek to oblasts/rayons, which is dangerous.

The above issues undermine motivation of both trainers and trainees and should be addressed.

The funding gap that was created due to the doubling of the per diems remains to be an issue. The current deficit is USD 273,360. With the current training speed available, money will run out by the end of the year. Several alternatives were suggested to cover the deficit:

- ✓ International programs were identified that included their programs and training costs (Project HOPE: USD 8,000; ADB (IMCI): USD 300; Rational Drug Use + EBM: USD 30,000). However, it covers the minuscule portion of the deficit;
- ✓ As suggested, the selection criteria for the participants to be trained have been revised and implemented.
- ✓ The training was investigated for possibly shortening the length of the program. However, it is impossible to decrease length without influencing the quality and, therefore, the decision was made to retain the current length.

Retraining of physicians is a crucial part of the reforms and should be completed with no interruptions in the process. It is strongly recommended to reallocate the money from other components or subcomponents or find other sources of funding as soon as possible so that the training process is continuous. In addition, in accordance with recent recalculations, 400 doctors were not included in the training program. During the midterm evaluation, it is recommended to recalculate the real numbers to assess the real needs.

The monitoring study was suggested to assess the effectiveness of the trainings and use of knowledge in practice. Working groups with a large participation of stakeholders (CCME, KSMA, MOH, and other associations) were created. They developed the questionnaire and are currently collecting data. The results should be finalized by the end of summer. This is an important study and the results should be shared and widely used. However, there should be an accurate interpretation of the results of the study. Lack of skills after a period of time from the training could be due to the system issues that prevent physicians to work according to what they were trained in. Modifications in the training program in this case will not result in better performance. Therefore, the causes of the gaps in skills should be addressed not only through review of the training material, but also through specific CQI projects that will identify and address system issues.

To decrease the dropout rate, a decision was made to make three-lateral agreements between trainee, CCME and MOH. According to the contract, a trainee is obliged to practice as a GP physician/nurse for at least three years.

Printing materials for the family medicine training is an issue that should be addressed in collaboration with ZdravPlus. There are three types of materials:

- a) One for family physicians was finalized and is in use. The estimated cost for the WB II oblasts is about USD 5,000;
- b) One for family nurses: ZdravPlus/STLI worked with CCME to prepare extensive "Nursing Notes" for trainings. They are ready to be printed. The cost for the WB II oblasts is about USD 13,000; and
- c) Materials are needed for the vertical programs that are being integrated into the family medicine training (IMCI, RH, STIs). The estimated cost for the WB II oblasts is about USD 7,000.

Overall, the family medicine training materials costs = USD 25,000.

Recommendations:

- 1. It is strongly recommended to reallocate the money from other components/subcomponents or find other sources of funding as soon as possible so that the training process is continuous;*
- 2. It is recommended to recalculate the real numbers to assess the real needs;*
- 3. Causes of gaps in skills identified in the monitoring study should be addressed through a review of the training materials and CQI projects;*
- 4. Distribution of guidelines is predominantly done through FGPA. However, it would be valuable if physicians that graduate from the family medicine training receive a copy of the guidelines; and*
- 5. Printing materials for family physicians and nurses are an important part of the successful training process. The issue should be resolved in collaboration with ZdravPlus.*

B. PROFESSIONAL DEVELOPMENT

1. Support to Family Group Practice Association (FGPA)

FGPA is very active and has received many grants from different organizations (USAID, WHO, ADB, OSI, IPPF, UNFPA, and others). There are currently 709 FGPs (out of which 30 are independent legal entities) and 89 FM Centers nationwide. FGPA is leading different types of training and conferences (pharmacotherapy of monitored diseases, trainings on guidelines use, in reproductive health, iodine deficiency and others). It is the main organization that is in charge of distributing guidelines for PHC and conducting trainings on their use. However, due to a high interest in protocols from educational organizations and secondary levels, a deficit of about 1,000 books was created.

