Mid-Term Evaluation of USAID/CAR Project

Quality Public Health and Primary Health Care in the Central Asian Republics

"ZdravPlus II"

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April 17, 2008

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Acknowledgements

The members of the evaluation team, Tina Cleland, Jill Boezwinkle, Karen Cavanaugh, Forest Duncan, and James Heiby, wish to express our immense and heartfelt gratitude to the USAID/CAR staff in Almaty, Astana, Bishkek, Tashkent, Dushanbe, and Ashgabat; to the ZdravPlusII staff in Almaty, Astana, Karaganda, Dushanbe, Bishkek, Ferghana, Issyk Kul; to our interpreters Larissa Yurassova (Kyrgyzstan and Kazakhstan), Djalilova Munavara (Tajikistan), Elena Zdravomyslova (Turkmenistan), Gulruh Caron (Uzbekistan); to our drivers Stawitski Slava, Guralevick Igor, Frank Alexey and Glazkov Sergey (Kazakhstan), Kiriyak Vassily (Kyrgyzstan), Asdov Nodir (Tajikistan), Vladimir Litvinov (Turkmenistan), and Tahoev Ibragim (Uzbekistan); and to all of the many patients, physicians, nurses, midwives, feldshers, professors and others throughout the region who so graciously shared with us your time, documents, insights and wisdom. We arrived in the middle of the coldest winter in Central Asian history and you warmed us with your renowned hospitality. You opened the doors to the health system for us and helped us to understand the challenges you have faced and the many accomplishments of which you are rightfully so proud. We thank you for your patience and good humor in the face of our considerable language difficulties, many requests, and inevitable snafus. We ask for your understanding of any errors we may have made in our interpretations of the information you shared with us. We thank you for the privilege of learning about your countries and seeing the region's health system through your eyes.

The team also wants to acknowledge ZdravPlus II's considerable effort to prepare papers requested by the team to facilitate our analysis. These papers supplement the PMP reports, and monthly, semi-annual and annual progress reports submitted by the ZdravPlus II. They were excellent resource documents for the team and should become part of the permanent legacy of the project. For this reason, we have included them as Annexes Q, R, S, T, U and W.

List of Acronyms

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

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

Executive Summary

A. Background and Objectives

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

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

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

B. Context

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

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

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

C. ZdravPlus II Performance Assessment

1. Overview:

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

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

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

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

2. Performance against Performance Monitoring Plan (PMP) Indicators

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

3. The Four Components

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

a. Stewardship

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

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

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

b. Resource Use

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

c. Service Delivery

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

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

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

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

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

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

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

d. Population and Community Health

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

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

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

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

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

4. **Performance by Country**

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

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

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

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

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

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

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

C. The Regional Approach

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

D. Lessons Learned

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

- Reform takes time.

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

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

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

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

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

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

2. 2010 and Beyond

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

I. Background and Context

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

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

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

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

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

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

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

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

"Zdrav*Reform* was first funded in 1994. Early in Zdrav*Reform*, three major problems were identified:

a. The very large, overly specialized, and fragmented health system with enormous amounts of excess capacity was no longer sustainable given the general economic and health budget collapse that occurred after the fall of the Former Soviet Union (FSU). Specifically, the hospital sector was very overdeveloped and fragmented and more cost-effective primary health care (PHC) was very weak or even non-existent.

b. In addition to the problems caused by health delivery system structure and financing, PHC was weak or non-existent due to the lack of family or general practice (all doctors were specialists) and the low capacity of PHC practitioners (catchment area physicians largely serving as dispatchers referring the high majority of their patients).

c. The system was not responsive to the needs of the population and the population was not involved in their health.

