Joint Assessment

of the

Kyrgyz Republic National Health Reform Program-Den Sooluk

2012-2016

Executive Summary

The new Kyrgyz program for health reform, Den Sooluk, is well designed but in need of further strategic improvements and of strengthening of the planned management and implementation arrangements. That's the conclusion of a joint assessment by national and international experts of this new national strategy (JANS).

General

This review took place from 3 to 15 October 2011. It overlapped with the Joint Annual Review of the ongoing program, Manas Taalimi and the discussion about the near final new program. The JANS was requested by the Minister of Health (MOH) of the Kyrgyz Republic. The aim was to present and discuss the analysis of strengths and weaknesses of Den Sooluk with senior Kyrgyz policy makers and other stakeholders against international guidelines of IPH+, and to suggest possible courses of action on specific issues to strengthen Den Sooluk. Five main areas were covered in the review: situation analysis & programming, process (of development of the new program), costs & budgetary framework, implementation & management, and monitoring, evaluation & review.

Information on some topics such as the plan for monitoring and information and on the overall budget envelope for the health sector, including for the larger medical equipment items, capital investment and drugs expenditures were not yet available at the time of the review. This impeded the assessment a bit. Leaving the capital investment items out of the program and out of the SWAp arrangements poses a risk to the development of the sector and of its sustainability. For the donors it may pose the risk of seeing their investments in e.g. primary health care (PHC) undermined by contradictory investments in for example separate emergency care services which could have been covered by PHC if properly resourced. The absence of a medium term budget framework (MTBF) further aggravates this.

Strengths

A key strength of the new program is the fact that it is a continuation of the two previous programs, Manas and Manas Taalimi. **The Den Sooluk is hence the third sector program supporting a continuous track of reforms each building upon implementation and achievements of the former and following certain sequencing**. Sector performance frameworks and policy analysis linked to the national policy debate have helped maintain continuity in reform implementation based on the sector programs. In follow up of a critical review of the prior programs and their implementation, Den Sooluk is more oriented towards quality strengthening and health systems change, making health reform sustainable and implementation more effective. At the same time priority disease programs as identified in prior program will continue with a focus on cardiovascular diseases (CVD) as the main cause of mortality (and of mortality at young age), on maternal and child health (MCH) and on Tuberculosis and on HIV/AIDS, related to the Millennium Development Goals (MDGs).

A second strength of the program is the **close and integrated collaboration with national and international development partners around DS implementation in a sector wide approach (SWAp) and with joint budget support via the State Budget and coordinated parallel funding, formalized since 5 years.** SWAp arrangements are likely to be continued for Den Sooluk for which partners are processing new formal agreements. A further key element of the KGZ SWAP is the organizing of 6 monthly joint annual reviews(JAR) reviewing progress in the sector and plans of work for the next year and for the MT utilizing a jointly agreed sector performance framework**.**

Many more strengths are identified in the new program, in its inclusive development process and in the way MOH, national stakeholders, civil society and development partners operate in a constructive way, e.g.

- The **reform proposals match the identified health and health systems problems** in a balanced way.
- **The DS can build on a new constitution**, which allows for more realistic approaches and entitlements to health protection and to the health care than the previous ones. This new constitution also shows the government's commitment to health reform.
- **The program aims at social health protection: universal coverage, fairness in financing, equal access to services and prevention of impoverishment, while using international best practices, with their implementation based on the results of specific pilots in KGZ.**
- **Costing of program activities has been carefully and realistically done,** in general and as far as this could be reviewed because of limited information.
- Overall, the **coordination, implementation and management arrangements are based on sound principles** and make organizational sense.
- The planned **activities are clearly defined, related to the strategy and results oriented**, **with concrete targets being set.**
- The **need for solving health human resources** in general and for strengthening management and supervision capacity in particular are **acknowledged**.
- **Financial management and procurement policy and standards are adequate**.
- **Sound monitoring and evaluation (M&E) mechanisms are seen as indispensable with excellent capacity available**. This is hitherto used to evaluate and provide independent guidance to policy development, implementation and review, including for the Joint Annual Reviews with development partners and civil society. A link with regional (oblast level) activities is made in the new program.

Areas for improvement

Despite the good analysis, design and planned implementation, which are only partly indicated above, there are some important health sector aspects not covered adequately and **some strategy aspects and their planned implementation that need strengthening**, among these:

- **Financial management, in particular in light of the planned increase of the autonomy of health services providers** as an important means to improve quality of care and efficiency in services delivery. This important area requires a separate component or section in the DS program.

- The strategy should be further expanded with a number of **sub-sector strategies** to cover areas which are currently not or not sufficiently addressed, such as:
    - investments and restructuring of hospitals in Bishkek
    - overall quality improvement
    - pharmaceutical management
    - human resources
    - public-private partnerships

- Although the leading thought behind the strategy is to have a more strategic and health systems oriented approach to solve generic problems which also have in the past impaired the implementation of disease oriented reforms, **the strategy shows limited link between the system oriented "components" and disease oriented "programs".** The implementation plan and the costing exercise do not visualize the programmatic and organizational connections between components and programs which thus may lead to a silo-based approach in implementation which the strategy this time intends to avoid.
- The analysis of barriers to implementation of previous strategies and to achieving results should be subject to a deeper review and go to the detailed **root causes of ineffective reform measures** and absent results of past programs. This would lead to better formulation and tailoring of activities in the new program.
- The overall governance of the health sector, of its current **triple payer system**, its tools for rational capital investment decisions, general oversight responsibilities and implementation need improvement to increase equity in access to services, prevent wasting of resources and to reduce informal payments. The role of other sector ministries and of government as such should also receive attention because many health related factors cannot be tackled with the MOH mandate but need to be influenced by other ministries.
- The absence of a clear **plan for reducing the gap in funding of the State guaranteed benefits package (SGBP)** begs for designing and implementing such plan as soon as possible, especially given effects on out of pocket payments and access to care issues in its absence.
- T**he plan of work, (POW) the management and implementation plan is vague in some areas**, e.g. who exactly will bear responsibility for implementation. Further clarity is needed on the link between activities and M&E;
    - What defines the "budget" from which 13% will be paid by the state for the health sector;
    - Concrete plans for solving the human resources crisis demands more detailing and deserves a specific sub-strategy, which also deal with the skewed distribution of staff;
    - An autonomization plan for hospitals is also missing;
    - How to solve the MOH capacity problems, in particular related to the foreseen increased autonomy of providers etc.

  The latter issue demands an independent review of MOH mandate, capacity and performance. While implementation is everything, as Manas and Manas Taalimi have learned, this part of the strategy and its implementation plan should certainly be improved to support the best possible returns on investments.
- The M&E arrangements are lacking **data auditing/verification** and a mechanism to connect national evaluation with local activities and improvement programs.

Risks

Den Sooluk will be confronted with risks in its further preparation path and especially in the implementation phase, including

- Continuity in policy making in light of the aftermath of Presidential elections end of October 2011 and possible change of government and/or minister of health.
- The perspective of other sector ministries towards the public health aspects of law making, implementation and enforcement in their respective sectors.
- The lack of financial resources and the lack of prioritization of activities, based on relative cost-effectiveness and health-value for the money.

Recommendations & next steps

The JANS report includes recommendations which mirror the identified shortcomings.

Annex one at the end of the report includes an overview of recommendations and responding changes in Den Sooluk following the JANS.

Acknowledgements

The team that did the joint assessment of the national strategy (JANS) would like to express its gratitude to all Kyrgyz officials and staff in the Ministry of Health and in the Mandatory Health Insurance Fund, to the management and staff of health services institutions, to representatives of UN Agencies and of donors, to the NGO's and many others that have helped the team by either providing documents or by granting interviews.

The team is especially thankful to the Den Sooluk preparation team which did a great job in difficult circumstances . The JANS review team likes to stress that the comments and critique on the draft Den Sooluk paper in this JANS report should not be interpreted as if the DS team has not worked optimally. On the contrary, the comments of the JANS team need to be seen as contributions to possibly further improve an already great document.

Phyllida Travis of WHO/Geneva, Health Systems Adviser, Maria Skarphedinsdottir of WHO/EURO, JANS focal point and Chris Lovelace, World Bank Senior Health Adviser, provided invaluable guidance to the review team.

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JANS team

The Joint Assessment was done by an independent team of national and international experts:

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List of abbreviations

AMI	Acute Myocardial Infarction
CVD	Cardio-Vascular Diseases
CQI	Continuous quality improvement
DP	Development Partner
DS	Den Sooluk
FAP	Feldscher Accoucheursky (midwife) Point
FGP	Family group practice
FGPA	Family Group Practice Association
GOK	Government of Kyrgyzstan
HCDC	Health Care Development Center
HCO	Health Care Organization
HPAC	Health Policy Analysis Center
HR	Human Resources
IDA	International Development Association
IHP+	International Health Partners Plus
JANS	Joint assessment of national programs
JAR	Joint Annual Review
KfW	Kreditanstalt für Wiederafbau (German Development Bank)
KR	Kyrgyz Republic
KGZ	Kyrgyzstan
LMIS	Logistics management information system
MT	Manas Taalimi
MCH	Maternity & Childhood
MDG	Millennium development goal

M&E Monitoring and evaluation

MHIF Mandatory Health Insurance Fund

MOH Ministry of Health

MTBF Medium term budget framework

NGO Non Governmental Organization

PH Public Health

PHC Primary health care

POW Plan of Work

PFM Procurement & financial management

QIP Quality improvement project

RHPC Republican Center on Health Promotion

SGBP State Guaranteed Benefits Package

SWAp Sector Wide Approach to health sector reform

TA Technical assistance

TOR Terms of reference

TB Tuberculosis

UNFPA United Nations Population Fund

UNICEF United Nations Children's Fund

USAID United States Agency for International Development

VHC Village health committee

WB World Bank

WHO World Health Organization

1. Introduction

The joint assessment of its national health reform program Den Sooluk (DS), was requested by the Minister of Health (MOH) of the Kyrgyz Republic to the International Health Partnership Plus (IHP+), and Development Partners (DPs) in order "to get a fresh look" and suggestions to further improve the design and planned implementation of the new sector program. The assessment was discussed with sector partners during the Joint Annual review of the Kyrgyz National Health Reform Program "Manas Taalimi" (MT) in May – June 2011, during which also a draft of DS was discussed extensively. The Minister of Health formally requested WHO support for organizing the JANS. WHO staff helped the MOH to develop the approach to the JANS, through teleconferences between WHO and senior MOH officials. Other partners were consulted and gave inputs on the JANS team, timing and program. The MOH confirmed the decision to have a JANS, choice of the team, and timing to partners

The team, working in Bishkek from 2 – 15 October 2011, had the following objectives

a. To make a joint assessment of Den Sooluk using the JANS Tool and accompanying guidelines as the guiding framework.
b. To present and discuss the analysis of strengths and weaknesses of Den Sooluk with Senior policy makers and other stakeholders, and possible courses of action on specific issues."

Den Sooluk preparation

The MOH DS preparation expert team started July 2010 and the draft program is based on

- Evaluation of Manas taalimi[1], which in turn is based on numerous evaluation reports, e.g. of the Health Policy Analysis Center[2] and document review[3]
- Extensive consultations with health sector representatives all over KGZ
- Consultations with Parliament in June and September 2011
- Policy dialogue with partners around Den Sooluk:
  - July and November 2010 joint annual reviews (JARs)
  - Written DP comments in May 2011
  - June 2011 joint annual review (JAR)

[1] Ministry of Health of the Kyrgyz Republic: Evaluation of the Kyrgyz Republic National Health Reform Program "Manas Taalimi"Implementation Report. Bishkek April 2011
[2] http://www.hpac.kg/index.php?lang=en
[3] A literature list is provided in Annex 2

The approach

The team studied the proposed DS program[4] (version of 12 September 2011) and some of the related documents before the start of the mission. A list of referenced literature and background documents is attached (Annex 3.2).

The complete POW and the results of the micro-costing exercise of the DS Program were not available at the start of the mission. However, the team received some of this during its mission from the DS preparation team by way of slide presentations. The macro-costing results related to the total health sector costs were not available for the team during its mission. This means that the team had no overall budget envelop and could not review the financial feasibility of the program and the activities as reflected in the POW.A detailed M&E plan and a set of indicators were not made available before or during the mission of the JANS team. However, the team was given a presentation of the outline of the M&E approach for DS.

The mission members had a kick off meeting with the Minister of Health and the other senior management of MOH, followed by meetings with stakeholders and ending the first week of its mission with a debriefing of the State Secretary of Health on the interim results of the mission and subsequent discussion. A list of persons met is attached (2). During the second week, the preliminary observations were presented to the participants in the Joint Annual Review (JAR), see list of participants and program (3 & 4) and extensively discussed directly thereafter and during the remainder of the week. The JANS team members continued to interact with the JAR participants during the second week of their mission when the Joint Annual Assessment of the MT program was done, which concluded with the Health Summit on 15 October 2011 (5). The results of this interaction with counterparts have been used to finish the report.

Den Sooluk development

The DS Program was initially developed by a National Group of Experts established by MoH in July 2010. Subsequently, working groups on health systems oriented Components and on Priority diseases were established, reporting to the DS Team. The team had extensive country wide consultations with health care sector officials and parliamentarians throughout the preparation period from July 2010 till October 2011. The consultations on the new program were preceded by a similarly wide consultation on the evaluation of the MT Program and its predecessor the Manas program. The barriers for their implementation were identified to some extent and acted as important input to the design of DS. The MT evaluation was published in June 2010. In June and September 2011 consultations were held with the Committee on Health Care, Social Policy, Labor and Migration of the Parliament (Jogorku Kenesh) of the Kyrgyzstan.

The draft of the DS Program was initially discussed with DP's in March 2011. During the May/June 2011 Joint Annual Review of MT and DS, further adaptations were agreed to be discussed during the Fall 2011 JAR, for which an updated version was submitted.

Many activities were carried over to the new DS strategy from the previous MT Program, as they had not been fully completed during MT implementation.

[4] MOH. Kyrgyz Republic Den Sooluk National Health reform Program 2012-1216, Draft of 12 September

2. Results of the assessment

The results of the Assessment done during the October 2011 mission are presented hereafter, structured according to the main attributes as referred to in the JANS tool and Guidelines[5] :

1. Situation analysis & programming
2. Process
3. Costs & budgetary framework
4. Implementation & management
5. Monitoring, evaluation & review

In general, the team was impressed by the soundness of the strategy and by the fact that a national team developed the program, which shows the capacity of the country. However, there are some missing elements, especially re financial management and (related) as regards the regulation of the intended increased autonomy of providers which is not matched with re-balancing of oversight and increased management capacity development. Sub-strategies are missing for a number of areas:

- Investments and restructuring of hospitals in Bishkek
- Overall quality improvement
- Pharmaceutical management
- Human resources
- Public-private partnership

These should be developed to guide implementation of activities, planned according to the new national health strategy, Den Sooluk.

