# GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Kyrgyzstan Case Study

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# Acronyms and Abbreviations

| | |
|---|---|
| APR | Annual Progress Report |
| CHSD | Center for Health System Development |
| DSSEC | Department of State Sanitary-Epidemiological Surveillance |
| FAPs | Feldsher-midwife points |
| FGP | Family Group Practitioners |
| FMR | Financial Management Reports |
| HPC | Health Policy Council |
| ICCI | Intersectoral Coordination Committee on Immunisation |
| JAR | Joint Annual Review |
| MDG | Millennium Development Goal |
| MoH | Ministry of Health |
| MHIF | Mandatory Health Insurance Fund |
| PHC | Primary Health Care |
| POW | Plan of Work |
| RBF | Results Based Financing |
| RCI | Republican Centre for Immunisation |
| SBP. | State (Guaranteed) Benefit Package |
| SES | Sanitary-Epidemiological Surveillance Service |
| SWAp | Sector wide approach |
| VHC | Village Health Committee |

# Summary of key findings, conclusions and recommendations

## Introduction

This summary of the Kyrgyz case study answers the first two GAVI HSS evaluation questions, namely:

- What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
- What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

It also highlights some key issues related to how well the Kyrgyz HSS intervention fits with GAVI's principles and values.

This in-depth case study was carried out as a desk based study in July and August 2009. It draws heavily from the findings of the Tracking Study (JSI/Indevelop/IPM 2009)

Kyrgyzstan has almost universal immunisation coverage although there are some pockets of under coverage – notably urban migrants who may be unaware of the need to register in their new residence to get access to free health care. Over the last decade or so it has implemented a series of far reaching systems and financing reforms which have helped transform the health system from one which was extremely fragmented, over centralised and hospital led to a more unified, PHC-led and responsive systems approach. These reforms – and the current reform thrust - are set out in Manas Taalimi – the sector strategic plan which covers the period 2006-2010. Although aid dependence is quite low there is an emerging SWAp process with a number of donors providing pooled funding and others parallel funding is support of Manas Taalimi.

The Kyrgyz Republic received GAVI HSS support totalling $1.15m for a period of 4 years in round 1. The Kyrgyz experience has, in general, been a positive one both in terms of consistency with GAVI principles and, at a very early stage, delivery of outputs.

GAVI support was provided against a backdrop of:

- modest economic growth and reducing poverty levels in recent years as the economy re-establishes itself following the collapse of the Soviet Union and economic chaos which ensured in the early 1990s
- the gradual transformation of the system from a centralised hospital led approaches to a more decentralisation, responsive, PHC led approach
- very high (although slightly declining) levels of immunisation coverage by low income country standards with pockets of under coverage largely associated with urban migrants
- an emerging SWAp process – incorporating pooled funding as well as parallel funding – in support of a country led strategic sector plan "Manas Taalimi"

The proposal represents just over 10% of the Kyrgyz Government's overall HSS programme. The GAVI supported components is spread between more traditional investments such as equipment purchases for primary care providers and the public health system at the rayon (district) level, strengthening means of transportation at rayon level, organizing mobile immunization teams, introducing supportive supervision, improving information technology, and integrated training of primary care providers although other funders (including Government) are larger contributors in this areas. The GAVI programme also includes more innovative interventions such as the introduction of performance-based payment incentives for primary care providers

The approach is particularly strong in terms of alignment – although GAVI will be a parallel financier of Manas Taalimi than a joint financier as originally intended – largely feeding into a strengthening SWAp process. GAVI funding has allowed the establishment of innovative performance based provider incentives which should influence the development of much larger schemes of this nature planned in the coming years

## Consistency with GAVI Principles

The approach adopted by the Kyrgyz Government has fostered significant **country ownership**. It was developed through a consultative process involving strong Government leadership from the Deputy Health Minister using pre-existing country mechanisms – the Intersectoral Coordination Committee on Immunisation (ICCI) and the Heath Policy Council (HPC). The proposal was largely drafted by a working group established for the GAVI HSS proposal with significant technical inputs from WHO and USAID. Stakeholders felt that adequate amounts of high quality technical assistance were provided to support the process.