No particular work on improving the health services using modern QI approaches currently exists. Initiation of specific QI projects in the health facilities requires a set of specific skills, some of which might be lacking in FGPA, since no special QI trainings were conducted. At the same time, FGPA has all the potential to initiate such effort among FGPs (train them and then provide TA). The consultant recommends for selected FGPA staff to visit Uzbekistan where a short informal training on QI could be organized and pilot facilities be visited to review the processes and results of local QI efforts at PHC facilities. It is also recommended to closely communicate with CQI trainers from the Family Medicine Training Center to understand the approach that was used and visit Issyk-Kul pilot region to review the process and results of local QI efforts. After the staff is comfortable with their level of skills and specific knowledge on QI, small pilots could be initiated and then rolled out.

Compliance to guidelines is monitored by the Health Insurance Fund (HIF). However, HIF does not provide much technical assistance (and it is not their responsibility) on investigating causes of incompliance and addressing them. This could be done by FGPA.

Normative basis for FGPs and family health workers are being developed. Six working groups were created that establish and formulate explicit functions of the family practice, including the rights and responsibilities of family health workers, looking at the content of care and system issues that prevent physicians to practice according to standards. These are: 1.) General issues; 2.) Structure; 3.) Medical services, including referral; 4.) Emergency services; 5.) Medical documentation; and 6.) Finance issues. FGPA is coordinating the activities of these working groups with technical support from the MOH. A final draft proposal from the working groups is expected by the end of July. It would be valuable if the draft document would be shared with the WB.

Motivation of family physicians remains to be an issue. The salary of specialists and hospital workers is still higher than that of family physicians. In the current transformation process, it is important to create stimuli for family practice. Non-financial incentives should also be considered, especially in remote areas (this could include housing for family physicians, animals, waiver from utilities payment, etc.). The community could (and is ready to, as shown during the QI conference) play a larger role in resolving the issue. One of the motivating factors is working conditions; however, only 40 percent of FGPs are relatively well equipped. FM Centers are more poorly equipped than FGPs. This issue should be investigated more in-depth and addressed.

FGPA remains to be dependent on donors. A financial sustainability analysis is recommended to assess future funding opportunities.

Recommendations:

1. *After a short training, it is recommended that FGPA initiates pilot quality improvement projects in pilot facilities;*
2. *FGPA should provide the results from the QI conference to the working groups that work on PHC normative basis. It would be valuable if they would incorporate the relevant recommendations;*
3. *FGPA should continue to play the leading role in the distribution of protocols for the PHC level and provide trainings, but be in coordination with CCME who could provide their graduates with clinical protocols;*
4. *List the benefits of being trained as a GP that could be an incentive, including salary, and address the disincentives; and*
5. *FGPA should consider a financial sustainability analysis to assess funding opportunities.*

2. Support of the Hospital Associations (HA)

HA leads several major areas of work related to inpatient care: restructuring of the health facilities, improving the quality of care provided to hospitalized patients, finance and management training to hospital leaders, and information dissemination (newsletter).

The QI effort was difficult to implement. Guidelines for inpatient care were only recently produced and not yet published and distributed. The staff of HA could benefit from additional, modern, quality improvement approaches. As in the case with FGPA, the consultant recommends that selected staff visit Uzbekistan where a short informal training on QI could be organized and pilot facilities be visited to review the process and results of local QI efforts. After the staff is comfortable with their level of skills and specific knowledge on QI, small pilots (for example, one interested hospital in Bishkek) could be initiated and then rolled out. This activity might also be implemented in Naryn where Swiss Red Cross operates, but further investigation of interests and opportunities is needed.

As part of the above quality improvement effort, it is recommended that the HA takes the leading role (in collaboration with EBM center staff) in training hospital staff in the use of newly developed protocols.

HA remains to be dependent on donors. A financial sustainability analysis is recommended to assess future funding opportunities.