However, the development of these sub level strategies should not hinder the start of program implementation.

The strengthening of financial management capacity deserves an explicit section in the DS Strategy paper itself given its importance for all levels of the health care sector, MOH and its implementing institutions and health services providers. Such strengthening would add to the credibility of the DS Program design and the trustworthiness of its implementers vis a vis the financiers in general and the Kyrgyz population in particular.

Further improvement of the Program can be done by further developing the POW, critically assessing the planned activities against actual need and the cost-estimates of the activities, by refining the implementation arrangements and, during the implementation itself, especially

[5] IHP+ Joint Assessment of National Health Strategies and Plans. Combined Joint Assessment Tool and Guidelines. Draft, Version 2, September 2011

strengthening the institutional set up and tools of the concerned implementers and the health sector as such.

In the assessment hereafter, a description of strengths is followed by an indication of the weaknesses and provided recommendations while also a number of implementation risks are indentified.

2.1 Situation analysis and programming

Attribute 1, The National strategy is based on a sound situation and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, governance, and institutional issues).

Strengths

- The DS is the third sector strategy supporting a continuous track of reform. The DS is based on an in-depth analysis of the experience gained during the preceding strategies, in which implementation barriers are identified and addressed according to a certain sequence of steps. This is all done in consultation with stakeholders. (See section 2.2. on Process)
- The DS proposes and matches program proposals to the gaps identified.
- The DS combines system strengthening with disease focus in public and individual health services, i.e. cardio-vascular diseases, mother and child health, HIV/AIDS and TB.
- Builds on achievements of 15 years of consistent reforms, institution and capacity building which in turn have been thoroughly externally evaluated and documented, e.g. by HPAC and its predecessor, the Health Policy Analysis Unit.
- The DS profits from close cooperation of Kyrgyz Government authorities and development partners over a period of 15 years, the last 5 years by way of a sector-wide approach (SWAp) which is expected to be continued
- The DS builds on a revised (2010) Constitution, which includes a clearer formulation of the rights of citizens to health protection and access to care; the latter can be restricted by law as to e.g. stay within available means, and protects important rights of citizens.

Weaknesses

- The program is missing explicit attention to some important areas:
    - Financial management and procurement strengthening

- An investment and optimization strategy for Bishkek to start solving the long standing problem of its hospital infrastructure capacity and lack of capital investments.
- A public-private partnership strategy
- A pharmaceutical management strategy
- An overall quality improvement strategy
- A human resources strategy

- Although it addresses the main diseases in the country, a formal burden of disease study is not done. Such study could provide the baseline for the monitoring and evaluation of the disease and economic impact of the implemented DS.
- The strategy prioritizes services delivery improvement to specific priority diseases, e.g.
  - It has limited involvement with other disease categories, with other specialties and services of hospitals and PHC and the management of hospitals, which will hamper the implementation and makes the other specialties waiting for another 5 years for quality improvement.
- More in general, the relations between the systems improvement aspects (called components in DS) and the priority disease oriented programs are not very clear in the strategy and lead to difficulties for stakeholders to recognize where they can find their particular stake in the sector being addressed. More important, it is not clear how and where the interaction will take place. This may lead to an unwanted continuation of the silo approach of Manas Taalimi instead of moving to an integrated approach in which the disease programs are like tracer diseases or trailblazers that take advantage of the strategic system oriented actions as foreseen in the program and of which the experiences and results can be used for other disease and services categories.
- Barriers could be more deeply evaluated during POW implementation. For example, one of the current barriers is formulated as: *"Low access of the population, especially of the patients with Acute Coronary Syndrome (ACS) and Acute Cerebrovascular Accident (ACA) to emergency health care, high-technological and specialized medical aid;"* This is rather generally formulated. What causes the lack of access? Is this the absence of a working ambulance system which could provide thrombolytic therapy at the place where the patient is picked up and which could make the biggest gain in the prevention of mortality or handicap from acute myocardial infarction. Or is it the absence of angioplasty possibility or coronary artery bypass surgery? Only further analysis would tell and a cost/effectiveness analysis could guide the priority setting for one or the other intervention Diabetes is missing as an important risk factor for cardiovascular (and other) disease(s).
- The governance of the health system is in need of strengthening:

- Oversight over MOH and MHIF lacks scope on performance effectiveness in some cases indicating lesser government, commitment e.g. in the unfinished agenda of Bishkek hospital restructuring.

- The relation between MOH & MHIF needs further clarification on important points and enhanced clarity on the cooperation process would be beneficial..

- Instead of the intended single payer system there is in fact a dual paying system: MOH for high tech and maintenance fund and MHIF for the services included in the State guaranteed benefits package (SGBP), both paying individual services. Bishkek city could even be added to this because it purchases the services for the insured in their area, has a benefits package which is different from the rest of the country with for some services different rates of payment. Hence such a triple payer system adds to administration costs and to dilution of purchasing responsibilities, which risk the effectiveness of the purchasing function.

- Parallel medical systems, such as for the Army, Railway systems etc. are under other jurisdictions than MOH and are not involved and not taken into account in DS or at least are not visible while the need and added value of having these parallel systems as separate from MOH can be questioned especially as regards the resource constraints of the country: human resources and money, and as regards the equity in access aspect.

- When looking at the unchecked tremendous growth in hospital admissions over the last five years (7% per year), the MHIF has apparently insufficient purchasing tools and capacity for review of contracted medical services, i.e. the services covered by the SGBP. Although MHIF has recently started to do some in depth review in one rayon where it found some inappropriate admissions, this appears not yet to be done routinely and systematically over the whole country.

- While use of policy analysis in policy making has been one of the strengths of the policy environment in Kyrgyzstan the draft document makes limited reference to the existing wealth of available evaluation reports and other background documents, with explicit literature references, which would make the report more credible for outsiders.

- Clear reference to the new Constitution is lacking. This would highlight a firm legal basis for DS policies and activities, while the requirements of the Constitution should in turn receive attention in public information and education/information of health managers and staff as well as in undergraduate studies.

- The approaches towards implementation and enforcement of health care related laws and regulations are not sufficiently described in the DS strategy.
  Current and improved laws might not be executed due to the lack of tools for their enforcement.

Risks

- The Kyrgyz Republic changed its political system in 2010 from a presidential to a parliamentary democracy with a newly elected Parliament. The election of a new President has taken place in October 2011. Changes in Government and perhaps a change of the top management of the ministry of health may be likely. This may pose a risk to the endorsement and implementation of the Den Sooluk program.
- Given the political context it is also not known what the attitude will be of other sector ministries such as agriculture and economy which should be involved in the implementation as regards public health related measures: i.e. tobacco and alcohol control. This may pose a risk to the endorsement and uptake of elements of the reform program.
- The DS Program will be implemented under the conditions of a new architecture of power: after the 2010 Constitution reform, the legislative and budget power is localized in the Parliament (Jogorku Kenesh); a real multi-party system and pluralism emerged; the Government is formed by the Parliamentary majority. On the one hand this creates new opportunities to gain political support for health care due to political competition. On the other hand, this creates new threats and risks due to instability, formation of new coalitions and probably more frequent change of the Cabinet of Ministers.

Attribute 2: National strategy sets out clear priorities, goals, policies, objectives, interventions, and expected results, that contribute to improving health outcomes and equity, and to meeting national and global commitments.

Strengths

- The program covers the 3 health MDG's and addresses some of the major causes of mortality in the country including, i.e. cardiovascular diseases (CVD).
- The DS is results oriented
- The DS has set targets for priority areas.

Weaknesses

- Some targets could be more precisely defined to be better measurable, e.g. the one related to thrombolytic therapy for acute myocardial infarction, which should set a timeline within which the therapy should start, the so-called door to needle time when only looking at what happens in the emergency room or in the hospital itself. Better might even be to look at the time between calling the ambulance or the doctor and the start of the thrombolytic therapy. This latter might indicate even more important shortcomings and reasons for delay of the start of the therapy.
- Defined milestones could be used more explicitly to yearly measure and regularly communicate progress to stakeholders, including parliament.
- The MDG on reducing poverty gets limited attention, especially as regards the impact of out of pocket payments (formal and informal). However, more attention is warranted:

- The increased number of hospitalizations combined with the gap in financing of the SGBP may have led to increased copayments per average patient. This is not analyzed and some of the hospitalizations perhaps not justified. However, a survey among discharged patients is underway and will bring some clarity in the near future.
- High prescribed volumes and high prices for medicines, of which most have to be paid out of pocket, will most likely have given cause for a rise in frequency and height in copayment.

Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness, efficiency and sustainability.

Strengths

- The DS program and also the Government of the Kyrgyz Republic aim for concurrence with international principles of social health protection: e.g.
  - Fairness in financing
  - Equity in access to essential care
  - Prevention of impoverishment
- During the 15 year course of the KGZ health reform pilot projects, preceding policy decisions or taking place at the start of implementation, and their evaluation have guided strategy and actions in the past when looking at feasibility and impeding and facilitating factors during the pilot phase. Such pilots will continue to underpin the proposed Program based activities.
- The country uses and will continue to use internationally tested policies and systems, such as
  - A single payer system (which still needs to be fully completed and further improved)
  - A payer provider split for management of health services
  - Using the purchasing mechanisms to strengthen value for money and to contain costs
  - Per capita financing for primary health care (PHC), case-based payment for hospitals and state budget funding for public health services, which are all international tested best practices although all payment systems have their pros and cons.
  - Using clinical practice guidelines based on evidence and international best practice.

Weaknesses

- The relative cost/effectiveness analysis of health technologies is not studied, raising some questions such as whether the proposed procurement of high tech equipment or expensive

drugs have health value for the money relative to other investment options, and medical technologies? The absence of such analysis, which supports more rational decisions, makes it difficult to resist pressure to introduce new and expensive technologies, and drugs in the State Guaranteed Benefits Package (SGBP), to introduce new screening programs or high tech equipment and high cost/high risk interventions.

- The exceptional position of Bishkek in services position, governance and payment system is not conducive for the achievement of equity in access for all citizens.
- Existing local government support, e.g. higher payment than the Mandatory Health Insurance Fund (MHIF) offers and the financing of services outside of SGBP, could lead to inequity in access to care.

Recommendations

- KGZ MoH should consider developing sub-strategies where these are missing, as indicated above.
- MOH may want to prepare for adjustments in the strategy, necessary in case of funding shortfalls or changing circumstances, via prioritization of planned program activities.
- MoH may also want to look for options for early dissemination of quality improvement activities via e.g. the development of a comprehensive quality improvement strategy of which the implementation will e.g. connect other specialties and services and the general management of a health facility with efforts and results of the priority disease related activities. This will facilitate the uptake of continuous quality improvement (CQI) methods and take into account their results.
- MoH may want to review diabetes as CVD risk factor and adjust program accordingly.
- Consider options to address signaled governance gaps, inequities and capacity problems.
- Pay explicit attention to the need for new general and financial management arrangements and their strengthening, especially in relation to planned increase in autonomy for hospitals and health services providers in general. This requires a separate section in the Program.
- MoH should consider creating or hiring capacity for cost/effectiveness analysis to support more rational decision making on investments and SGBP extension.
- Tasks (activities) & interventions to overcome the existing barriers should be further and more in-depth be reviewed for root causes, be more precisely defined and elaborated in POW and annual implementation plans with matching activities.
- Define and prioritize activities in the POW, taking into account possible political, economic and other risks.
- Consolidate and streamline the efforts of MOH and MHIF in the improvement of the health care sector financing system.

- Include reference to the available underpinning analysis/materials for the proposed activities/interventions in the POW, as referred to in the meetings with the DS preparation team.

  Promote wider incorporation of legal aspects into education, training and retraining of health workers and HCOs managers, referring to new Constitution.

Attribute 4: An assessment of risks and proposed mitigation strategies are present and credible.

Strengths

- The DS strategy has a designated section on "program implementation strategy" catering for some of the foreseen risks in taking the strategy forward among them lack of clarity of roles and responsibilities.

- The sector program hence outlines four levels of responsibility and maps two of these - the central (MOH departments and centers) and regional level against priority areas and system components. The DS envisaged technical coordinators will be responsible for specific priority areas and have a role in bridging between priority areas and the program components. The strategy further envisages strengthening the role of oblast health coordinators for overall coordination at the regional level.

- The DS broadly maps major international partners by priority area, program component and main national counterparts and outlines in broad terms main channels and focus of international funds within the SWAP as well as the role of joint annual reviews in bringing major actors together for performance review and planning.

Weaknesses

- In taking the DS forward risk management could be further strengthened through development of sub strategies (inclusion in the POW) matching major identified gaps/risks such as the human resource crisis and the need for strengthening MoH capacity in light of foreseen increase in provider autonomy and others as identified.

2.2 PROCESS: Soundness and inclusiveness of development and endorsement process for the national strategy[6]

Attribute 5: Multi-stakeholder involvement in development of the national strategy and operational plans and multi-stakeholder endorsement of the final national strategy.

[6] More details can be found in Annex 7
[8] E.g. the Law on Health Care Organizations, 2004

Strengths

- Wide coverage of the launching of the process of DS National strategy development in mass media indicates the transparency of the process. Competition for enrollment into the DS Preparation Team was announced in the large-circulation newspaper «Vechernii Bishkek». The composition of the approved DS team of strategy developers was published at the MOH website.
- The process of DS preparation and ultimate discussion during the October 2011 JAR and the Health Summit shows wide inclusion of health care representatives of different levels from over the country, together with representatives of Academia, NGO's, Parliament, DP's and of all MOH levels albeit with different intensity. Some parliamentarians also participated in the discussions on the pages of large-circulation newspaper "Vechernii Bishkek", therewith contributing to raising awareness among the general population about the planned new program.
- NGOs, also actively participated in the DS discussions during the JAR, submitting separate proposals for inclusion, e.g. on HIV and on accountability of MOH to NGO's for HIV/AIDS implemented programs. NGOs have suggested that donors should also practice openness and accountability for their projects implemented in the health sector.
- The top management of the MOH and MHIF supported the process of the Program development.

Weaknesses

- The DS development process saw limited participation of the Government itself and of other ministries, of MHIF, state administrations and local self-governance bodies, and of private health care providers. Other sector ministries will be important for the implementation of lifestyle related prevention activities, e.g. alcohol and tobacco control.
- Some activities and interventions, including their costs, were proposed for inclusion in DS, its Plan of Work and the DS budget by national top-level institution managers, such as for CVD and TB, without much participation of others. It is not clear to what extent these proposals will be scrutinized on need and cost-effectiveness.
- The schedule of DS related preparation meetings, its venue and time were not made public beforehand. That's why probably the possibility to participate in the further development of the DS Program was limited. Minutes were kept of the meetings; written proposals were studied and archived. By the time of the JANS mission, an evaluation of the proposals was not available.