The activities supported are **well aligned** with national priorities; each component of the proposal can be cross referenced to the Manas Taalimi. However, there is less use of Government systems than was originally intended. The aim was that GAVI would become a joint financier and pool its funding with those of other donors (World Bank, KfW, DFID, SDC and SIDA**).** In practice, it is reported that the GAVI support has been "taken out of the SWAp". In the Kyrgyz context this means that it has, in effect, a parallel funder of activities using a separate account but which still remain under the Manas Taalimi framework (along similar lines of the GAVI approach in Nepal and Cambodia).. Activity reports are prepared and fed into the Joint Annual Review (SWAp) process. They are prepared earlier than might be the case otherwise but are not necessarily an additional requirement. The programme has used pre existing structures to design, manage and oversee implementation of the GAVI HSS proposal – an Intersectoral Coordination Committee (which has been operating since December 2000) and the high level decision making body the Health Policy Committee The programme does not use a PIU but has established a Technical Coordinator role and Financial and Disbursement Specialist. The M&E framework is reasonably harmonised with that of Manas Taalimi. The framework for the latter is being modified and GAVI HSS indicators are increasingly being incorporated. This approach contrasts to that of the Global Fund which uses totally separate arrangements

The process has been reasonably **inclusive**. Key stakeholders have participated with the Republican Centre for Immunisation (RCI) and the Mandatory Health Insurance Fund (MHIF) being actively involved and leading the working group. The Working Group involved a range of stakeholders including MoH, MHIF, Sanitary-Epidemiological Surveillance Service (SES**)**, RCI and the Center for Health System Development (CHSD**)** with technical support from WHO, UNICEF and ZdravPlus (USAID) with a smaller core writing team. However, there was no external review process and there has been no participation from civil society at any stage

Some components are **results oriented**. The performance based incentives approach which is being piloted in 2 district will subsequently be rolled out more broadly as part of the GAVI HSS proposal with the aim to achieve national coverage by 2011 (with complementary support from MHIF.

In principle the GAVI approach offers a significant degree of **predictability** as the country knows in advance its annual entitlements and such figures can be incorporated into the MTEF. In practice, MoH complained of the late arrival of GAVI HSS tranches which has delayed activities**.** A key area of uncertainty related to the question of whether the proposal

should focus on a narrow range of activities closely related to immunisation or whether it should emphasise broader health systems strengthening. In the event, some broader activities were included such as support to Village Health Committees but with a large share of support going to more downstream (immunisation related) activities.

Prospects for **sustainability** appear reasonable. At the recent Joint Annual Review the development partners have taken a strong line on Governments failure to meet finance targets and have been assured that Government will meet its commitments. Although some activities in the HSS proposal do involve ongoing costs – including performance based funding – Government has expressed its intention to gradually take on the funding costs for this activity. Specific commitments have not been made for other components. However, GAVI support is not large in the context of overall funding – it only accounts for just over 10% of all HSS activities relevant to immunisation (joint financiers cover just under 60%). Government also has a track record of support for immunisation – currently meeting 69.8% of immunisation programme costs (covering all but vaccines and injection supplies). At the same time the country faces new sustainability challenges associated with the introduction of the pentavalent vaccine (with GAVI support) in 2009

The approach combines a mix of proven interventions with new, **innovative** approaches. The performance based incentives component aimed at improving productivity and incentives for primary care providers was introduced with the encouragement of GAVI. As noted above this will be rolled out nationally with complementary support from MHIF The lessons learnt through this will feed into a larger programme of performance based financing supported under the World Bank led Innovative Results Based Financing (RBF) Initiative. This initiative aims to expand the use of output- or performance-based financing in HNP, with a focus on MDGs 4 and 5 supported by a US$100 million trust fund funded by the Government of Norway and operate through a World Bank Trust Fund,