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

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

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

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

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

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

> [In the] Performance Monitoring Plan (PMP) tables (Annex P), ZdravPlus II Project Regional/Technical Overview paper (Annex Q), Implementation Strategies paper (Annex R), and matrix tables (Annex S) there is more detail; but in general, intended results were/are as follows:
>
> A. Form new PHC sector, restructure and rationalize hospital sector and shift savings to PHC, and introduce new health financing system increasing both equity and efficiency in individual health services
>
> B. Service delivery:
> - Introduce family or general practice to increase capacity and improve service delivery in PHC and gradually expand scope of services in PHC by integrating priority programs
> - Specific service delivery improvements in priority program areas by implementing new CPGs or standards or implementing WHO programs using facility level quality improvement techniques
> - Broadly promote EBM, develop new CPGs, and rational drug use
>
> C. Greater population and community involvement in their health
>
> D. Improve overall stewardship in the health sector
>
> E. Expand the scope of the health reforms to include next generation areas of improving financing system and service delivery for public health, infectious diseases, and undergraduate medical education.
>
> The indicators that the reforms are sustainable and that countries are self-directing their health care systems are as follows:

A. The intended results outlined above

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

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

III. Purpose of Evaluation

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

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

IV. Country and Regional Findings

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

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

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

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

- **Stewardship:** (1) Policy dialogue mechanisms and processes, health policy content, and the legal and regulatory framework; (2) Solidify institutional structure, roles and relationships with the health sector and across sectors where necessary, and (3) Contribute to monitoring and evaluation systems for health reform and health service delivery, (4) Policy marketing and public relations and (5) Donor/project collaboration and coordination.

- **Resource Use**: (1) Health delivery system structure and human resources planning; (2) Health financing – collection, pooling, purchasing/provider payment; (3) Health information systems; and (4) Health management. This component is very broad. It collapses three major health system functions--health finance, human resources, and health information systems. It also encompasses some elements of the service delivery and governance functions from the health system framework which WHO and USAID now use.

- **Service Delivery**: This component addresses the provision of quality patient care. There are five main activity areas 1) Medical education and human resource capacity development in family medicine (FM) and maternal and child health (MCH), 2) Evidence based medicine and clinical practice guidelines, 3) Peer review through continuous quality improvement, 4) Health purchaser quality assurance systems, licensing and accreditation, 5) Upgrading buildings and equipment and 6) Pharmaceuticals. In Kyrgyzstan, this component also includes SES reform.

- **Population and Community Health**: This component is devoted to involving

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

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

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

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

1) The recommended priorities for health system strengthening over the remaining project period through December 2009, and

2) The recommended priorities for country programs beginning in 2010 when the ZdravPlus II project ends,

3) The potential for countries to move along the development continuum from "Developing" to "Transition" to " Sustaining Partner" over the next two years. (An analysis for each country is included in Annexes A1-E1).

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

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

D. 1. Kazakhstan Country Findings

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

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

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

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

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

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

- Assist the MOH in analyzing performance under Phase I of the State Health Care Development Program and assist with the design and implementation of Phase II to deepen and expand reforms. As has been done so well to date, the project must collaborate closely with the World Bank in these efforts. The new $296.1m World Bank sector loan (which will be co-financed by the GOK with a $178.4m contribution) and increasing GOK budgetary allocations to health will provide the resources necessary to implement Phase II, and the priorities that follow.

- Protect pooling at the oblast level; maintain the single payer system; and roll out further the information systems (developed in Karaganda) required to support pooling. The MOH is facing pressure from some oblast governors to restore pooling to the rayon level. It must resist these pressures as rayon level pooling seriously undermines the efficiency and equity of the financing system.

- Develop model budgets for PHCs which can represent targets for budget allocations to manpower, pharmaceuticals, supplies, utilities, and capital expenditures.

- Implement fully the new provider payment systems, make changes in Treasury operations to permit reimbursements on a monthly as opposed to annual basis, and remove chapter budgeting that restricts facility management autonomy.

- Establish a government outcome-based budget system (pay for performance) and introduce it in all oblasts.

- Strengthen the Continuous Quality Improvement functions for Safe Motherhood and Arterial Hypertension programs at the clinical practice level. Focus especially on the mentoring function whereby experts observe practice, provide feedback, and demonstrate improved techniques. The team heard frequently that health workers receive training but some health professionals find it difficult or are unwilling to put it into practice.

- Involve the Sanitation and Epidemiological Services (SES) on CPG working groups and enlist their support in issuing and implementing new guidelines.

- Work with the GOK and ZdravPlusII to identify incentives that will increase involvement of the medical academies in the development of CPGs and in revising their curricula for EBM and bringing their curriculum up to international practice standards. Possibly reactivate ZdravPlus II funding of the Morehouse School of Medicine in order to introduce models for incorporating EBM and CPGs into the medical curriculum.