Recommendations:

- During further preparation for the implementation of DS and during the strategy implementation MoH should consider ways to gain understanding and support of patients' associations, the private medical sector, other ministries, state administrations, local self government bodies and mass media, including the management and Steering Council of the

Public TV-Radio Company. The latter should cover DS and inform the public at large and health workers about DS and its implementation.

- The need to and costs of activities should be more widely checked, outside the direct circle of interest groups.

Attribute 6: There are indications of a high level of political commitment to the national strategy.

Strengths

- A solid legislative framework has been created and a number of bills[8] necessary for DS implementation were adopted during implementation of the previous health care reform programs.
- New legislation takes into account the interests of health in other sectors and policies. The DS Program is developed under the conditions of a new Constitution[9], which breaks with the soviet-type declarative promises of unsustainable free health care of previous Constitutions under which Manas and MT reform programs were designed and implemented, and which were contradicted by specific health sector laws that endangered the health sector and devalued the legal basis of health care policies. The right to health protection and care as included in the 2010 Constitution sounds more realistic now, which creates a solid legal basis for the DS program and shows the political commitment to health reform. Political commitment to health reform is further manifested in the efforts to maintain the current level of health care financing as percentage of total Budget spending and in the significant increase in wages of health workers in 2010.

Risks:

- Political commitment may change in case of Minister of health is replaced after the Presidential elections, end October 2011.

Recommendations:

- MoH should consider ways to gain understanding of and support from advocacy groups and consumer associations to jointly promote and execute the right to health protection. This would be very useful also in convincing other sector ministries to make their contributions to creating a healthier society.

[9] Article 47 of the Constitution, enacted on 27 June 2010, states: "1.Everybody shall have the right to health protection. 2. The State shall create conditions for health/medical service of everybody and shall take measures to develop state/public, municipal and private health care sectors. 3. Free health care, as well as exempt health care shall be provided within the state benefits package, envisaged by the Law. 4. Withholding of facts and consequences by officials, endangering people's lives and health, shall entail liability, envisaged by the Law».[9]

- MoH should further consider ways to gain understanding and support of all Parliamentary fractions, in order to mitigate threats for DS implementation in case of formation of new parliamentary coalitions and change of Cabinet of Ministers.

Attribute 7: The national strategy is consistent with relevant higher- and/or lower-level strategies, financing frameworks and plans.

Strengths:

- The DS program aims to create necessary conditions for the protection and promotion of the health of the population and of each person, which flows from the new Constitution and matches health related MDG's. DS is a successor of MT and Manas Programs which were related to national development and poverty reduction strategies, Currently, a new Interim Development Strategy 2012-2015 is in preparation. Further, DS is linked to the State Program on HIV/AIDS Epidemic Prevention.

Weaknesses:

- There is no reference in the DS document itself to any general national program on e.g. general development or on poverty reduction. Super-national agreements, such as the one for treatment of migrants in host countries, which is important for combating TB and HIV infections, are not listed.
- The DS Program is not related to programs of other sectors, such as the «Concept of Education» and the «Strategy of Social Protection Development ».
- Public Health issues are not fully reflected in the new Law "On Local Self-Governance[10]", i.e. do not provide for explicit attention of local government representatives for health protection issues[i]. Only the members of the Parliamentary Committee on Health Care participated in the discussions during the development of DS.

Risks:

- The implementation of the DS Program might be hindered due to insufficient prioritization of health issues in other sector programs. This might limit the possibilities of effective inter-sector partnership. The risk persists of potential antagonism of different programs, for example the intention of the government aimed at economic revival in the republic might stimulate tobacco and alcohol production and lead to de-regulation of the pharmaceutical sector. This may affect and have a negative effect on planned lifestyle interventions and on quality and availability of safe and affordable medicines.

Recommendations:

- Consider ways to support the wide integration of the DS Program into the Country Development Strategy for 2012-2015, the Regional Development Program and the Social Protection Development Strategy, currently being developed.

[10] Law «On Local Self-Governance», June 16, 2011

- Consider ways to gain understanding and support of a wider range of Committees in the Parliament: e.g. the Committee on Human Rights and Equal Opportunities; the Committee on Budget & Finance, etc. This will support priority setting of inter-sector health protection issues during discussion and adoption of a wide range of laws. It will enable parliamentary oversight of the execution of these (also health related) laws.

2.3 Costs and budgetary framework

Attribute 8: The **national strategy has an expenditure framework that includes a comprehensive budget /costing of the program areas covered by the national strategy**.

Strengths

- By the time, the JANS Team had started its work, the DS Team had completed micro-costing estimates, which covered the costs/expenses directly related to the DS program implementation (operating expenses), including areas such as procurement of less expensive medical equipment, computer equipment, software, training and study-tours, consultative services and printing of materials. The total cost was estimated in the amount of 47.0 M USD. Costs were well estimated, based on the costs and tendencies of previous years and on experience gained through MT Program implementation. Expenditures were estimated using the current state tariffs, e.g. for per diems, which makes the expenditure framework as presented realistic and justified.
- With technical support, the DS Team, in charge of development of the National Strategy, managed to create software on an Access software platform, which enabled the team to do all the estimates much faster, avoiding technical errors.
- Calculations on micro-costing are based on the POW of the DS Strategy implementation, and are clearly linked to the envisaged activities and interventions by components.
- Some mismatch of the POW with the DS strategy, revealed by JANS is not related to the quality of the work, done by the DS team on costs estimates but more by the underlying policy process and the role of technical working groups.
- The calculations envisage some potential risks due to the changes of prices in subsequent years of the DS program implementation, and for this purpose annual inflation coefficients are applied, which fit the inflation indexes, set by the KGZ National Bank.
- Estimates of Micro-costing look quite realistic in general.

Weaknesses

- The JANS team did not get a comprehensive forecast of financing both against state/public and external sources.

- The cost of major capital expenditures, such as for the procurement of expensive equipment, construction and capital repair of buildings, were not taken into account, in the micro costing exercise. Same for the costs of medicines.
- Micro-costing includes only the expenditures, which are planned to be covered by donor's funds. Calculations and forecasting were done by the DS Team on their own. Despite the correct approach and methodology applied to estimates, the entire process was not explained and documented, and that might cause a negative impact on the credibility of the costs framework among potential participants of future DS strategy financing.
- Besides, as the lessons learned through MT implementation show, changes entered to the POW at the DS implementation stage, will imply necessity to revise calculations. However, so far there are no written guidelines on the budget and financing framework. So it would be necessary to institutionalize and document the process of calculation to not lose the institutional memory and remain consistent.
- In spite of a wide participation of all stakeholders in the process of the national strategy development, the level of inclusion of parties, especially MOH and MHIF into the work related to development of the POW and micro-costing exercise was limited.

Attribute 9: The strategy has a realistic budgetary framework and funding projections. If the strategy is not fully financed, there are mechanisms to ensure prioritization in line with overall objectives of the strategy

Strengths could not be observed due to lack of information**.**

- An overall financing/budgetary framework, covering all planned investments and expenditures, was missing at the time of the review, hence the realism of the proposals could not be judged.

Weaknesses

- Despite the fact that the POW has envisaged activities for almost all the set objectives, the feasibility of their implementation does not look convincing, as there are still barriers at e.g. the legislative level. Signaled barriers are also not reviewed in depth, which may impact the implementation. As the POW was developed with almost no participation of the relevant structures in charge of economic and fiscal policy, the expected result for some interventions is not clear and is uncertain.
- These uncertainties indicate some weaknesses in the interaction of MOH and MHIF in the area of development of general policy of health sector financing. Despite the significant progress achieved through MT implementation within the framework of SWAp, many issues, concerning further strengthening of the Single Payer System are not sufficiently reflected both in the strategy and in the POW. The issue of financing of individual services from different sources (Republican budget, local budget) by various payers (MOH, MHIF, Bishkek City administration) is ambiguously reflected in the DS; yet this "triple payer system" is one of serious obstacles for completion of Single Payer System formation in health sector and therewith affecting the implementation of DS.

- One of the most important issues – implementation of the SGBP remains unsolved. According to estimates, the gap of this program financing comprises about 25-37% of the SGBP cost. As this Program represents almost the main/basic package of services, provided by the health sector and consuming approximately 70 % of all the funds managed by Single Payer, the issue of sustainability of this program financing is of strategic importance. Unfortunately, neither the strategy, nor POW does envisage clearly defined measures on reducing the financial gap.
- According to the situational analysis data, the number of hospital admissions has significantly increased during the last few years against the decreased number of visits to primary health care facilities. This worsens the financial gap. However, DS strategy does not envisage any interventions to mitigate the risk and e.g. reduce unnecessary and possibly inappropriate admissions, i.e. a potential efficiency gain is not explored and not foreseen to be explored, thus loosing an opportunity to close the SBP funding gap.
- The above gaps in combination with the lack of health sector financing framework, based on MTBF, do not allow at this stage to be convinced of the feasibility of achieving the expected results.
- The lack of a budget framework for DS is partially due to the fact that the MOH has not yet identified priorities in the POW. This subsequently upholds both donors and the Government to identify their contributions into DS financing.
- Despite few positive results related to the solution of the issues of financial management and fiduciary risks, some problems remain unsolved, such as institutionalization of financial (external) audit and the introduction of an improved computerized system of accounting.
- At the meetings and interviews of HCOs managers, they pointed out that sustainable financing, especially the investment part of financing of the program, is of utmost importance and is an instrumental factor for implementation of the planned activities.
- Despite the annual health care budget execution at the level of 95% in general (Rule [1]2) in compliance with the covenants of the Grant Agreement between the KGZ Government and IDA (International Development Association), delays in financing of the investment part of the MOH budget, as well as re-programming of funds during program implementation still create uncertainty for the implementation of some activities; thus delays in financing of MT to non-accomplishment of primary care physician trainings. Yet, the POW for DS implementation does not stipulate any activities to mitigate such risks. In the past any in between reprogramming of MT budgets was not done in a transparent way. An improved approach to mitigate this is not foreseen in DS
- The DS Program does not envisage the issues of institutionalization of external and operational audits.

Recommendations

To complete the work on development of the DS strategy and on a basic package of documents on its implementation at a qualitative level, taking into account the gaps and comments, identified by JANS, it is recommended to:

- More actively involve MOH & MHIF into the process of program costing and general expenditures estimation;
- Develop guidelines /instructions for users on calculation of strategy implementation costs and the budget framework;
- More clearly link the activities with the set objectives, some activities will need further elaboration due to limited experience with the particular activity
- Estimate cost of DS strategy with the funds for other activities using multi-year budget forecast (MTBF), and identify the sources of financing taking into account expected revenues of non-state /public sector

2.4 Implementation and management

Overall

- The previous strategy, Manas Taalimi, has been implemented with the support of many donors of which a number have formally agreed to a Sector-wide Approach (SWAp). Some of the involved donors were pooling their contributions at the Ministry of Finance/Treasury others offered parallel funding. All worked very closely together and coordinated their investment efforts, implementation support and evaluation of the program. The SWAP in KGZ was quite favorably evaluated[11], in comparison with SWAps in other countries. Reviews conducted indicate Kyrgyzstan is a high performer on several evaluation parameters including areas where SWAPs often are weak such as results management and systems for regular monitoring and evaluation of sector plans. Also a recent review pointed at some strong characteristics of the Kyrgyz health reform program[12]: continuity & leadership.
- Overall, the implementation and management arrangements called for in Den Sooluk are based on sound principles and make organizational sense. However, their lack of sufficient detail puts implementation at risk. In particular, there is no clear plan in place for how to adjust or revise implementation if targets are not being met, or how to use M&E data to adjust activities.

[11] Denise Vaillancourt, Independent Evaluation Group(IEG), World Bank. Do health sector-wide approaches achieve results? Emerging evidence and lessons from 6 countries, IEG Working Paper 2009/4

[12] Ibraimova, Ainura et el. Kyrgyzstan: a Regional Leader in Health System Reform: http://ghlc.lshtm.ac.uk/files/2011/10/GHLC-book_Chapter-5.pdf ; quoted from : Balanova, Dina et. Al, editors. Good Health at low Costs, 25 years on. What makes a successful health system. The London School of Hygiene and Tropical Medicine, 2011.

- In addition, the activities in Den Sooluk, while based on important disease priorities, were not chosen through cost-effectiveness analysis or according to evidence. As a result, the activities in the POW, even if fully implemented, may fail to achieve the health goals they are intended to accomplish. They are also not necessarily the best use of financial resources.
- There are a few minor overall risks to Den Sooluk implementation. The continued availability of financial resources of the program depends on global financial stability and continued donor support. The program is also dependent on continued commitment from the Government of the Kyrgyz Republic & of Parliament.

Attribute 10. Operational plans are regularly developed through a participatory process and detail how strategic plan objectives will be achieved.

Strengths

- Den Sooluk contains an elaborated 5 year plan of work. The POW covers the full five years of the strategy, and details the activities that support the strategy.
- Developed through a participatory process of relevant stakeholders for each component – the process was mostly inclusive and comprehensive. The Den Sooluk POW was developed through a process of working group discussions, composed of high level experts working on the respective components or programs without much participation of e.g. secondary level hospital staff, PHC staff, MHIF and MOH itself, though technical input was received from relevant MoH bodies.
- The POW focuses on achievement of clearly defined activities. For example, one maternal health activity is "Improve knowledge and skills of obstetrician-gynecologists, obstetricians, anesthesiologists, intensive care doctors of TH on postpartum bleeding management and use of second-line medication in case of severe obstetric hemorrhage."[13]

Weaknesses

- The POW does not link activities to monitoring and evaluation. The progress and impact of Den Sooluk could be better tracked if it is tied to POW activities directly to specific indicators and targets, rather than grouping them by priority program area.
- The roles and responsibilities of implementing partners would benefit from additional elaboration in the POW. Currently, it uses very broad terms such as "PHC Level" or does not identify the implementing partner.

Recommendations

- In the annual work plans based on the Den Sooluk POW, specifically name the responsible party for every activity. Also make a link between the implementation of the "Components", addressing the more generic issues such as health finance, public health etc. and the priority disease oriented programs to assure that representatives of both categories are described in the detailed plans of work with their respective responsibilities and tasks and feed into other components and programs..

[13] MoH: Den Sooluk Plan of Work

- Link each Den Sooluk activity to a target or indicator, and develop a mechanism for adjusting annual plans of work if those yearly targets are not being met.

Attribute 11: National strategy describes how resources will be deployed to achieve outcomes and improve equity, including how resources will be allocated to sub-national level and non-state actors.