There is little explicit focus on equity which is perhaps of less concern given the high coverage rates. Nonetheless some activities do focus on addressing the needs of difficult to reach groups. Annual immunisation weeks, for example, target internal migrants and immigrants amongst others. It is also proposed to carry out an assessment of socio economic inequalities in access to primary health care and immunisation in 2010. This should shed light on the issue and be a useful input to the 2012 evaluation

**Flexibility** is a key strength of GAVI HSS and is a feature which other countries have taken advantage of. In the Kyrgyz Republic there appears to have been a reluctance to make

changes to planned activities even when there was a clear case for doing so and a lack of clarity about what steps needed to be taken to do so. As a result the potential benefits of flexibility have not been realised and the Government has not necessarily spent funds as it would have ideally liked to have. The Tracking Study also noted that greater coordination between GAVI HSS and UNICEF (who separately assess cold chain maintenance needs and repair) could have improved efficiency

Key aspects for the 2012 evaluation to follow up on include:

- the extent to which the performance based initiative was properly evaluated and led to credible results which were incorporated into the design of the Results Based Financing Initiative programme
- the results of the socio economic survey into access to immunisation to be carried out in 2010

# 1 Scope, Approach and Methodology

## 1.1 Background

This report contains the findings of the case study which was carried out as a desk based study in July 2009. It is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested from HLSP. To keep this report short these broader methodological issues are not be discussed here. A summarised description of the study approach is at **Annex 1**.

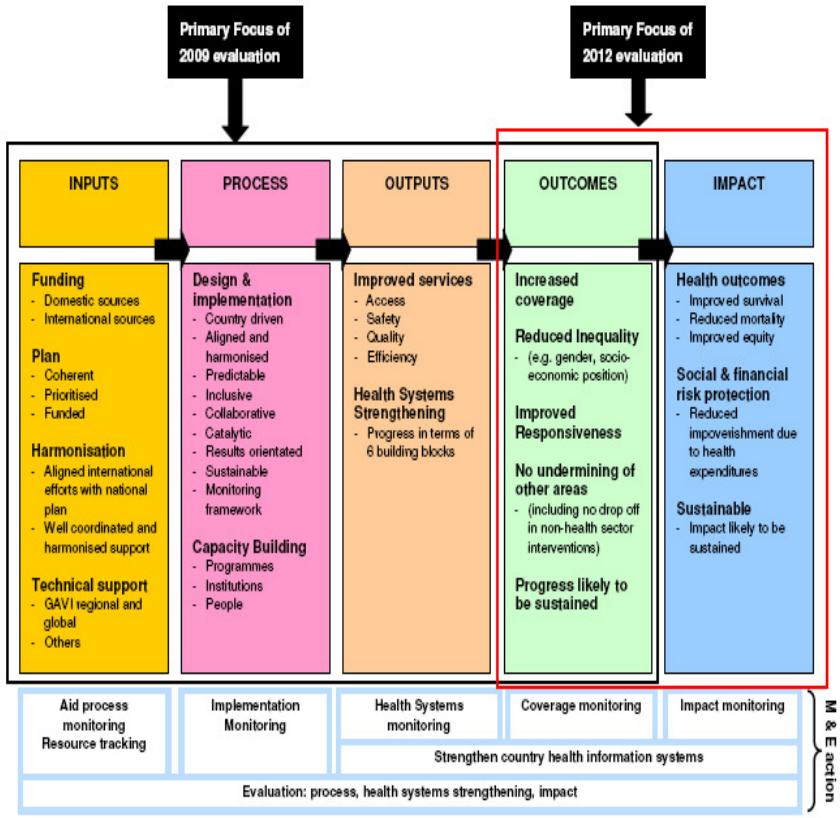
## 1.2 Brief conceptual framework of the evaluation

This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note that in view of the short time elapsed since the first HSS applications were approved in 2006 that this evaluation –the first one ever conducted on the GAVI HSS component- will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

**Figure 1: The conceptual framework - logical progression from inputs to impact**




The priority evaluation questions are summarised in Box 1 below.