Recommendations:

1. *HA should take the leading role in providing training in guidelines for hospital staff;*
2. *After a short training, it is recommended that HA initiates pilot quality improvement projects in pilot facilities; and*
3. *HA should consider a financial sustainability analysis to assess funding opportunities.*

3. Medical Accreditation Commission (MAC)

Activities of the MAC go in accordance with plans. Since 2002, MAC has accredited 44 new health facilities. A big step forward was completed (with support from ZdravPlus) towards MAC's independence: an application was sent for accreditation to "Kyrgyz Standard." After accreditation, MAC will be able to become an independent legal entity. This will allow a more objective accreditation process. In line with this, MAC has submitted the suggestion to the government to hold responsibility of accreditation for all medical facilities (including SES, medical resorts, and others). The new law is not yet approved.

MAC has recently re-published standards separating hospitals from PHC standards. Accreditation standards were developed three years ago. In the changing environment of health reforms, some points do not correspond to reality anymore and need to be revised, taking into account new clinical protocols and new normative bases.

No incentives currently exist for accreditation. MAC should take a more active position and play a larger role in creating these incentives. Several factors could play a role: special coefficients from the health insurance fund for accredited facilities (higher than non-accredited facilities), preference of HIF to be given to accredited rather than non-accredited facilities, increased awareness of communities to demand that the facility is accredited, and many others). More effective communication should be done with FGPA and HA. Two seminars were conducted last year on the role of accreditation, but more are needed.

During the accreditation process, MAC has identified a series of repetitive problems (ex. Patients' rights, IHI, documentation, etc.). MAC should largely involve FGPA and HA in addressing these issues during their seminars, even when not connected to accreditation.

MAC remains dependent on donors (only 1/22 part is covered through fees for services). A financial sustainability analysis is recommended to assess future funding opportunities.

Recommendations:

1. *MAC should consider revising current standards to be in line with the changing environment;*
2. *A system of incentives should be set to motivate facility administration and staff to request accreditation;*
3. *It is recommended that MAC more extensively involves HA and FGPA in addressing different issues; and*
4. *MAC should consider a financial sustainability analysis to assess funding opportunities.*

4. Promotion of Evidence Based Medicine (EBM)

Creation of National Medical Library (NML) is an important step to improve the access to medical scientific information for health professionals (scientists and practicing physicians and nurses), students and population. The building was selected (current Scientific and Research Institute of Pediatrics and Gynecology) and preliminary assessment of the renovation costs were done. However, renovation works have not started due to disagreement on the new location of the Research Institute. Since renovation works, transfer of the library and equipment installation will take a significant amount of time. The mission strongly advises making an urgent decision on the premises of the NML. In resolving this issue, alternatives are possible:

- ✓ An agreement is reached with the research institutes on the new location. In this case, renovation works should start immediately. Books in the current library should be packed and moved immediately after the renovation is over. At the same time, explicit functional responsibilities of the newly expanded NML should be developed. Staff necessities should be assessed based on functions, identified and trained.

- ✓ A new **suitable** building has been found for the NML. The difficulty in finding a new location resides in the fact that a large space is required to accommodate the library itself and accompanying organizations (such as EBM Center, FGPA, HA, MAC) in order for everyone to have convenient access to the same resources, as well as the necessity to have a large conference hall to be used for training purposes. If this is not possible, the consultant recommends that these functions be separated since the presence of the functions is more important than their physical location. Coordinating mechanisms could be further developed.

Other alternatives could be discussed.

Promotion of an evidence-based practice is a crucial function necessary to achieve quality of care. A well-organized EBM center plays an important role in the implementation of this function. Therefore, it is important that it is formally organized in the near future (either as part of the NML or as a separate center). Explicit functions of the center should be developed and described. This should include: development of clinical standards (guidelines, protocols, algorithms, quick reference guides and others as necessary), training of medical staff (doctors, nurses), training of medical students (undergraduate, postgraduate), training of trainers (for example at the Medical Academy), course development, serving as a resource center on EB practice and rational drug use for anyone interested (based on requests), promotion of EB practice to patients, and others. As soon as functions are developed, staff and equipment needs should be assessed. EBM Center could not necessarily occupy a separate location but be housed by an institution (Medical Academy, CCME, research institute, NGO, other); however, it should have a separate mandate, convenient location, and have enough space for staff, equipment, a local library, and trainings. Being located within an institution offers a better chance for the financial sustainability of the center. In any case, recurrent costs should be calculated.