Strengths

- DS defines organization of service delivery and addresses equitable allocation of resources.

Weaknesses

- Current logistics, information and management system resource constraints are described in Den Sooluk, but there is no detailed plan for how to overcome those constraints.
- Human resource needs are clearly identified but plans to remedy those gaps are insufficient and not fully elaborated.
- The items that make up the state budget for calculation of the contribution to the health care sector are not clearly identified (SWAP Budget rule 1. 2010: 13%) The percentage of state budget devoted to health is essentially meaningless if the total budget is not consistently defined. The percentage may be fixed, but the denominator for that percentage is not.
- Non-state actors are not considered in Den Sooluk. Considering the many factors that influence health, that is an oversight. Parallel health systems are also not referred to.
- Same for the role of parallel health systems which may also draw from DS implementation, its resources and otherwise influence the impact of DS on the MOH led health system.

Recommendations

- Develop additional planning documents to support Den Sooluk and elaborate on the topics addressed in the strategy and POW. These documents should cover: 1) human resource planning, with specific attention to health care providers in rural areas and general practitioners; and 2) a plan for overcoming weaknesses in the current logistics management information system (LMIS) in Kyrgyzstan and establishing a financial base to maintain it.
- Set an unequivocal base for the calculation of the yearly budget contribution to the health sector. This will ensure that the budget is calculated consistently and the amount allocated is consistent and reliable throughout the fiscal year and can be safely used for planning.
- The Government of Kyrgyzstan has limited legitimate influence over non-state actors, but it can make policy decisions on issues such as the sale of alcohol and tobacco. It would be useful to develop a policy document that addresses the non-state actors that affect health and delineates the policy approach which will be used to address them.

Attribute 12: The adequacy of existing institutional capacity to implement the strategy has been assessed and there are plans to develop the capacity required

Strengths

- Human resources needs have been broadly identified. Den Sooluk mentions lack of human resources capacity in the matrix of barriers for all four priority program areas. It also addresses the topic in section 4.2, provision of individual medical services.[14]
- Den Sooluk mentions the need for effective supervision and management. In the section on health financing, it states that "it is necessary to specify exactly the areas of activities, authority and responsibility of each party, regulations and order of their relationships and functioning. This section of the program considers the issues of formation of health care sector financial policy, distribution of roles, functions and responsibilities of different parties in health care financial system, as well as increasing of autonomy of medical services providers and increasing of their potential."[15]
- The strategy explicitly calls for technical assistance as needed. It recognizes that the Ministry of Health does not currently have the capacity to implement every aspect of the Den Sooluk program and makes provision for outside technical assistance.

Weaknesses

- Despite the inclusion of human resource needs in the document, the Den Sooluk program does not specify any mechanism for meeting HR needs. While it discusses reorganization services and developing new concepts of care, it does not explicitly address the issue of staff retention in the health sector, or the ongoing shortage of PHC personnel.[16]
- Den Sooluk depends on sound administrative leadership, but MoH capacity for planning and budgeting is challenged due to high staff turnover. This hinders long term planning capacities.

Recommendations

- As the POW is revised, include a detailed assessment of HR needs against existing capacity, followed by a capacity building plan to meet these needs. This plan should include provider training, provider retention, salary levels, and geographic coverage. At present rural areas suffer severe shortages of health care providers.
- To support successful implementation of Den Sooluk, the MoH will need to build capacity on planning and budgeting, and address turnover through incentivizing staff retention. This could include positive incentives such as increasing salaries for financial staff or negative incentives like contractual penalties for personnel who leave their jobs within a certain amount of time after receiving training, e.g. no access to further specialty training.

[14] MoH, Den Sooluk draft programprogram, p34.
[15] MoH Den Sooluk draft program, p43
[16] The shortage of PHC personnel was referenced in donor, MOH, and civil society meetings attended by the JANS team.

- Rather than calling for technical assistance as needed, a supporting document could be developed for Den Sooluk that identifies that specific tasks and areas that will require TA and estimates when the TA will be required.

Attribute 13: Financial management and procurement arrangements are appropriate, compliant, and accountable. Action plans to improve public financial management (PFM) and procurement address weaknesses identified in the strategy and in other diagnostic work

Strengths

The MoH procurement policy as referred to in Den Sooluk Procurement Policy is harmonized with National Law and similar to World Bank Guidelines[17]. Donors feel that it is a good policy based on sound principles.

Financial management, procurement systems and performance are adequate on national level and in current health system. These solid procedural underpinnings mitigate some of the fiscal risks of Den Sooluk.

- The MoH and the MHIF are steadily improving their capacity for financial management and oversight.

Weaknesses

- Den Sooluk calls for increasing the autonomy of health care facilities. The current financial management system is not set up for oversight of autonomous health care providers and will require substantial additional capacity if it is to do so.
- As previously mentioned, there is high turnover among financial staff, both at the national level and at the facility level. This limits MOH capacity to exert proper financial oversight and follow procedures, and leads to excessive donor involvement.
- Possibly as a result of high turnover, both audits and procurement are very slowly executed. This will slow implementation of Den Sooluk unless the MOH is able to increase its capacity.
- The Den Sooluk implementation process does not take into account the likely conflict of interests between vertical health care structures and the general health system. This will slow integration of priority programs into primary health care unless that conflict is eliminated.

Recommendations

- The MOH and MHIF should consider options for taking a stronger role in ensuring integration of vertical health services into primary care.
- The human resource planning mentioned previously in this chapter should take into account financial management capacity.
- The MOH should consider developing a concept for the new financial structures necessary to oversee autonomous health care facilities.

[17] http://siteresources.worldbank.org/INTPROCUREMENT/Resources/ProcGuid-05-04-ev1.pdf (searched 31Oct 2011

- The MOH should consider ways to expand its capacity for fiduciary risks mitigation such as auditing and financial management through training and other capacity building measures.

Attribute 14: Governance, accountability, management and coordination mechanisms for implementation are specified.

Strengths

- The program recognizes the importance of intra-sector and inter-sector coordination, especially with regard to tobacco and alcohol sales and flour fortification. However, local government does not play a significant role in inter-sector activities.
- Den Sooluk specifies a wide range of partners for coordination, including MoH bodies & other GOK institutions.

Weaknesses

- External coordination is addressed in DS but management and oversight mechanisms are not fully described.
- Supervision and oversight systems for resource use and HR are not discussed in the plan. Overall, the role of the GOK needs to be highlighted and made specific.
- Transparency, accountability, oversight, enforcement and reporting mechanisms within the Ministry are not ready for the new structure of autonomous health care facilities, or to work effectively with the MHIF.
- The Manas Taalimi plan was not fully implemented, in part because the Ministry of Health chose to fund other priorities rather than Manas Taalimi. Den Sooluk is at the same risk; it is dependent on the Ministry of Health to prioritize Den Sooluk's Plan of Work in the face of competing budget demands.

Recommendations

- Publish publically the planned DS budget and any deviations from that budget which occurs. This will create public accountability for Den Sooluk as an MoH priority.
- Externally assess current mandate, capacity and performance of the MOH against its planned new role in a system of autonomous health care institutions.

2.5 Monitoring, evaluation and review

Attribute 15, The plan for monitoring and evaluation (M&E) is sound, reflects the strategy and includes core indicators; sources of information; methods and responsibilities for data collection, management, analysis and quality assurance.

General positive preconditions

- Both the DS Program itself and the interviews with DS Team and MOH officials clearly indicated the important role of M&E and the wide use of results for policy decision making and coordination of health sector activities to achieve the objectives of the new National health reform program.

- A lot of experience and capacity in the area of M&E have been gained and is used in the health sector by officials at MOH and other national and regional institutions as well as by development partners. The first National Indicators package was already developed in 2002. In subsequent years, a huge work was done on the development of an adjusted new Indicators package (2006), further revised at the mid-term review of Manas Taalimi (2008) to trace progress of «MT» implementation. In 2006 the function of monitoring was institutionalized into the Department of Strategic Planning of the MOH, which currently is in charge of timely data collection, formation and presentation of the data according to the Indicators Package;

- The evaluation function is performed by organizations outside the MOH, namely by the independent Health Care Policy Analysis Center (HPAC), which was preceded by the Health Policy Analysis Unit of MOH, and other organizations with research capacity. This ensures objectivity of evaluation results. Besides, an effective mechanism for interaction between MOH and research organizations was created, which envisages annual formation of the list of research priorities and approval of this list at the Policy Council of the MOH of the Kyrgyz Republic.

Strengths

- A new M&E approach and structure was developed as part of Den Sooluk albeit presented only verbally for discussion. The approach fits the structure of DS[18];

- This new approach has the following four pillars: (i) package of indicators based on routine and annually monitored data, (ii)studies/researches of coverage with key services, (iii) studies of the health care system on request of MOH/MHIF, (iv) large scale surveys (Household Surveys and Discharged Patients interviews);

- Further the outline of the M&E approach aspires to (i) strengthen the role and M&E capacity at the Oblast and tertiary health care organization level; (ii) setting a baseline for evaluation in 2012 and has foreseen in midterm (2014) and final (2016) study/research covering the four priority health programs (CVD, MCH, TB and HIV) and (iii) represents an innovation of M&E under DS, which will enable to trace progress in accessibility, quality and outputs & outcomes of delivered services, as well as progress in the removal of detected barriers for reform implementation;

W**eaknesses**

- At the time of the JANS start, the M&E plan and indicators were not yet developed and could not be assessed during the mission of the JANS team;

[18] M&E Strategy of the National Program «Den Sooluk for 2012-2016», Presentations on the 6th 13th of October, 2011 at JAR

- Information, acquired during the JANS review indicated that the roles, responsibilities and mechanisms of coordination of all organizations to be involved in M&E process should be defined more clearly:

    - In 2006 a "Department of Strategic Planning" was established in the MOH (currently– «Department of Coordination and Reform Implementation») with a "Division of Program development". Besides this, a Division of Monitoring and Evaluation"" was established (March 2010) under the Republican Center of Health Care Development & IT (RCHD&IT). As of today, the responsibility of data collection as regards the Indicators Package is still with the «Division of Program development» of the MOH although its name does not fit with the functions performed). The capacity of the staff in both structures (MOH and RCHD&IT) requires further enhancement, especially in the area of analysis of collected data;
    - Given wider involvement of other structures into the M&E process, such as Oblast level and tertiary HCOs, it remains unclear how information would flow from health services providers, and at which level data will be aggregated and analyed;
    - Possibly the Oblast state administrations could be involved into M&E. Determination of their role and way of involvement also require further work;
    - So far, the mechanism to conduct evaluation of performance/activity of program implementers (MOH, subordinate organizations, HCOs) has not been defined yet. It is advised to also involve the MOH Public Steering Committee;

- Data quality assurance and data auditing are not addressed sufficiently. This becomes especially important in cases of conflict of interests (e.g. when both program implementation and its M&E are laid upon the same structure);

- Weak M&E capacity at Oblast and Rayon levels will require intensive training of designated staff and at the initial stage regular checking of the collected data;

- The preliminary budget for M&E of DS program was made available for JANS mission. However, for getting accurate of M&E costs, and of monitoring in particular, a detailed M&E plan/indicators would be necessary.

Attribute 16. There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action.

Strengths

- Periodic performance reviews of sector programs have been a recognized strength of the KGZ health sector. Starting from 2006, a regular Joint Annual Review (JAR) of the National Health Reform Program implementation progress takes place , actually twice a year– May and October) with wide involvement of all stakeholders (MOH, MHIF, subordinate institutions, DPs, and civil society organizations); based on an agreed sector performance framework.

Weaknesses

- The discussion of M&E results mainly takes place at the national level during JARs. However regular feedback on M&E results to stakeholders at Oblast /Rayon levels, i.e. Oblast state administrations, health services providers and the population at large still needs further development:
- Providing effective feedback of M&E findings into decision making, leading to subsequent action is needs further strengthening at the national level and is weak at the regional/oblast level.

Recommendations

- Develop a comprehensive and sufficiently detailed National M&E framework and implementation plan;
- Clearly identify roles, responsibilities and accountability of all organizations involved in M&E process;
- The capacity to conduct M&E and analysis of performance data of the health sector in general and of involved program implementers in particular should be strengthened at all levels (national, regional and service providers);
- Mechanisms should be envisaged to involve the civil sector into evaluation of DS Program implementation;
- M&E results should be shared with data providers and to be used for e.g.
    - intermediate and rapid follow up by MOH, its implementing bodies and individual health services providers, e.g. via benchmarking, comparative analysis and internal quality improvement systems;
- It is advised to adjust the budget for M&E according to the estimated needs to fulfill the task at hand and subsequently to include the activities in the Plan of Work and in the costing.
    - The implementation of the M&E plan should not face the same problem as MT: budgeted money for surveys was not disbursed and planned surveys could not take place.

ANNEXES

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
1. SITUATION ANALYSIS AND PROGRAMMING Clarity and relevance of priorities and strategies selected, based on a sound situation analysis			
Attribute 1: The National strategy is based on a sound situation and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, governance, and institutional issues)	• Although it addresses the main diseases in the country, a formal burden of disease study is not done. Such study could provide the baseline for the monitoring and evaluation of the disease and economic impact of the implemented DS.		First baseline survey/study is planned to be conducted in 2012
	• It has limited involvement with other disease categories, with other specialties and services of hospitals and PHC and the management of hospitals, which will hamper the implementation and makes the other specialties waiting for another 5 years for quality improvement.		The Program Components include the interventions, aimed at improvement of the entire health care system. Many barriers, identified by priorities and their ways of solution are common for the entire health care system.