**Box 1: Examples of Questions for the HSS Evaluation Study**

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

## 1.3 Approach to the Country Case studies

11 in-depth studies were carried out. Usually the HLSP country lead consultant was assisted by one or more national consultants or national research institutions depending on the circumstances and the study usually involved at least one country visit. [1] In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were able to count on the support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study - led JSI/InDevelop-IPM - covers very similar areas (albeit form a different angle) to those of this HSS Evaluation study, so attempts were made to achieve synergies between the two studies.

In Kyrgyzstan, as in other countries, the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called “Focal Points” based at either the World Health Organisation (WHO) or UNICEF. This case study was carried out through analysis of existing documents including the draft Tracking Study validated by a conversation with the study lead. The original intention had been for the consultant to undertake a country visit to coincide with the Tracking Study workshop in early July. Unfortunately due to a family emergency this did not prove possible. Given the relatively small size of the grant and the availability of a good Tracking Study draft it was decided not to include a country visit. As the work was carried out after the team’s review workshop in Barcelona in mid June the study focused on analysis of the proposal and the Tracking Study, review of data from recent Health Summits and follow on validation processes by email and telephone with the lead consultant on the Tracking Study team and a donor health adviser (DFID)

[1] The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

# 2 Kyrgyz Country Case Study

## 2.1 Country Context

### 2.1.1 Economic and social status

Kyrgyzstan is a low income country with a per capita income estimated at $433 per head in 2004. Following economic collapse in the early 1990s - following the break-up of the Soviet Union - economic growth has resumed and poverty levels have declined. In 2006 the infant mortality rate stood at 34.5 deaths per 1,000 live births. Life expectancy was 68.5 years: 72.7 years for females and 64.5 years for males and the total fertility rate was 2.7 births per woman.

### 2.1.2 Health situation, priorities and programmes

#### Overview of Strategy

After gaining independence the Kyrgyz Government inherited a system with excessive infrastructure dominated by hospital care and overspecialised services incorporating extremely centralised management, high levels of bureaucracy, fragmentation and duplication in the delivery of health care and supported by inefficient financing mechanisms

The MANAS Health Care Reform Programme, established in 1996, implemented a series of far reaching reforms – aimed at moving towards universal access to health care - including:

- a restructuring of the delivery systems including the strengthening of family medicine a start to the rationalisation of the hospital sector including the provision of greater autonomy at the facility level and the development of a State Guaranteed Benefit Package.
- the establishment of a single payer system and a purchaser provider split
- introduction of mandatory health insurance with new provider payment methods (capitation based for PHC and case based for hospital care) and contracting arrangements.
- the pharmaceutical sector was privatised and an essential drugs list established.

Despite a declining resource base (with overall Government spending going into sharp decline and the share of public expenditure going to health also going down) results have been impressive. Kyrgyzstan is seen as one of the most progressive states in the region and

provided the process continues potentially acts as a model for health sector reform in the region.

Government's health strategy for 2006-2010 – Manas Taalimi – builds on these reforms focusing, in particular, on a number of areas previously untouched including:

- reorienting resources towards addressing the MDGs,
- strengthening public health and prevention services,
- strengthening MoH capacity in policy formulation, priority setting, policy-based budget planning and monitoring and evaluation, and
- improving the quality of services

Other key issues include the need to:

- address the emerging human resource crisis with large outflows of doctors to Russia and Kazakhstan.
- strengthen and modernise undergraduate medical education and
- ensure consistency between the health financing system and the overall financial management system and the need to ensure the State Guaranteed Benefits Package (SGBP) is adequately funded as it expands

**Sector financing and coordination arrangements**

A sector wide approach (SWAp) has been adopted in the health sector. Many of the building blocks for a SWAp were in place, or in preparation, well before the SWAp was officially established in 2006. The SWAp has built on a range of interventions and interactions over a long period of time between key donors who, at the same time, were able to build strong relationship with key Government staff.