- In partnership with WHO, strengthen the national framework for PHC monitoring

and evaluation system.

- Collaborate with Project Hope in integrating TB services into the PHC system.

- Coordinate with UNFPA in securing GOK budget funding for contraceptives; establishing a better FP/RH monitoring and evaluation system; and improving health management education at the KSPH, notably the module on commodity logistics management. The UNFPA program ends in 2009.

- Assist NGOs such as the Kazakhstan Association of Family Practitioners and the Business Women Association of Kazakhstan to produce business plans and fundraising initiatives that ensure their sustainability. Advise the MOH on areas where they should contract out services that NGOs can perform.

- Inform the public about family medicine and the "patient friendly" benefits of the health reforms.

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

- Advise the MOH and WB on restructuring the hospital system; improving the cost-efficiency of new and existing hospitals; and rationalizing the continuum of care between primary care and hospital care facilities. Kazakhstan plans to build 200 new hospitals with its newfound wealth. For years, the issue was how to spend scarce funding most efficiently; now the issue shifts to spending more plentiful funding most efficiently.

- Explore and, if feasible for some locations, expand the family group practice model to include the social services and patient clubs pioneered in the "Demeu" family medicine center in Astana.

- Produce additional periodic studies of the impact of co-payments on under-the-table payments and the reduction in out-of-pocket costs to lower income families.

- Pilot the Village Health Committee program implemented in Kyrgyzstan.

- Mount a program to inform the Global Fund about the CAR approach to integrating DOTS into the primary care system, and seek support for a pilot to address the news roles for hospitals and primary care facilities in the treatment of TB.

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

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

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

D.1.3. Kazakhstan Recommendations for 2010 and Beyond

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

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

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

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

- Collaborate with the GOK, World Bank, and other development partners to review, update, and implement Phase II of the State Health Care Reform Program. The program will likely include many of the activities we highlight below.

- Roll out the primary health care reform model to other oblasts. Kazakhstan needs to "catch up" with Kyrgyzstan and Uzbekistan with the rollout of these reforms.

- Develop service delivery programs to address other major diseases such as bronchial asthma, trauma, and diabetes.

- Modernize the curriculum of medical academies by incorporating EBM in all clinical disciplines. Support the organization responsible for EBM to institutionalize a systematic approach for promoting Evidence Based Medicine and developing Clinical Practice Guidelines.

- Strengthen the health management curriculum at the Kazakhstan School of Public Health and medical academies and establish a mentoring program to ensure graduates practice new management skills.

- Improve the efficiency and effectiveness of specialty outpatient care and inpatient care. This entails examining the continuity of care and the delineation of appropriate levels of care. These issues underpin determinations of excess capacity in the system as well as the quality of care. Resolving them in a rational way will increase the cost effectiveness of the health care, and better serve the patient.

- Support the rationalization and reform of the Sanitation and Epidemiological Service, which often contradicts and impedes progress in institutionalizing new clinical practice guidelines based on EBM.

D.2. Kyrgyz Republic Country Findings

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

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

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

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

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

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

Stewardship:

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

MHIF funds, violation of patient rights, or corruption.

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

Resource Use:

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

Service Delivery:

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

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

Community and Population Health:

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

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

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

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

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

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

D.3. Tajikistan Country Findings

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

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

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

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

the health sector.

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

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

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

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

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

- Maintain close collaboration with the World Bank and other donor partners in encouraging the new MOH leadership to advance the reform agenda.

- Maintain the small, but significant progress that has been made in reforming primary care by establishing evidence-based family medicine as the clinical gold standard for the country.

- Assist the Health Financing Working Group and the MOH in implementing the National Health Financing Strategy; including implementation of the Basic Benefit Package, the primary health care capitation system, the hospital case based reimbursement system, the supporting health information system. Begin piloting improved hospital management systems. The initiatives are critical to making the health system more efficient, effective, and equitable--and attracting and maintaining a quality health care workforce.