In the creation of the EBM center, it is recommended to consider current available resources. For example, the Drug Information Center (located in the Drug Department) has very similar goals in promoting EB practice, but is narrowed to the rational drug use. They are currently struggling to survive, since WHO, which created the center 4 years ago, has stopped funding and no new financial sustainable mechanisms were developed. Their current resources (staff-5, computers-5, library, and furniture) combined with the resources of the group that currently assists the development of guidelines (staff-2, computers-2, furniture, and library) could serve as a good basis for the new EBM center with little additional resources needed.

Subscriptions for journals and books were made and are renewed on a regular basis. A library board was developed and meets quarterly to agree on the list of books to be procured for the library.

The working group on clinical practice guidelines developed and approved 95 protocols (47 for PHC, 28 for secondary care and 20 for tertiary care); six are in the process of being approved by the working group. External validation of both the guidelines and processes of their development is important to reassure the high quality of the product.

The previous set of 31 guidelines was reprinted in smaller quantity than needed – deficit about 1,000 copies. This should be covered as soon as possible. Taking into account the deficit of the previous set of 31 protocols, the consultants recommend a more careful calculation of the needs for the books (educational institutions should be included in the calculation). To reduce printing costs, it is highly recommended to separate publication of the protocols by level (protocols for PHC should be published in a separate book from protocols for secondary or tertiary levels). To assure continuity of care and knowledge of care provided at the previous level, it is suggested to reinforce referral slips where the major details of care are described.

In addition to the practice field, the guidelines were also introduced in the educational field. CCME has fully adapted its courses to be in compliance with guidelines; KSMA has started introduction at the

postgraduate FM department. It is recommended that students at the undergraduate level benefit from the product by adapting the content of their courses as well.

In addition to the content modifications, it is important to teach knowledge management skills as early in the medical education process as possible. It is recommended to develop a short training course on knowledge management and EBM as an approach and to introduce them as part of the undergraduate education. As a first step, trainers have to be prepared. The staff of the EBM Center using KSMA's resource centers could perform this job.

Recommendations:

- 1. A decision should be made as soon as possible regarding the location of the NML with subsequent decisions on the location of the accompanying organizations;*
- 2. The mission recommends that an EBM center be created. To assess the needs, explicit functions should be described. The Drug Information Center could be merged with the EBM group and serve as a basis for the new EBM center;*
- 3. The needs for new protocols should be carefully calculated for each level of care and be printed as separate books in respective amounts;*
- 4. The content of the courses at the KSMA undergraduate level should be updated to be in compliance with clinical protocols;*
- 5. It would be valuable to develop and introduce the knowledge management course at the KSMA;*
- 6. An additional set of 31 protocols should be printed to cover the deficit; and*
- 7. An external validation of guidelines should be organized.*

C. PHARMACEUTICAL MANAGEMENT

1. Strengthening Quality Control of Drugs and Rational Drug Use

Equipment was supplied and some was installed. Staff has been trained on the use of new equipment. Issues with equipment are as follows:

- ✓ Not all technical details are always present in the equipment due to a not detailed enough initial description;
- ✓ Instructions in the Russian language are not always present;
- ✓ Qualified personnel for training or servicing the equipment is not always available.

The laboratory staff is addressing these issue with distributors.