Manas Taalimi provides the overarching sector framework. It is accompanied by a five-year Programme of Work, a five-year sector expenditure programme and Medium Term Budget Framework and a common Performance Monitoring Instrument which sets out a range of outcome, outputs and input (including fiduciary) indicators

Government prepares an Annual Programme of Work setting out key actions, activities, responsible agencies, sources of financing and timing in 8 programme areas. This has

recently been expanded to include parallel funded activities so it is possible to get a flavour of the scope of overall activities (if not expenditure). Other key documents review include the procurement plan and the progress against milestones and targets

Health Summits are organised by the Department for Strategic Planning and Reform Implementation and are held in May and September of each year. They involve staff from Health and Finance Ministries, and a range of donors including DFID, KfW, SIDA, SDC, USAID, WHO, UNICEF and the World Bank. The May summit focuses on past performance. In advance of the meeting Government is expected to prepare a report on progress against the Programme of work and progress against key indicators (the Monitoring Indicators Package). The September summit is forward looking. Its aim is to seek agreement on the following year's programme of work, the procurement plan and the health budget.

Funds from on budget donors are transferred to a special account at the National Bank of the Kyrgyz Republic. These are subsequently channelled to one of MoF's local currency accounts where pooled funds are co-mingled. Off budget funds support is either channelled to providers directly or through special accounts against which spending can be tracked. World Bank procurement rules apply to *all* on budget donor spending in the health sector

The Programme of Work is funded by a number of donors. The World Bank is the lead donor of the on budget donors (DFID, KfW, WB SIDA and Swiss). Donor support arrangements are set out in the "Memorandum of Mutual Understanding between the Government of the KR and participants of co-financing for support of health sector reforms program "Manas Taalimi" of the Kyrgyz Republic for 2006-2010" (July 22, 2006). Following the September 2006 Summit donors agreed to provide $13m in 2007 with DFID support heavily frontloaded. Other donors – including the UN, USAID, AsDB and JICA - are providing off budget support

At the May 2009 Joint Annual Review the development partners concluded that

- progress in implementation of Manas Taalimi in 2008 had been strong
- the Joint Annual Review process had been managed extremely well by the MOH and the Strategic Planning Department
- the roles of Deputy Ministers of Health, department heads and component leaders in the review process had been exemplary

Future plans and challenges identified include:

- developing the next sector strategy when the current Manas Taalimi programme ends – the MOH will begin development of the next sector strategy after forthcoming health summit– and extension of the SWAp to support it
- adoption/expansion of the results-based financing approach with support from a World Bank Multi Donor Trust Fund. This will be designed by the end of 2009, and implemented in 2010-2012
- Integration of global initiatives (notably the Global Fund)
- Incorporation of additional parallel financed projects including the USAID Health Improvement Project and the KfW MCH Programme into the SWAp

### 2.1.3 Child and maternal health situation

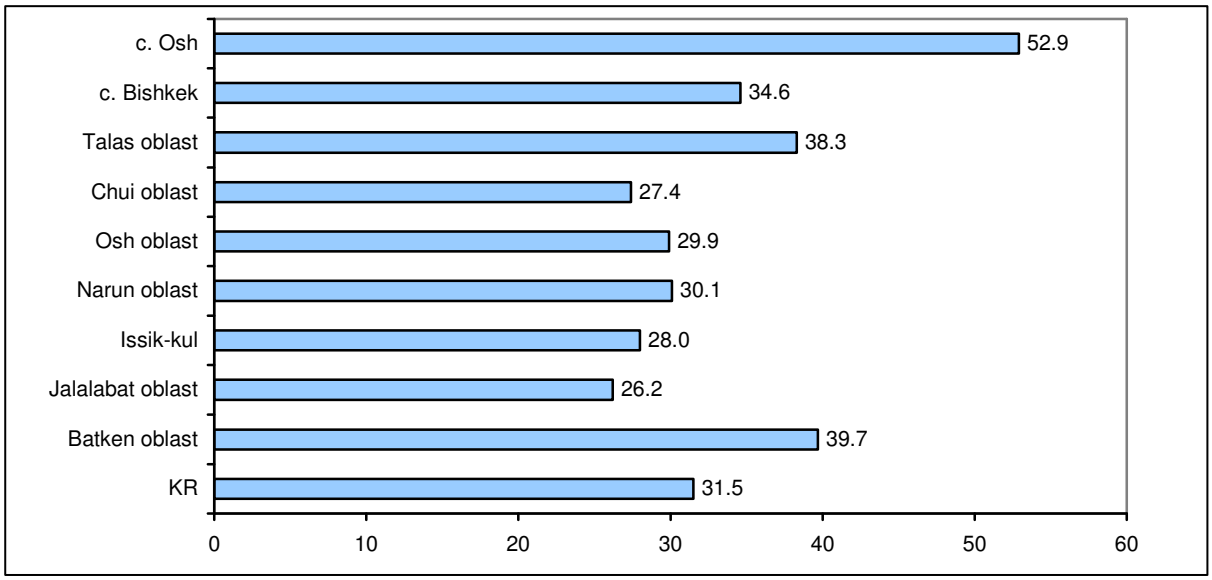
Health outcomes are relatively good by low income country standards but are showing little evidence of improvement (table 1). There are also significant geographical inequities in outcomes as shown in Table 2 in relation to the Under-Five Mortality Rate (U5MR).