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 1 (continued)	• More in general, the relations between the systems improvement aspects (called components in DS) and the priority disease oriented programs are not very clear in the strategy and lead to difficulties for stakeholders to recognize where they can find their particular stake in the sector being addressed. More important, it is not clear how and where the interaction will take place. This may lead to an unwanted continuation of the silo approach of Manas Taalimi instead of moving to an integrated approach in which the disease programs are like tracer diseases or trailblazers that take advantage of the strategic system oriented actions as foreseen in the program and of which the experiences and results can be used for other disease and services categories.		Changes are entered into the section, describing the Program Components: Objectives/tasks; and the main activity directions are aimed at overcoming of the barriers, defined in the Priority (directions) and hindering delivery of key services

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 1 (continued)	• Barriers could be more deeply evaluated during POW implementation. For example, one of the current barriers is formulated as: "Low access of the population, especially of the patients with Acute Coronary Syndrome (ACS) and Acute Cerebrovascular Accident (ACA) to emergency health care, high-technological and specialized medical aid;" This is rather generally formulated. What causes the lack of access? Is this the absence of a working ambulance system which could provide thrombolytic therapy at the place where the patient is picked up and which could make the biggest gain in the prevention of mortality or handicap from acute myocardial infarction. Or is it the absence of angioplasty possibility or coronary artery bypass surgery? Only further analysis would tell and a cost/effectiveness analysis could guide the priority setting for one or the other intervention.		It is planned to carry out baseline studies/surveys in 2012 to assess the coverage of population with key services
	• Diabetes is missing as an important risk factor for cardiovascular (and other) disease(s).		Corresponding amendments and modifications are entered both to the Program (DS Scope) and POW
	• The governance of the health system is in need of strengthening:		

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 1 (continued)	• Oversight over MOH and MHIF lacks scope on performance effectiveness in some cases indicating lesser government, commitment e.g. in the unfinished agenda of Bishkek hospital restructuring.		Restructuring of health care facilities in Bishkek and Osh cities is incorporated into the POW and is defined as one of the key milestones/benchmarks
	• The relation between MOH & MHIF needs further clarification on important points and enhanced clarity on the cooperation process would be beneficial		Relation between MOH and MHIF - is one of the priorities, reflected in DS
	o Triple payer system adds to administration costs and to dilution of purchasing responsibilities, which risk the effectiveness of the purchasing function		is proposed for the Agenda of the MOH Policy Councils' meetings
	o Parallel medical systems, such as for the Army, Railway systems etc. are under other jurisdictions than MOH and are not involved and not taken into account in DS or at least are not visible while the need and added value of having these parallel systems as separate from MOH can be questioned especially as regards the resource constraints of the country: human resources and money, and as regards the equity in access aspect.		is proposed for the Agenda of the MOH Policy Councils' meetings requires further

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 1 (continued)	• MHIF has apparently insufficient purchasing tools and capacity for review of contracted medical services, i.e. the services covered by the SGBP. Although MHIF has recently started to do some in depth review in one rayon where it found some inappropriate admissions, this appears not yet to be done routinely and systematically over the whole country		is planned in the M&E processes
	• While use of policy analysis in policy making has been one of the strengths of the policy environment in Kyrgyzstan the draft document makes limited reference to the existing wealth of available evaluation reports and other background documents, with explicit literature references, which would make the report more credible for outsiders.		is included/incorporated

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 1 (continued)	• Also reference to the new Constitution is lacking which would forms a firm legal basis for DS policies and activities, while the requirements of this Constitution should receive attention in public information and education/information of health managers and staff as well as in undergraduate studies.		Both the DS Program Mission and Objectives fit the clauses and requirements of the new Constitution Article 47.1. 1.Everybody shall have the right to health protection.2. The State shall create conditions for health/medical service of everybody and shall take measures to develop state/public, municipal and private health care sectors. 3. Free health care, as well as exempt health care shall be provided within the state benefits package, envisaged by the Law.
	• The approaches towards implementation and enforcement of health care related laws are not sufficiently described in the DS strategy.		In the POW much attention is given to the issues of legislation improvement and development of tools for their implementation and oversight
	• Current and improved laws might not be executed due to the lack of tools for their enforcement.		

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 2: National strategy sets out clear priorities, goals, policies, objectives, interventions, and expected results, that contribute to improving health outcomes and equity, and to meeting national and global commitments.	• Some targets could be more precisely defined to be better measurable, e.g. the one related to thrombolytic therapy for acute myocardial infarction, which should set a timeline within which the therapy should start, the so-called door to needle time when only looking at what happens in the emergency room or in the hospital itself. Better might even be to look at the time between calling the ambulance or the doctor and the start of the thrombolytic therapy. This latter might indicate even more important shortcomings and reasons for delay of the start of the therapy.		Agree
	• Defined milestones could be used more explicitly to yearly measure and regularly communicate progress to stakeholders, including parliament.		Package of Indicators is developed by years. Milestones will be defined later subject to discussion with DPs
	• The MDG on reducing poverty gets limited attention, especially as regards the impact of out of pocket payments (formal and informal). However, more attention is warranted:		

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 2 (continued)	o The increased number of hospitalizations combined with the gap in financing of the SGBP may have led to increased copayments per average patient. This is not analysed and some of the hospitalizations perhaps not justified. However, a survey among discharged patients is underway and will bring some clarity in the near future.		Reduction of SBP gap along with health care quality improvement and extension of exempt drugs supply of Primary Health Care (PHC) will facilitate to reduce financial burden of population
	o High prescribed volumes and high prices for medicines, of which most have to be paid out of pocket, will most likely have given cause for a rise in frequency and height in copayment.		One of DS objectives is to enhance the state influence on price formation in pharm.sector
Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness, efficiency and sustainability.	• The relative cost/effectiveness analysis of health technologies is not studied, raising questions including whether the proposed procurement of high tech equipment or expensive drugs going to have health value for the money relative to other investment options, and medical technologies? The absence of such analysis, which supports more rational decisions, makes it difficult to resist pressure to introduce new and expensive technologies, and drugs in the State Guaranteed Benefits Package (SGBP), to introduce new screening programs or high tech equipment and high cost/high risk interventions.		It is necessary to implement a set of activities with involvement of international consultants to develop the methodology for carrying out cost/effectiveness analysis of health services; this activity is included into the POW under the Component "Health Care Financing "

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 3 (continued)	• The exceptional position of Bishkek in services position, governance and payment system is not conducive for the achievement of equity in access for all citizens.		This point is reflected in the DS Implementation Strategy
		• MoH may want to look for ways for early dissemination of quality improvement activities via e.g. the development of a comprehensive quality improvement strategy of which the implementation will e.g. connect other specialties and services and the general management of a health facility with efforts and results of the priority disease related activities. This will facilitate the uptake of continuous quality improvement (CQI) methods and take into account their results.	Concept for Health Services Quality Improvement will be approved in 2012 before the interventions implementation process starts
		• Review diabetes as CVD risk factor and adjust program accordingly.	included both into the DS program and POW

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 3 (continued)		• Pay explicit attention to the need for new general and financial management arrangements and their strengthening, especially in relation to planned increase in autonomy for hospitals and health services providers in general. This requires a separate section in the Program.	Section 4.3.3. of the Program reflects/covers the issues of financial management and improvement of staff capacity
		• MoH should consider creating or hiring capacity for cost/effectiveness analysis to support more rational decision making on investments and SGBP extension.	included into the POW
		• Tasks (activities) & interventions to overcome the existing barriers should be further and more in-depth be reviewed for root causes, be more precisely defined and elaborated in POW and annual implementation plan with matching activities.	
		• Define and prioritize activities in the POW, taking into account possible political, economic and other risks.	the function of prioritization is laid upon the Health Policy Council

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
		Consolidate and streamline efforts of MOH and MHIF in the improvement of the health care sector financing system.	will be discussed at the Policy Council's meeting
		Promote wider incorporation of legal aspects into education, training and retraining of health workers and HCOs managers, referring to new Constitution.	reflected in the POW on improvement of capacity

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
2. PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy			
Attribute 5: Multi-stakeholder involvement in development of the national strategy and operational plans and multi-stakeholder endorsement of the final national strategy.	• The DS development process saw limited participation of the Government itself and of other ministries, of MHIF, state administrations and local self-governance bodies, and of private health care providers. Other sector ministries will be important for the implementation of lifestyle related prevention activities, e.g. alcohol and tobacco control.	• During the further preparation for the implementation of DS and during the strategy implementation itself it is advised to gain understanding and support of patients' associations, the private medical sector, other ministries, state administrations, local self government bodies and mass media, including the management and Steering Council of the Public TV-Radio Company. The latter should cover DS and inform the public at large and health workers about DS and its implementation.	The National DS Strategy was discussed at three JARs and Health summits with involvement of representatives of the government, Parliament, Ministry of Finance, National Agency of Local Self-Governance, Local State Administrations, NGOs
	• Some activities and interventions, including their costs, were proposed for including in DS, its Plan of Work and the DS budget by national top-level institution managers, such as for CVD and TB, without much participation of others. It is not clear to what extent these proposals will be scrutinized on need and cost-effectiveness.	• The need to and costs of activities should be more widely checked, outside the direct circle of interest groups.	it seemed impossible to do the cost effectiveness study
Attribute 6: There are indications of a high level of political commitment to the national strategy.		• MoH should consider ways to gain understanding of and support from advocacy groups and consumer associations to jointly promote and execute the right to health protection. This would be very useful also in convincing other sector ministries to make their contributions to creating a healthier society.	agree

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 6 (cont)		• It is further advised to gain understanding and support of all Parliamentary fractions, in order to mitigate threats for DS implementation in case of formation of new parliamentary coalitions and change of Cabinet of Ministers.	agree
Attribute 7: The national strategy is consistent with relevant higher- and/or lower-level strategies, financing frameworks and plans.	• There is no reference in the DS document itself to any general national program on e.g. general development or on poverty reduction. Super-national agreements, such as the one for treatment of migrants in host countries, which is important for combating TB and HIV infections, are not listed.	• Consider ways to support the wide integration of the DS Program into the Country Development Strategy for 2012-2014, the Regional Development Program and the Social Protection Development Strategy, currently being developed.	Agree. Interventions are entered into the POW of the Country Dvt Strategy (CDS) from the POW of the National health care reform program, agreed upon with the executors (MOH Departments, lower structures). Currently, the POW for the CDS has not been developed yet
	• The DS Program is not related to programs of other sectors, such as the «Concept of Education» and the «Strategy of Social Protection Development ».	• Consider ways to gain understanding and support of a wider range of Committees in the Parliament: e.g. the Committee on Human Rights and Equal Opportunities; the Committee on Budget & Finance, etc. This will support priority setting of inter-sector health protection issues during discussion and adoption of a wide range of laws. It will enable parliamentary oversight of the execution of these (also health related) laws.	the issues of strengthening of inter-sectoral cooperation are covered in the DS Program

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
	• Public Health issues are not fully reflected in the new Law "On Local Self-Governance ", i.e. do not provide for explicit attention of local government representatives for health protection issues . Only the members of the Parliamentary Committee on Health Care participated in the discussions during the development of DS.		POW was forwarded to the National Agency of Local Self-Governance on approval

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
3. COSTS AND BUDGETARY FRAMEWORK FOR THE STRATEGY Soundness and feasibility			
Attribute 8: The national strategy has an expenditure framework that includes a comprehensive budget /costing of the program areas covered by the national strategy.	• Micro-costing includes only the expenditures, which are planned to be covered by donors funds. Calculations and forecasting were done by the DS Team on their own. Despite the correct approach and methodology applied to estimates, the entire process was not explained and documented, and that might cause a negative impact on the credibility of the costs framework among potential participants of future DS strategy financing.		the mechanism for estimations is described and is enclosed to Micro costing as Annex/attachment
	• Besides, as the lessons learned through MT implementation show, changes entered to the POW at the DS implementation stage, will imply necessity to revise calculations. However, so far there are no written Guidelines on the budget and financing framework. So it would be necessary to institutionalize and document the process of calculation to not lose the institutional memory and remain consistent.		the process of estimations is described and is enclosed to Micro costing as Annex/attachment

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 9: The strategy has a realistic budgetary framework and funding projections. If the strategy is not fully financed, there are mechanisms to ensure prioritization in line with overall objectives of the strategy	• Despite the fact that the POW has envisaged activities for almost all the set objectives, the feasibility of their implementation does not look convincing, as there are still barriers at e.g. the legislative level. Signaled barriers are also not reviewed in depth, which may impact implementation. As the POW was developed with almost no participation of the relevant structures in charge of economic and fiscal policy, the expected result for some interventions is not clear and is uncertain.		Activities on inventory, revision of NPB(??) of health care sector are included into the POW

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 9 (continued)	• These uncertainties indicate some weaknesses in the interaction of MOH and MHIF in the area of development of general policy of health sector financing. Despite the significant progress achieved through MT implementation within the framework of SWAp, many issues, concerning further strengthening of the Single Payer System are not sufficiently reflected both in the strategy and in the POW. The issue of financing of individual services from different sources (Republican budget, local budget) by various payers (MOH, MHIF, Bishkek City administration) is ambiguously reflected in the DS; yet this "triple payer system" is one of serious obstacles for completion of Single Payer System formation in health sector and therewith affecting the implementation of DS.	• More actively involve MOH & MHIF into the process of Program costing and general expenditures estimation;	The Program envisages strengthening of the roles of Health Care Reform Steering Council and Policy Council, as well as initiation of joint activity

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 9 (continued)	• One of the most important issues – implementation of the SGBP remains unsolved. According to estimates, the gap of this program financing comprises about 25-37% of the SGBP cost. As this Program represents almost the main/basic package of services, provided by the health sector and consuming approximately 70 % of all the funds managed by Single Payer, the issue of sustainability of this program financing is of strategic importance. Unfortunately, neither the strategy, nor POW does envisage clearly defined measures on reducing the financial gap.	• Develop Guidelines /instructions for users on calculation of strategy implementation costs and the budget framework;	engagement of consultants to develop the methodic for the SBP estimation is envisaged in the POW
	• The number of hospital admissions has significantly increased during the last few years against the decreased number of visits to primary health care facilities. This worsens the financial gap. However, DS strategy does not envisage any interventions to mitigate the risk and e.g. reduce unnecessary and possibly inappropriate admissions, i.e. a potential efficiency gain is not explored and not foreseen to be explored, thus loosing an opportunity to close the SBP funding gap.	• More clearly link the activities with the set objectives, some activities will need further elaboration due to limited experience with the particular activity ;	reflected in the POW

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 9 (continued)	• The above gaps in combination with the lack of health sector financing framework, based on MTBF, do not at this stage allow being convinced of the feasibility of achieving the expected results.	• Estimate cost of DS strategy with the funds for other activities using multi-year budget forecast (MTBF), and identify the sources of financing taking into account expected revenues of non-state /public sector	to estimate the general Program cost, international consultants' assistance is required ; is envisaged in the POW
	• Despite few positive results related to the solution of the issues of financial management and fiduciary risks, some problems remain unsolved, such as institutionalization of financial (external) audit and the introduction of an improved computerized system of accounting.		See Section 4.3.3.
	• At the meetings and interviews of HCOs managers, they pointed out that sustainable financing, especially the investment part of financing of the program, is of utmost importance and an instrumental factor for implementation of the planned activities.		agree

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 9 (continued)	• Despite the annual health care budget execution at the level of 95% in general (Rule №2) in compliance with the covenants of the Grant Agreement between the KGZ Government and IDA (International Development Association), delays in financing of the investment part of the MOH budget, as well as re-programming of funds during program implementation still create uncertainty for the implementation of some activities; thus delays in financing of MT has led to non-accomplishment of primary physician trainings. Yet, the POW for DS implementation does not stipulate any activities to mitigate such risks. In the past any in between reprogramming of MT budgets were not done in a transparent way. An improved approach to mitigate this is not foreseen in DS		The POW envisages activities to improve transparency of use of donors' funds and to revise reporting forms
	• The DS Program does not envisage the issues of institutionalization of external and operational audits.		The issues of institutionalization will be tackled in the due course of DS Program implementation (included into the POW)