All drugs that are currently imported undergo control through the laboratory. However, illegal drugs are rarely checked. Investigating the number of tests done at the laboratory, there is a clear increase in the number of drugs tested and a slight decrease in the proportion of defect drugs (in 2000: 5,866 drugs were tested and 269 were defect; in 2001: 7,677 drugs were tested and 402 were defect; in 2002: 10,056 drugs were tested and 536 were defect; 1st quarter of 2003: 3,459 drugs were tested and 51 were defect). The majority of drugs are being tested as a regular control of import (85.6% out of all tests performed). The structure of defects (incompliance with standards) is due to the following reasons:

Description of exterior: 55.02%;

Package: 20.52%;

Mechanical inclusions: 5.5%,

Authenticity: 4.4%,

Label: 12.22%; and

Microbiological purity: 1.31%.

It is expected that all drugs brought for humanitarian distribution undergo tests for quality control before being distributed. Although this will give more control over imported drugs, the administration should be careful not to delay the distribution process.

The drug department plays a role in the distribution of the equipment. The difficulty is to redistribute old equipment that was exchanged with new equipment. When health facilities receive new equipment, the old equipment (even in working condition) is often hidden in the basement. It is recommended that a more rational use of equipment and the transfer of the working pieces to facilities that lack them (for example, from hospitals to FGPs). Preferably, this transfer should occur within the same oblast. If this is not possible, facilities in need should be identified and given the equipment.

A lot of effort was placed on developing a new regulatory basis for drugs: the Law on Drug Policy, Law on drugs, Concept on rational use of medical equipment. Changes were introduced in the resolution on the order of reception and distribution of humanitarian assistance. In addition, the Essential Drug List is currently being reviewed and will be finalized during the fall of 2003. Drug formulary was developed and approved and is currently at the printer for duplication. The distribution will start by the end of summer.

At the beginning of 2003, the government accepted the suggestion to waive drugs from VAT (20%). A study now is being conducted on the decrease of prices in the pharmacies. A careful interpretation of the results is suggested, since the decrease in prices will occur only after all drugs procured before the order (i.e. with VAT) would be completely sold.

The law on drugs allows health care workers (physicians and nurses) from remote areas where there is no pharmacy to sell drugs in retail to patients *after a special training*. By current estimates, there are about 300 remote villages that can benefit from this law. About 100 are in urgent need. The training that will allow health workers to sell drugs is planned to be conducted on a "fee for service" basis. The cost of the training is 1200 KG Som (about USD \$30.00), but few people can afford it, since living and transportation expenses should be covered in addition. Since there is a clear conflict of interest, more control on compliance with standards should be done. The best case scenario is when the drugs for sale are distributed in accordance with the protocols, rather than the newly formed dealers buying drugs from the nearest pharmacy based on their preference.

Street drug dealers continue to be a problem. To address the issue, the Drug Department has hired several Pharmaceutical Inspectors that, on a regular basis, visit bazaars and black drug markets. However, these inspectors have not been given the authority to withdraw drugs from dealers or to fine them. The most they can do is call the police who have the authority to place charges. According to the new law on drugs, fines for selling illegal drugs have been increased fivefold. Control measures are often ineffective and promote corruption. It is recommended that a stronger emphasis be placed on the community campaigns. The EBM Center, the current drug information center, and the health promotion center could all be involved in the process.

Recommendations:

1. *More attention should be given to the rational use of equipment;*

2. *Continuous development of the normative documents is important, especially with regards to new introductions in the system (i.e. working with street drug dealers, pharmaceutical activities of medical workers in remote villages, etc.);*
3. *Larger involvement in health promotion and EBM centers and a shift of target to population is a necessary part of addressing the issue of street drug dealers; and*
4. *The issues concerning laboratory equipment should be addressed.*

Annex 8: Acronyms and Abbreviations

CME	Continuous Medical Education
CQI	Continuous Quality Improvement
FGP	Family Group Practice
FGPA	Family Group Practice Association
FMC	Family Medicine Center
FMTC	Family Medicine Training Center
HA	Hospital Association
KSMI	Kyrgyz State Medical Institute (for Postgraduate Training and Continuous Education)
MAC	Medical Accreditation Commission
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health
QA	Quality Assurance
QI	Quality Improvement
RN	Registered Nurse
STLI	Scientific Technology & Language Institute
WHO	World Health Organization