- Stay the course supporting the Centers of Excellence and training and re-training

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

- Roll-out the Safe Motherhood and Arterial Hypertension CQI programs to a few selected rayons and oblasts. The pilot sites the team visited demonstrated clearly the successful acceptance—by health professionals and patients—of the new safe motherhood practices based on international standards. Collaborate with the World Bank to provide additional equipment such as incubators for the intensive care wards, in facilities in and outside of Dushanbe.

- Launch publicity campaigns about the impact of EBM on maternal and infant mortality and morbidity. Involve the President, MOH and others in influential positions. Public interest stories should be organized through the press center about the satisfaction of patients and providers in the PHC sites where EBM is practiced. Strengthen the MOH CPG process and continue supporting the Evidence Based Medicine Center and the Drug Information Center in continuing their impressive work.

- Strengthen the MOH CPG process and continue supporting the Evidence Based Medicine Center and the Drug Information Center in continuing their impressive work.

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

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

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

D.3.3. Tajikistan Recommendations for 2010 and Beyond

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

- Review progress to date and collaborate with the government and other donors to chart the course for continuing the reform movement. Options might include a Sector-wide Assistance Approach (Swap) similar to the one in Kyrgyzstan or a State National Health Care Plan such as the one Kazakhstan is using to guide its reforms.

- Continue strengthening and broadening capacity at government and facility levels to implement health financing including health information system reforms.

- Assist the MOH to issue a Health Code as is being done in Kazakhstan to ensure Tajikistan's health care laws and regulations are consistent and complementary to one another.

- Complete the training and re-training of doctors in family medicine and roll-out nationwide the Safe Motherhood and Arterial Hypertension programs. Pilot additional clinical practice guidelines developed and approved by the Tajikistan School of Public Health or other appropriate institution.

- Strengthen and expand health promotion initiatives at government and facility levels.

- Explore opportunities for reforming the Sanitation and Epidemiological Service and ensuring its programs support new clinical practice guidelines.

D.4. Turkmenistan Country Findings

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

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

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

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

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

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

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

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

Stewardship

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

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

for all types of health care.

Resource Use

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

Service Delivery

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

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

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

Community and Population

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

D.4.3. Turkmenistan Recommendations for 2010 and Beyond

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

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

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

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

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

D.5. Uzbekistan Country Findings

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

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

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

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

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

Stewardship

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

Resource Use

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

activity through 2009.

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

Service Delivery

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

Community/Population

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

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

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

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

D.5.3. Uzbekistan Recommendations for 2010 and Beyond

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

D.5.3. Uzbekistan Recommendations for 2010 and Beyond

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

D.6. Regional Findings

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

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

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

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

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

V. Technical Comments

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

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

One essential step is to support the expansion of EBGs beyond the small number currently in place, and establish EBM as a standard for health care generally. ZdravPlus II support is needed to support such an expansion, building the institutional capacity within the health system to sustain and update evidence-based standards for all of health care.
In the countries of the former Soviet Union, EBM may be perceived as in conflict with recognized experts who have traditionally promoted certain clinical practices without supporting evidence. Conflicting guidelines are clearly undesirable, and these experts should be included in the guideline development process. However, the development process must specify the central role of clinical and scientific evidence, rather than subjective opinion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. The Value of the Regional Approach

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

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

even more compelling in the CAR, based on their shared history, health system structures, language, and physical proximity.

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

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

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

VII. Lessons Learned and Best Practices

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

- **Reform takes time**.

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

complementary funds in the hundreds of millions.

- Government counterparts and local community members perceive the support from ZdravPlus II as cooperation from USAID and from the people of the American people, creating an immense amount of **goodwill for the United States and USAID.**

- ZdravPlus II's innovative approach demonstrates that **health projects can contribute to progress in governance and civil society**. The project has made inroads in development of civil society, government capacity, transparency, participation, and press in countries where direct work toward these aims would not be as feasible.

- **Donor harmonization, project coordination and integration** will maximize the impact of each donor's efforts and reduce the host country costs of servicing the donors. In addition, coordination helps to create a united front when engaging in dialogue on policy decisions with the host government and has enabled the project to move more efficiently and effectively within the political arena. ZdravPlus II has worked to bring together the World Bank, Asian Development Bank, DFID, Swiss Red Cross, and governments united in support of common development programming.