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
4. IMPLEMENTATION AND MANAGEMENT Soundness of arrangements and systems for implementing and managing the programs contained in the national strategy			
Attribute 10: Operational plans are regularly developed through a participatory process and detail how strategic plan objectives will be achieved.	• The POW does not link activities to monitoring and evaluation. The progress and impact of Den Sooluk could be better tracked if it is tied to POW activities directly to specific indicators and targets, rather than grouping them by priority program area.	• In the annual work plans based on the Den Sooluk POW, specifically name the responsible party for every activity. Also make a link between the implementation of the "Components", addressing the more generic issues such as health finance, public health etc. and the priority disease oriented programs to assure that representatives of both categories are described in the detailed plans of work with their respective responsibilities and tasks and feed into other components and programs.	covered/included into the POW
	• The roles and responsibilities of implementing partners would benefit from additional elaboration in the POW. Currently, it uses very broad terms such as "PHC Level" or does not identify the implementing partner at all.	• Link each Den Sooluk activity to a target or indicator, and develop a mechanism for adjusting annual plans of work if those yearly targets are not being met.	entered- Technical Coordinators

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 11: National strategy describes how resources will be deployed to achieve outcomes and improve equity, including how resources will be allocated to sub-national level and non-state actors.	• Current logistics, information and management system resource constraints are described in Den Sooluk, but there is no detailed plan for how to overcome those constraints.	• Develop additional planning documents to support Den Sooluk and elaborate on the topics addressed in the strategy and POW. These documents should cover: 1) human resource planning, with specific attention to health care providers in rural areas and general practitioners; and 2) a plan for overcoming weaknesses in the current logistics management information system (LMIS) in Kyrgyzstan and establishing a financial base to maintain it.	The POW now envisages activities on planning of doctors through interaction of higher medical educational schools and health care organizations (creation of sites, all kind of practical classes in the regions/oblasts)
	• Human resource needs are clearly identified but plans to remedy those gaps are insufficient and not fully elaborated.		entered to the POW
	• The items that make up the state budget for calculation of the contribution to the health care sector are not clearly identified (SWAP Budget rule 1. 2010: 13%) The percentage of state budget devoted to health is essentially meaningless if the total budget is not consistently defined. The percentage may be fixed, but the denominator for that percentage is not.		The process of state budget forecasting and execution will be described in the Operational Guidelines
	• Non-state actors are not considered in Den Sooluk. Considering the many factors that influence health, that is an oversight. Parallel health systems are also not referred to.		Will be solved step by step in the due course of the DS Program implementation with participation of private sector

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 11 (continued)	• Same for the role of parallel health systems which may also draw from DS implementation, its resources and otherwise influence the impact of DS on the MOH led health system.		This issue requires joint political decision, and will be tackled during the Program implementation process
Attribute 12: The adequacy of existing institutional capacity to implement the strategy has been assessed and there are plans to develop the capacity required	• Despite the inclusion of human resource needs in the document, the Den Sooluk program does not specify any mechanism for meeting HR needs. While it discusses reorganization services and developing new concepts of care, it does not explicitly address the issue of staff retention in the health sector, or the ongoing shortage of PHC personnel.	• As the POW is revised, include a detailed assessment of HR needs against existing capacity, followed by a plan to meet these needs. This plan should include provider training, provider retention, salary levels, and geographic coverage. At present rural areas suffer severe shortages of health care providers.	The POW envisages activities to improve the system of assessing the HR needs through updating of software for HR database, database on health workers and in the Oblast HCOs and improvement of the system of registration for further licensing of staff for medical practice. Another direction - further formation of incentives and social-economic factors to make Family doctors' profession more appealing, with revision of remuneration of health workers at PHC level

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 12 (continued)	• Den Sooluk depends on sound administrative leadership, but MoH capacity for planning and budgeting is challenged due to high staff turnover. This hinders long term planning capacities.	• To support successful implementation of Den Sooluk, the MoH will need to build capacity on planning and budgeting, and address turnover through incentivizing staff retention. This could include positive incentives such as increasing salaries for financial staff or negative incentives like contractual penalties for personnel who leave their jobs within a certain amount of time after receiving training, e.g. no access to further specialty training.	The issues of improvement of capacity of financial specialists are covered in the Section 4.3.3.
		• Rather than calling for technical assistance as needed, a supporting document could be developed for Den Sooluk that identifies that specific tasks and areas that will require TA and estimates when the TA will be required.	
Attribute 13: Financial management and procurement arrangements are appropriate, compliant, and accountable. Action plans to improve public financial	• Den Sooluk calls for increasing the autonomy of health care facilities. The current financial management system is not set up for oversight of autonomous health care providers and will require substantial additional capacity if it is to do so.	• HR Planning should take into consideration the capacity in financial management area	See Section 4.3.3.

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
management (PFM) and procurement address weaknesses identified in the strategy and in other diagnostic work	• As previously mentioned, there is high turnover among financial staff, both at the national level and at the facility level. This limits MOH capacity to exert proper financial oversight and follow procedures, and leads to excessive donor involvement.	• MOH should consider options to develop concepts for new financial structures, capable to do oversight over HCOs, becoming more autonomous in the view of reforms	included into the POW
	• Possibly as a result of high turnover, both audits and procurement are very slowly executed. This will slow implementation of Den Sooluk unless the MOH is able to increase its capacity.	• The MOH should consider options to expand its capacity for fiduciary risks mitigation such as auditing and financial management through training and other capacity building measures.	included into the POW
Attribute 14: Governance, accountability, management	• External coordination is addressed in DS but management and oversight mechanisms are not fully described.	• Publish publically the planned DS budget and any deviations from that budget which occurs. This will create public accountability for Den Sooluk	The POW envisages activities to improve transparency of use of donors' funds and to revise reporting forms
	• Supervision and oversight systems for resource use and HR are not discussed in the plan. Overall, the role of the GOK needs to be highlighted and made specific.	• Externally assess current mandate, capacity and performance of the MOH against its planned new role in a system of autonomous health care institutions.	covered in the POW

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
and coordination mechanisms for implementation are specified.	• Transparency, accountability, oversight, enforcement and reporting mechanisms within the Ministry are not ready for the new structure of autonomous health care facilities, or to work effectively with the MHIF.		covered in POW
	• The Manas Taalimi plan was not fully implemented, in part because the Ministry of Health chose to fund other priorities rather than Manas Taalimi. Den Sooluk is at the same risk; it is dependent on the Ministry of Health to prioritize Den Sooluk's Plan of Work in the face of competing budget demands.		this point is reflected/covered in the DS Implementation strategy

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
5. MONITORING, EVALUATION AND REVIEW Soundness of review and evaluation mechanisms and how their results are used			
Attribute 15: The plan for monitoring and evaluation (M&E) is sound, reflects the strategy and includes core indicators; sources of information; methods and responsibilities for data collection, management, analysis and quality assurance.	o As of today, the responsibility of data collection as regards the Indicators Package is still with the «Division of Program development» of the MOH although its name does not fit with the functions performed). The capacity of the staff in both structures (MOH and RCHD&IT) requires further enhancement, especially in the area of analysis of collected data;		reflected both in the scope of DS and POW
	o Given wider involvement of other structures into the M&E process, such as Oblast level and tertiary HCOs, it remains unclear how information would flow from health services providers, and at which level data will be aggregated and analysed;		covered in the Section on M&E; launching of a pilot in one region is scheduled for 2013
	o Possibly the Oblast state administrations could be involved into M&E. Determination of their role and way of involvement also require further work;		at the Oblast (regional) level the role of Oblast Coordinators and Coordination Commissions is strengthened
	o The mechanism to conduct evaluation of performance/activity of program implementers (MOH, subordinate organizations, HCOs) has not been defined yet. It is advised to also involve the MOH Public Steering Committee;		covered in the Section on M&E

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 15 (continued)	• Data quality assurance and data auditing are not addressed sufficiently. This becomes especially important in cases of conflict of interests (e.g. when both program implementation and its M&E are laid upon the same structure);		External control of data quality is included into the POW (1 time a year)
	• Weak M&E capacity at Oblast and Rayon levels will require intensive training of designated staff and at the initial stage regular checking of the collected data;		is covered in M&E Section
	• The preliminary budget for M&E of DS program was made available for JANS mission. However, for getting accurate of M&E costs, and of monitoring in particular, a detailed M&E plan/indicators would be necessary.		is covered in M&E Section
Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action.	• Provision of regular feedback on M&E results to stakeholders at Oblast /Rayon levels, i.e. Oblast state administrations, health services providers and the population at large still needs further development	• Develop a comprehensive and sufficiently detailed National M&E framework and implementation plan;	Section 5 of the DS Program
	• Providing effective feedback of M&E findings into decision making, leading to subsequent action needs strengthening at the national level and is weak at the regional/oblast level.	• Clearly identify roles, responsibilities and accountability of all organizations involved in M&E process;	covered in M&E Section
		• The capacity to conduct M&E and analysis of performance data of the health sector in general and of involved program implementers in particular should be strengthened at all levels (national, regional and service providers);	covered in M&E Section

Annex 1. Table of JANS findings and DS amendments and replies			
Attributes	**Weaknesses**	**Recommendations**	**Den Sooluk**
Attribute 16 (continued)		• It is necessary to strengthen analysis (MOH, lower organizations, HCOs);	covered both in the Program and POW (Components СУ and M&E Section)
		• Mechanisms should be envisaged to involve the civil sector into evaluation of DS Program implementation;	covered in DS program and POW (Component "Stewardship" and M&E Section)
		• M&E results should be shared with data providers and to be used	covered in M&E Section
		o intermediate and rapid follow up by MOH, its implementing bodies and individual health services providers, e.g. via benchmarking, comparative analysis and internal quality improvement systems;	covered in M&E Section
		• It is advised to adjust the budget for M&E according to the estimated needs to fulfil the task at hand and subsequently to include the activities in the Plan of Work and in the costing.	covered in M&E Section, POW and included into Micro costing
		o The implementation of the M&E plan should not face the same problem as MT: budgeted money for surveys was not disbursed and planned surveys could not take place.	covered in M&E Section

Annex 2 Background documents

Government of Kyrgyz Republic. Law «On Local Self-Governance», June 16, 2011

Ibraimova, Ainura et el. Kyrgyzstan: a Regional Leader in Health System Reform: http://ghlc.lshtm.ac.uk/files/2011/10/GHLC-book_Chapter-5.pdf ; quoted from : Balanova, Dina et. Al, editors. Good Health at low Costs, 25 years on. What makes a successful health system. The London School of Hygiene and Tropical Medicine, 2011.

IHP+ Joint Assessment of National Health Strategies and Plans. Combined Joint Assessment Tool and Guidelines. Draft, Version 2, September 2011

Ministry of Health of the Kyrgyz Republic: Evaluation of the Kyrgyz Republic National Health Reform Program "Manas Taalimi"Implementation Report. Bishkek April 2011

MOH. Kyrgyz Republic Den Sooluk National Health reform Program 2012-1216, Draft of 12 September

Vaillancourt,Denise. Independent Evaluation Group(IEG), World Bank. Do health sector-wide approaches achieve results? Emerging evidence and lessons from 6 countries, IEG Working Paper 2009/4

Annex 3 List of persons met

Institution	Name (no patronymic names)	Position
Ministry of Health	Dr.Sabyrbek Jumabekov	Minister
	Dr.P.Suumbaeva	State Secretary
	Dr.S.Abdikarimov	Deputy Minister Deputy Minister
	Ms. Zarina Nazarova	Head of Financial Department
	Ms.G.Kenjeeva	Head of Planning and Financing Division
	Dr.Larissa Kachibekova	Acting Head of Department on Coordination and Implementation of Reforms
	Dr.D.Saginbaeva	Head
	Dr.D.Aldaseva	Senior Specialist Department of Organization of Health Care
	Dr.Eshkodjaeva	Deputy Head of MCH Division
	Dr.T.Isakov	Director Department on State Sanitary Epidemiological Surveillance
	Dr.L. Davidova	Deputy Department on State Sanitary Epidemiological Surveillance
	Dr.G.Aitmurzaeva	Director Republic Health Promotion Center
	Asel Shapakova	Leading Specialist of Department on Coordination and Implementation of Reforms
Mandatory Health Insurance Fund	Mr.M. Kaliev	Director
	Kalicha Bolokbaeva	Senior specialist
National Institute of Cardiology and Therapy	Dr Aigul Djumagulova Dr Ryskul Kyrmanalieva,	Director Head of Scientific-Organizational-Methodic Department
Republican AIDS Center	Dr.J. Kurmanalieva	General Director
Republican TB Center	Prof.A.Alisherov	General Director
FGP Association	Dr.S.Mukeeva	Head
MOH DS Team	Kuanych Jeimuratov	Head of team and Acting Director of Hospital Association
	Dr.Azamat Imakeev	Public Health Expert
	Chinara Abdrahmanova	Stewardship Expert
	Klara OsKombaeva	Finance Expert
	Rahat Cholurova	Quality of Care Expert

	Aigul Abdukarimova	Human Resources Expert
NGO's	Roza Rayapova	1) NGO "Help Age" (elderly people)
	Tatiana Lim	"Association of Partnership Network (HIV, TB, TB – vulnerable groups)"
	Aibar Sultangaziev ,	"Association of Partnership Network (HIV,TB, – vulnerable groups)"
	Djumabekova Tamara	"Association of Parents of Disabled Children"
	Turdubekova Nazgul	Public Fund " Child's Rights Defenders League"
UNFPA	Meder Omurzakov	Assistenent Representative
UNICEF	Cholpon Imanalieva	Health & Nutrition Specialist
WHO	Oscon Moldokulov	Head of WHO Kyrgyz Country Office
	Dr.Phyllida Travis	Health Systems Advisor, HQ
GAVI	Dr.Bakhuti Shengelia	Director, country reviews and grant renewals
KFW Development Bank	Mr.Ulrich F.Dorf	Division Chief, health & Education Asia
	Dr.Joachim Schuurman	Senior Medical Advisor,
	Kunnura Rayimbekova	Program Officer
Swiss Development Corporation	Elvira Muratalieva	National Program Officer
Swiss Red Cross Kyrgyz-Swiss Health reform Support Project	Tobias Schüth	Project Coordinator
USAID	Dr.Chinara Kamerli	Country Health Officer
	Ms. Sheila O'Dougherty	Director USAID/Abt Central Asia Quality Health Care Project
	Dr.Barton Smith	Deputy Regional Director for Quality
World Bank	Mr.Chris Lovelace	
	Dr.Nedim Naganjac	Senior Health Specialist, Team Leader KG Health Program
	Dr.Asel Sargaldakova	Health Specialist
	Mr.Ian Morris	Consultant,Macro economist

Annex 4 Agenda Joint Annual Review

Agenda of the

Joint Annual Review within Health Summit XI, October 8-14, 2011.

Day/Time	Activities	Venue	Notes
Day 1, Monday, October 10, 2011.			
8:30-9.15 9.30-10.30	DPs meeting **Kick-off meeting for all JAR participants** Unveiling: Djumabekov S.A. – Minister of Health of the KGZ Opening remarks: Niyazalieva D.A.- chairman of the Committee on Health, Social Policy, Labor and Migration of JK of the KGZ Opening remarks: the representative of donor's community Information on agenda of the JAR Presenter: Kachibekova L.I. – acting head of RCID of MOH of the KGZ	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
10.30-11.00	Coffee break		
11.00-12.30	**Review of the draft program "Den Sooluk"** and discussion Presenter: Djemuratov K.A.- head of the team on program development "Den Sooluk"	Conference hall RCHSD&IT (Simultaneous translation)	
12.30-2.00	Lunch		
2.00 - 3.30	**Summary of Joint Assessment of the National Strategy "Den Sooluk" (JANS)** Presenters: JANS group	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
3.30 – 4.00	Coffee break		
4.00 - 6.00	**Review of conceptual /strategic issues of "Den Sooluk"** ***Moderators:*** *Suyumbaeva P.U. - Secretary of state, MOH of the KGZ / Joachim Schüürmann (KfW)* ***1. Presentation "Den Sooluk Reforms***	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session

	Strategy, *Joachim Schuurmann (KfW)* 2. ***Discussion on conceptual/strategic issues of Den Sooluk including overarching barriers and milestones***		
Day 3, Tuesday, October 11, 2011			

9.00 - 9.30	**Review of the Actions plan and cost calculation methodology of the program "Den Sooluk"** presentation- Oskombaeva K. –the working group member on program development "Den Sooluk"	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
9.30 - 12.30 (Coffee break- 10.30- 11.00)	**Discussion of Den Sooluk priorities** Working group on program development "Den Sooluk"		Parallel sessions
	1. CVD *Moderator: Djumagulova A.S./Director of NCCT*	VIP-hall of RCHSD&IT	
	2. **MCH** *Moderator: Eshhodjaeva A.S./head of unit MCH MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	
	3. **TB** *Moderator: Alisherov A.Sh./director NTBC*	National TB center	
	4. **AIDS/HIV** *Moderator: Kurmanalieva J./general director of Republican AIDS center*	*Republican AIDS center, 2 building*, training room, 3rd floor	
12.30 -14.00	**Lunch** **Presentation of the book "HIT Kyrgyzstan"**		WHO Observatory
14.00 - 17.00 (Coffee break- 10.30- 11.00)	**Discussion of components of the program "Den Sooluk"** Main directions, actions plan, cost Working group on program development "Den Sooluk"		Parallel sessions
	Public health Presenter: Imakeev A.K. *Moderator:* *Abdikarimov S.T.- chief state sanitary doctor – deputy minister*	RCHP, training room, 1st floor	
	Individual services Presenter: Djemuratov K.A.. *Moderator: Mambetov K.B. – deputy minister*	Conference hall RCHSD&IT	
	Health financing Presenter: Oskombaeva K.T. *Moderators:*	VIP-hall RCHSD&IT	

	Kaliev M.T./ Nazarova Z.D. *Director of MHIF head of DF of MOH of the KGZ*		
	Health resource generation HR/Medicines/IT Presenters: Abdukarimova A.A., Cholurova R.A. *Moderators:* *Ismailov M.A./ Murzakarimova L.K./ Kurmanov R.A.* *Head of HRD, MOH of the KGZ /Director RMIC /Director DDP&ME*	2nd floor RCHSD&IT **(malachite hall)**	
	Stewardship Presenter: Abdrahmanova Ch.A. *Moderator: Suyumbaeva P.U.- Secretary of State, MOH of the KGZ*	3rd floor RCHSD&IT (**training room)**	
Day 4	**Wednesday, October 12, 2011**		
9.00 - 10.30	**Presentations of the working group following the results of the program priorities discussion (expected results, work plan, cost calculation)** Working group *Moderator: Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
10.30 - 11.00	Coffee break		
11.00 - 12.30	**Presentations of the working group following the results of the program components discussion (expected results, work plan, cost calculation)** *Moderator: Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	
12.30 - 14.00	Lunch **Round table: Social work in health care in the KGZ**	Conference hall RCHSD&IT (Simultaneous translation)	USAID, "Quality Health Care" project
	Macroeconomic aspects of implementation of "Den Sooluk" *Moderator: Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
14.00 - 14.30	**Current costs and forecasting government health sector financing for forthcoming period** **Presenter:** Nazarova Z.D. - head of DF, MOH Of the KGZ	Conference hall RCHSD&IT (Simultaneous translation)	
14.30 - 15.00	**Political approaches on funding gap decrease in health system (program macrocosting "Den Sooluk")** **Presenter:** Ian Mooris – expert of WB	Conference hall RCHSD&IT (Simultaneous translation)	
15.00-15.30	Discussion and Conclusions on Resource	Conference hall	

	Environment and Macro Costing for Den Sooluk –facilitated by WB	RCHSD&IT (Simultaneous translation)	
15.30-16.00	Coffee break		
16.00-17.30	Continued: Discussion and Conclusions on Den Sooluk Costing and Investment – facilitated by WB	Conference hall RCHSD&IT (Simultaneous translation)	

Day 5	**Thursday, October 13, 2011**		
	Implementation mechanisms and introduction assessment of the program "Den Sooluk" *Moderator: Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*		Plenary session
9.00 - 9.30	**Introduction mechanisms of the program "Den Sooluk"** **Presenter:** *Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	
9.30-10.30	Discussion		
10.30 - 11.00	Coffee break		
11.00 - 11.30	**M&E of the program "Den Sooluk"** **Presenter:** Kachibekova L.I. – acting head of RCID, MOH of the KGZ	Conference hall RCHSD&IT (Simultaneous translation)	
11.30-12.30	Discussion		
12.30 - 14.00	Lunch		
14.00 - 14.30	**Fiduciary risks of the program "Manas Taalimi" and their prospect decrease in the program «Den Sooluk»** **Presenter:** Nazarova Z.D. – head of DF, MOH Of the KGZ	Conference hall RCHSD&IT (Simultaneous translation)	
14.30 - 15.00	**Fiducial estimation of Den Sooluk** **Presenter:** WB expert	Conference hall RCHSD&IT (Simultaneous translation)	
15.00-15.30	Discussion	Conference hall RCHSD&IT (Simultaneous translation)	
15.30 - 16.00	Coffee break		
16.00 - 17.30	Discussion of fiduciary risks	Conference hall RCHSD&IT (Simultaneous translation)	
Day 6	**Friday, October 14, 2011**		
9.00 - 10.30	**Summary of JAR** *Moderator: Suyumbaeva P.U. – Secretary of state, MOH of the KGZ*	Conference hall RCHSD&IT (Simultaneous translation)	Plenary session
	Preparation to Health Summit		
Day 7	**Saturday, October 15, 2011**		
9.00 - 13.00	**Health Summit XI**		Hotel "Ak-Keme"

Annex 5 Agenda Health Summit

XI Health Summit, October 15, 2011

Agenda

Venue: Hotel «Ak-Keme»

09.00-10.00	Registration of participants
10.00-10.05	Opening speech Djumabekov S.A. *Minister of Health of the KGZ*
10.05-10.10	Welcome to the participants Djunusov I. K. *Vice-Prime Minister of the KGZ*
10.10-10.15	Welcome to the participants from Jogorku Kenesh (Parliament)
10.15-10.20	Welcome to the participants Mambetjanov M. *Minister of Finances of the KGZ*
10.20-10.25	Welcome to the participants Kaliev M.T. *Director of the MHIF under the KGZ Government*
10.25-10.30	Welcome to the participants *Development Partners' (DP) representative*
10.30- 11.00	Presentation of the National Health Care Reform Program «Den Sooluk» for 2012-2016. Djumabekov S.A. *Minister of Health of the KGZ*
11.00 – 11. 30	View of DPs' on the results of JAR within the framework of XI Health Summit *DVs' representative*
11.30 - 12.30	Questions& Answers, Discussion

Annex 6 List of participants

XI Health Summit
List of Invited Participants

(October 15, 2011, Hotel «Ak-Keme»)

KGZ Government		
1.	Junusov I.K.	Vice Prime Minister, KGZ Government
2.	Muratov A.A.	Head of the Department of Social Welfare, Health Care, Labor and Migration, KGZ Government Office
3.	Isaev S.E.	Expert of the Department of Department of Social Welfare, Health Care, Labor and Migration, KGZ Government Office
Jogorku Kenesh (Parliament) of the KGZ		
4.	Niyazalieva D.A.	Chairwoman of the Committee on Health Care, Social Policy, Labor and Migration, JK of the KGZ
5.	Asymbekova G.U.	Deputy Chairwoman of the Committee on Health Care, Social Policy, Labor and Migration, JK of the KGZ
6.	Baltabaev T.B.	Member of the Committee on Health Care, Social Policy, Labor and Migration, JK of the KGZ
7.	Abdyldaev M.Yu.	Leader of the Fraction «Ata Jurt»
8.	Tursunbekov Ch.A.	Leader of the Fraction «SDPK»
9.	Isaev K.K.	Leader of the Fraction «Republic »
10.	Tekebaev O.Ch.	Leader of the Fraction «Ata-Meken»
11.	Kulov F.Sh.	Leader of the Fraction «Ar-Namyc»
12.	Lyaschenko E.E.	Head of the Division on Health Care, Social Policy, Labor and Migration, JK of the KGZ
Ministry of Finances of the KGZ		
13.	Mambetjanov M.T.	Minister of Finances
14.	Shaidieva D.Dj.	State Secretary
15.	Kojokeev A.O.	Deputy Minister
16.	Abarbekova A.M.	Head of the Department of Social Expenditures Financing
17.	Dosaliev B.A.	Head of the Department Projects Development Support
18.	Ibraimova Ch.A.	Head of the Department of Planning & Investment Projects Implementation
19.	Baketaev A.K.	Head of the Budgetary Department
20.	Baimurzaev M.A.	Head of the Health Care Division, MOF
MHIF of the KGZ		
21.	Kaliev M.T.	Director
22.	Narmanbetov U.J.	Deputy Director
23.	Alymkulov E.S.	Head of the Economy & Finances Department
24.	Shimarova M.S.	Head of the Strategic Development Department
25.	Azizbekova J.A.	Head of the Health Insurance Program Implementation Unit
26.	Mombekov B.B.	Director of Bishkek Territorial Department of MHIF
27.	Kudaibergenov N.N.	Director Director of Chui Oblast Territorial Department of MHIF
28.	Omokeev M.K.	Director of Osh Oblast Territorial Department of MHIF
29.	Parhanov A.K.	Director of Osh City Territorial Department
30.	Nyshanov T.M.	Director of Jalal-Abad Territorial Department of MHIF
31.	Jusupbekov B.	Director of Batken Territorial Department of MHIF
32.	Emilbaev U.S.	Director of Talas Territorial Department of MHIF
33.	Shameeva S.A.	Director of Naryn Territorial Department of MHIF
34.	Kyrgyzbaev T.O.	Director of Issyk-Kul Territorial Department of MHIF
Central Committee, Trade Union of Health Workers		
35.	Saaliev N.S.	Chairman
MOH of the KGZ		
36.	Djumabekov S.A.	Minister

37.	Syumbaeva P.U.	State Secretary
38.	Mamabetov K.B.	Deputy Minister
39.	Abdikarimov S.T.	Deputy Minister
40.	Narbekov O.N.	Acting Deputy Minister
41.	Kachybekova L.i.	Acting Head of the Department of Reforms Coordination & Implementation (RC&ID)
42.	Saginbaeva D.Z.	Head of MHC Department
43.	Nazarova Z.D.	Head of Financial Department
44.	Ismailova M.A.	Acting Head of Department of Cadre & Work Organization
45.	Sydykanov A.S.	Head of the Public Health Division
46.	Beishebaeva Z.Y.	Head of the Procurements Division, (RC&ID)
47.	Ayilchiev A.E.	Head of the International Cooperation Sector, (RC&ID)
48.	Sydygalieva B.O.	Consultant, (RC&ID)
49.	Turdueva T.	Chief Specialist, Division of Program Development, (RC&ID)
50.	Shapakova A.	Leading Specialist, Division of Program Development, (RC&ID)
51.	Churmukova R.A.	Specialist, Division of Program Development, (RC&ID)
52.	Tokbaeva N.	Leading Specialist, Procurements Division, (RC&ID)
53.	Muktarov S.	Specialist, Procurements Division, УКиВР
54.	Burdyaeva M.K.	Specialist of International Cooperation Sector, УКиВР
55.	Omorova D.I.	Chief Specialist, Reporting & Recording Division
56.	Kenjeeva G.A.	Head of Planning &Finances Division
57.	Kalykov A.M.	Head of Reporting & Recording Division, Finance Department
58.	Nogoibaev B.	Acting Chief Specialist of Reporting & Recording Division, Finance Department
59.	Eshkhodjaeva A.S.	Deputy Head of Department of Health Care Delivery
60.	Toimatov S.Sh.	Head of Curative Preventative Care, Department of Health Care Delivery
61.	Umetalieva N.E.	Head of Division of Education & Science, Department of Cadre & Work Organization
62.	Asanalieva K.B.	Head of Internal Audit Sector
63.	Djakipova R.S.	Chief Specialist of the Department of Health Care Delivery
64.	Kadyrbekov U.K.	Acting Head of Licensing of Health Services Sector, Department of Health Care Delivery
65.	Baitikova S.T.	Press Secretary
66.	Bayalinova E.K.	Head of Press Center
67.	Ryskulov Sh.A.	Reviewer of the Press Center
68.	Kurmanov R.A.	General Director, Department of Drugs Supply & Medical Equipment
69.	Isakov T.B.	General Director of Department of State Epidemiological Surveillance
70.	Kitarova G.S.	Director of the Republican Center for Health Care Development & IT
71.	Aldasheva D.B.	Consultant
72.	Orozalieva G.S.	Local consultant
Republican Organizations		
73.	Nuraliev M.A.	Chief Doctor of the National Hospital
74.	Djumagulova A.S.	Director of the National Center of Cardiology & Therapy
75.	Zurdinov A.Z.	Rector, Kyrgyz State Medical Academy
76.	Chubakov T.Ch.	Rector, Kyrgyz State Medical Institute of Training & Retraining of Cadre
77.	Alisherov A.Sh.	General Director of the National TB Center
78.	Sultangazieva B.B.	Acting Director of the National Center of Oncology
79.	Uzakbaev K.A.	Director of the National Center of MCH
80.	Abdramanov K.A.	Director of the National Scientific Research Center of Heart Surgery& Organs Transplantation
81.	Mamakeev M.M.	Director of the National Surgical Center
82.	Raimjanov A.R.	Director of the National Center of Hematology