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

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

- ZdravPlus II's **bottom up and top down approach** is important to creating lasting change and ownership of reform efforts. The project approach to health reform is very comprehensive and it is unique to find a project that is addressing both the political and legal levels along with the community and service delivery levels. The attention to the multiple layers of change and intention to link the components in meaningful ways programmatically will serve well for sustainability.

- **Key stakeholders are important to change.** Well-placed advocates accelerate change once institutions in place. Significant investment in the knowledge, skills and capacity of health reformers at the operating level, such as facility managers, will sustain changes in health reforms as long as supportive policy change does not lag too much. But the establishment of institutions, acceptance of new methods by opinion leaders is only the first step. **Implementation challenges need a knowledgeable guide for success.**

- **Creating regular forums** (i.e., seminars, conferences, workshops) for sharing ideas and formulating new approaches facilitates understanding of the reforms and creates linkages.

- **Maintaining flexibility and agility with dynamic governments** has made ZdravPlus II very successful. Engaging in health reform efforts across five countries requires navigation of a variety of stakeholders and political climates and ZdravPlus II has been able to stay abreast of changing relationships, priorities, and personnel. Objectivity and consistency were also recognized as important project characteristics. ZdravPlus II is seen as a valuable technical resource rather than aligned with a particular political agenda.

- **Promoting innovative and comprehensive design elements that correspond to the abilities and needs of each country** has improved health reform efforts. For example, the creation of a mandatory health insurance fund in the Kyrgyz Republic, promoting performance incentives for primary health care workers in Uzbekistan, using global capitation based payment for primary care with differentials to adjust for population composition and burden of disease, integrating health and financial information systems in the Kyrgyz Republic, creating rayon level monitoring of clinical run charts for several key health issues in Uzbekistan, integrating PHC retraining into undergraduate training curriculum, and institutionalization of PHC CME, and privatizing the pharmaceutical sector in the Kyrgyz Republic.

- **Engagement of civil society organizations and professional associations** contributes to country ownership and sustainability. For example, the Family Group Practice Association, the Medical Accreditation Commission, the Hospital Association, Village Health Committees, and the Press Center within the MOH all play a key role in educating the public about the reforms and guiding aspects of

the reform process in the Kyrgyz Republic.

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

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

B. Technical Direction.

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

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

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

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

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

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

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

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

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

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

C. Project Management

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

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

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

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

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

IX. Conclusion

- Through the ZdravPlus II project, USAID's continued investment in health sector restructuring in the five Central Asian Republics since 1994 is having a remarkable impact on addressing the health challenges facing each country.

- This success is due in large measure to the project's ability to tailor its vision and strategy to each country; sequence reforms in response to changing political climates

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

- All governments and donors regard ZdravPlus II as the indispensable technical expert in the region. The project earned this reputation through its unique knowledge of the region and the health issues gained over almost fifteen years of implementation.

- USAID is successfully supporting health reform initiatives even though congressional directives constrain the Zdrav budget and programming flexibility. As health reform moves from debating policies to implementing complex changes, the technical relevance of work across countries is growing, not diminishing in importance.

- Zdrav's success in the region has attracted international interest, its model of reform being the first of its kind in the world. It attracts many study tours from other countries; is the subject of numerous academic papers; and merits more documentation and dissemination. For example, comparing the health reform experience in Kazakhstan, a middle-income country, with Kyrgyzstan, a low-income country, will add substantially to the nascent body of knowledge on evidence-based health system reform.

- Zdrav's implementation strategy to strengthen health systems (a horizontal approach) and target specific diseases or conditions (a vertical approach) is of groundbreaking importance. This vertical approach (i.e., a diagonal approach) can make a valuable contribution to informing the debate about whether and how a combined approach can work to maximize health outcomes.

- At both the national and community government levels, the Zdrav series is benefiting areas of government beyond the health sector. Examples are reforming the Treasury system for disbursing operating funds; defining the roles and responsibilities of government institutions; and expanding the role of civil society.

- USAID should continue its commitment to supporting health reform in Central Asia through 2009 and beyond, both to reap the full benefits of restructuring the health care systems and growing Central Asia as a classroom for the world.

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