83.	Tokmatova A.N.	Director of the National Scientific Research Center of Human Reproduction
84.	Moldotashev I.K.	Director of the National Scientific Research Center of Balneology & Rehabilitation Treatment
85.	Jetigenova J.K.	Acting General Director of the Republican Center
86.	Begmatov A.K.	Director of the Republican Center of Mental Diseases
87.	Tokubaev R.B.	Director Republican Center of Narcology
88.	Murzakarimova L.K.	Director Republican Medical-Information Center
89.	Kurmanalieva J.M.	General Director of the Republican Center «AIDS»
90.	Kalilov J.S.	Head of the Republican Center on Immunoprophylaxis
91.	Gaibulin D.Sh.	Director Republican Center Republican Center on Quarantine& Especially Dangerous Infections
92.	Kasymov O.T.	Director of NGO «Preventative Medicine»
93.	Aitmurzaeva G.T.	Director of the Republican Health Promotion Center
94.	Kerimalieva J.A.	Director of the Republican Dermatology & Venerology Center
95.	Aitkuluev N.S.	Director of the Republican Clinical Infectious Hospital
96.	Begilerov I.S.	Director of the Republican Hospital of Forensic Medicine
97.	Turganbaev J.T.	Director of the Republican Morbid Anatomy Bureau
98.	Uchkempirova S.M.	Chief Physician of the Republican Diagnostic Center
99.	Bagyshbekova G.A.	Head of In-Patient Facility of the Military-Medical Service of Taxation Committee
100.	Akbaeva J.T.	Head of the Republican Hospital and Polyclinic of the KGZ Ministry of Interior
101.	Sagynbaev M.A.	Director of Curative –Sanatory Unit
102.	Soltobekova N.I.	Deputy Head of Medical Service under the State Service of Administrating Punishment
103.	Asanov B.A.	Colonel of Medical Service, Ministry of Defense of the KGZ, candidate of medical sciences.
Bishkek City		
104.	Usubakunova A.I.	Vice-Mayor
105.	Murzaliev A.D.	Director of Health Care Department of Bishkek City
106.	Omuraliev K.T.	Deputy Chief Physician of Bishkek SES
107.	Sulaimanov S.B.	Chief Physician of Railroad Hospital
108.	Shayakhmetov I.B.	Director of the City Center on Prevention & Fight against AIDS
109.	Bayaliev S.A.	Director of Bishkek Medical College
Osh City		
110.	Khadjaev D.B.	Vice-Mayor
111.	Nuraliev A.J.	Director of FMC №1, Osh City
112.	Karataeva U.S.	Chief Physician of Osh SES
Chui Oblast		
113.	Maitikova Ch.N.	Vice Governor
114.	Asylbekov E.S.	Director of Oblast FMC
115.	Bolotbekov B.A.	Director of the Oblast Merged Hospital (OMH)
116.	Sekishev J.S.	Chief Physician of the Issyk-Ata Rayon SES
117.	Almenbaev B.A.	Director of Tokmok Medical College
Osh oblast		
118.	Tezekbaev K.T.	Vice Governor
119.	Akimova V.A	Director of the Oblast FMC
120.	Sulaimanov Sh.A.	Director of Osh Inter-Oblast Merged Clinical Hospital
121.	Razykova T.	Chief Physician of Kara-Suu Rayon SES
Jalal-Abad oblast		
122.	Egemberdieva J.Sh.	Vice Governor
123.	Miyanov M.O.	Director of the OFMC
124.	Shamshiev A.A.	Director of OMH
125.	Jorobaev U.S.	Chief Physician of Jalal-Abad City SES
Batken oblast		
126.	Orozova K.B.	Vice Governor
127.	Toroev S.T.	Director of the OFMC

128.	Aijigitov T.	Director of OMH
129.	Shermatov G.A.	Chief Physician of Batken Rayon SES
Talas oblast		
130.	Botikov R.T.	Deputy Governor
131.	Shadiev A.M.	Acting Director of OFMC
132.	Djumaliev Sh.A.	Director of OMH
133.	Aidarov J.A.	Chief Physician of Talas Rayon SES
Naryn oblast		
134.	Esenamanova S.K.	Deputy Governor
135.	Berdikojoeva A.K.	Director of OFMC
136.	Atbaev M.A.	Director of OMH
137.	Muradilov J.Sh.	Chief Physician of Naryn Rayon SES
Issyk-Kul oblast		
138.	Kenenbaeva N.C.	Deputy Governor
139.	Akunova J.K.	Director of OFMC
140.	Ismailov K.K.	Director of OMH
141.	Makeev T.K.	Chief Physician of Karakol SES
Public Steering Council & NGOs		
142.9	Orozaliev S. O.	Chairman Medical Accreditation Commission
143.	Uchkempirova R.M.	Chairwoman Public Steering Council (PSC), Director of «Socium-Consult»
144.9	Mukeeva S. T.	Executive Director of FGPA and Medical Nurses, PSC member
145.9	Politi I.V.	Chairman of Public Organization «Social Protection of Population of the KGZ»
146.	Estebesova B.A.	Chairwoman of Association of Programs «Partnership Network»
147.1	Jiteneva V.G.	Chairwoman of Public Organization «Alliance of Good Forces»
148.1	Titov V.O.	Director of Company «Avanko», PSC member
149.1	Makenbaeva B.J.	Chairwoman of Public Organization «Mental health and Society », PSC member
150.	Mamutova S.K.	Chairwoman of Public Organization «Diabetic Association of Kyrgyzstan», PSC member
151.1	Djankorozova M.K.	Coordinator of MeTa Project
152.1	Kerimova N.R.	Chairwoman of «Kyrgyz Association of Obstetricians – Gynecologists and Neonatologists» (KAOGN)
153.	Saktanova T.S.	Chairwoman of Nurses Association of the KGZ
154.	Akbagysheva Z.A.	President of the KGZ Women's Congress, Deputy Chairwoman of the KGZ PSC
155.	Alaferdov A.K.	President of the Public Organization «Azeri», PSC member
156.	Atanov K.T.	Chairman of Association of Rural Health Committees, Deputy Chairman of the KGZ PSC
157.	Baktybaev Z.S.	Deputy Editor of the «Alibi» newspaper, PSC member
158.	Musabekov O.J.	Representative of Public Organization «Aikol Ala-Too», PSC member
159.	Mambetova G.M.	Teacher of the "Pharmacy" department of the Kyrgyz State Medical Institute of Training & Retraining of Cadre, PSC Executive Secretary
160.	Duishenova D.	Project «Support»
161.	Bekbasarova Ch.B.	National Coordinator of Tobacco Control
Country Coordination Committee		
162.1	Ermekov B.	Member of the Secretariat
International Organizations		
World Bank		
163.1	Mrs Dinara Djoldosheva	Program and Loan Portfolio Manager
164.	Mr Nedim Yaganec	Health Care & Social Protection Project Manager
165.1	Mrs Asel Sargaldakova	Health Care & Social Protection Project (in SWAp context) Manager , Health Officer
WHO		

166.	Mr Oskon Moldokulov	Head of the WHO Office in Kyrgyzstan
167.	Mrs Melita Jacabs	Advisor on Health Policy Issues, WHO EURO, Barcelona
168.	Maria Scarpedinsdotter	Technical Officer, Policy, Country Systems & Services, WHO EURO, Copenhagen
169.	Bernd	Technical Officer, European Observatory of Health Care Systems & Policy
170.	Filiada Travis	Coordinator, Development & Services of Health Care Policy, WHO Headquarters, Geneva
171.	Dr Andreas Khasman	Advisor on Health Policy, WHO Country Office, Republic of Moldova
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172.	Mrs Aigul Sydykova	Program Coordinator
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173.	Mr Johim Schurmann	Central Asia Health Sector Coordinator
174.	Mrs Kunnura Raimbekova	Program Officer
175.	Mrs Olga Gorovenko	Senior Portfolio Officer
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176.	Mrs Andrea Studer	Deputy Country Director
177.h	Muratalieva E.	Program Coordinator
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177	Mr Tobias Schutz	Country Coordinator
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178.	Mrs Sara Feistein	Country Manager of Quality Health Care Project
179.	Mrs Chinara Kamarli	Country Specialist on Health Care, USAID Kyrgyzstan
180	Mrs Djamilya Alisheva	Country Manager, USAID Project – "Dialogue on HIV/AIDS & TB"
181	Mr Barton Smith	Regional Director on MCH, USAID Project "Quality Health Care"
182	Ibraimova A.S.	Deputy Regional Director
183	Daniel Parson	Regional HIV Director
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184	Mrs Damira Biibosunova	Country Coordinator
UNICEF		
185.	Mrs Cholpon Imanalieva	Coordinator on Health Care & Nutrition Program
UNFPA		
186.	Mr Meder Omurzakov	Executive Representative
187.	Mrs Nurgul Smankulova	National Coordinator on Reproductive Health Programs
188.	Mr Azamat Bayalinov	Reproductive Health Specialist
UN		
189.	Mr Jonathan Weitch	Acting UN Resident Coordinator in the KGZ
GIZ		
190.	Mrs Gizela Khaifa	Regional Director «Health Care Systems Development in Central Asia» Project
191.	Mrs Cholpon Asambaeva	National Coordinator
Global Fund		
192.	Mr Nurbolot Usenbaev	Manager of Global Fund Malaria Project
GAVI		
193.	Mrs Asel Adjaparova	Coordinator of Health System Strengthening, GAVI in the KGZ

Public Fund «Center for Health Care Policy Analysis»		
194.	Mrs Murzalieva G. A.	Director
195.	Mr Temirov A.A.	Deputy Director
«Soros-Kyrgyzstan» Foundation		
196.	Mr Aibek Mukambetov	Director of «Public Health program, «Soros-Kyrgyzstan» Foundation
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197.	Mr Kleto Chashi	Coordinator of Medical Division
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198.	Mr Alimjan Koshmuratov	Expert on Health Policy
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203.	Oskonbaeva K.T.	Expert
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Annex 7

Process of development of the National Health Reform Program «Den Sooluk»

The previous health care reform program «Manas Taalimi» (MT) was supported by a number of international agencies and donors, which agreed upon a Sector Wide approach (SWAp)[19] with the KGZ Government[20].

Development Partners (DP), including SWAp signatories, have Joint Annual Reviews (JAR) of the progress in implementation of MT twice a year, which in spring are devoted to Manas Taalimi implementation, achievements and approaches, and in the fall – to the Work Plan for next year, including procurement plans and next steps. The process of preparation of the JAR is characterized by the fact that it is prepared by the MOH and the agenda is jointly developed with DP's. Manas Taalimi Midterm Review Report was prepared by the MOH jointly with HPAC[21] and found useful by stakeholders, especially as regards its analytical nature.

The 2011 MT Evaluation Report, prepared by MOH[22] was completed shortly before the May-June 2011 JAR. The Report was prepared by a Working Group, consisting of MOH Secretary of State, MOH staff and HPAC representatives, jointly with some contractors or DPs' representatives. This evaluation report was based on the regular MOH Progress Reports submitted in preparation for the six monthly JAR, based on data of the Medical-Informational Center, National Statistic Committee, household surveys, reports of HPAC, published during the last 5 years, and National Health Accounts. The evaluation report was further based on the information, collected during DS preparation visits to all the regions, during which people were interviewed in-depth about the perceived problems in general, and MT implementation in particular. Civil society was not involved.

It should be pointed out that, the JAR preparation process itself was not assessed: e.g. whether the JARs are effective and whether it improved the efficiency of the review process compared the period prior to the SWAp; whether JAR saves time for the Kyrgyz officials and staff; whether it is useful to gather all partners around the table; whether it has led to synergy in the review process; whether the review process was sufficient (time and depth wise) to disclose all aspects of implementation; and adequate to solve them; whether the Kyrgyz partners had a fair chance to carry out a review of Development Partners' activity and provide feedback to them. These issuesare yet to be raised.

[19] Joint Statement on Health Sector Wide Approach between the Government of the Kyrgyz Republic and the Donor Community. Bishkek, 6 October 2005.

[20] MOH and the Ministry of Economy and Finance of the Kyrgyz Republic, on behalf of the Government; On behalf of the international organizations: World Bank, the Department for International Development (DFID/UK), the German Development Corporation (KFW/FRG), the Swiss Development Corporation, the United States Agency for International Development (USAID), the World Health Organization (WHO), the United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), United Nations populations Fund (UNFPA), Asian Development Bank (ADB) and the Swedish International Development Corporation Agency (SIDA)

[21] Ministry of Health of the Kyrgyz Republic: Mid-Term Review Report. Manas Taalimi Health Sector Strategy. Bishkek. May 7, 2008.

[22] Ministry of Health of the Kyrgyz Republic (MOH): Evaluation of the Kyrgyz Republic National Health Reform Program 'Manas taalimi' Implementation Report, Bishkek, April 2011

Towards Den Sooluk preparation/development

The preparation and development of the successor health care reform program Den Sooluk formally started in June 2010, but was anticipated back in 2008 during a JAR. The team of national experts was recruited through open competition. International experts were selected to support the process and visited the country twice to provide guidance for the program design. All efforts were financially supported by WHO. Development Partners and Parliament members were informed and received updates on the progress. Preliminary results were presented to an expanded audience at the plenary meeting during the 2010 November JAR. The preparation team, under the guidance of the Secretary of State, had visited all oblasts twice to discuss proposals to be incorporated into DS by the medical community and civil society. In March 2011 a first draft of the 2012-2016 DS Strategy was translated and disseminated to stakeholders, including DPs. DPs gave their joint comments to the Minister of Health and evaluated the DS as a good program, oriented towards removal of the shortcomings of the Manas Taalimi Program and its implementation barriers; demonstrating continuity in systems strengthening; outlining the framework of priorities and activities in a more productive way. In a joint letter DPs gave some recommendations to further strengthen DS without changing priorities.

At the spring 2011 JAR, the March 2011 DS draft was discussed. Though some new proposals were inserted by an independent national expert, upon agreement with the Minister of Health, the decision was made to refrain from discussing these additional proposals on establishment of Health Care Fund, fund-holding at primary health care level and the introduction of co-payment for deliveries. These proposals were only available in Russian and not previously discussed in the regions. After joint discussion it was agreed that such significant changes could not be incorporated at this late stage in the process and based on the conclusions and comments made during the 2011 spring JAR, the DS proposal was further developed and timely submitted for the 2011 October JAR.