**Table 1: Infant, child and maternal mortality rates**

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| **Infant** mortality rate (death of infants under 1 year old per 1,000 live-births) | 25,7 | 29,7 | 29,2 | 29,8 |
| Mortality rate of **children under 5 years** old (per 1,000 live births) | 31,2 | 35,2 | 34,6 | 36,6 |
| Rate of **maternal** mortality (per 100 000 live-births) | 46,4 | 61,0 | 53,0 | 63,2 |

**Source***:* RMIC

**Table 2: Inequity in Health Outcomes: U5MR by region, 2008**




Source: Tracking Study

### 2.1.4 Key immunisation trends

The Republican Center of Immune-prophylaxis (RCI) was established in 1994 to strengthen immunisation services. Its main functions are policy development, EPI monitoring, ensuring the procurement and distribution of vaccines and system oversight and surveillance.

The May 2008 Mid Term Review of Manas Taalimi found coverage rates to be high with the proportion of children vaccinated according to the national immunisation calendar at 95.8% in 2007 This represented a decline from the previously observed coverage of 99%. Coverage is lowest in Bishkek. This decline is most likely due to increasing internal migration. Internal migrants, mostly in the capital Bishkek, constitute a pocket of under-coverage in terms of vaccination. Many migrants are not aware that they can receive free primary care and vaccinations without being registered in their new place of residence. On the other hand, PHC workers in parts of Bishkek are overwhelmed by their ever increasing workload. In rural areas poor roads, lack of cars, and resources for fuel, outreach activities are nearly impossible in these areas.

### 2.1.5 Health systems barriers

The GAVI HSS proposal contains a list of around 10 assessments that have informed the decision on the barriers to be addressed by the GAVI HSS (Box 1):

**Box 1: Identification of Health System Bottlenecks**

1. Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Health Care Financing
2. Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Restructuring of service delivery
3. Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Primary health care
4. Assessing Human Resource Issues in the Kyrgyz Health System
5. Findings from the Multiple Indicator Cluster Survey, 2006
6. Review of "Manas 2": Public health component
7. SWAp Joint Review Summary Statement, May, 2006 and September, 2006
8. Health and access to health care among urban migrants

Source: draft Tracking study

**Barriers to accessing health services remain for vulnerable population groups and in poor and remote areas.** Although the Kyrgyz health system has an extensive provider network, access barriers remain: (a) There is a lack of primary care and para-medical providers in remote mountainous areas which tend to have high poverty rates leading to pockets of under-coverage of immunization and weak maternal and child health services; (b) There is an emerging human resource crisis in rural areas with rapid loss of medical personnel due to migration of personnel to the capital city and to Russia and Kazakhstan where salaries are significantly higher; (c) Out-of-pocket burden of care seeking remains high, particularly for the poor despite achievements in financial protection; (d) Although the State Guaranteed Benefit Package ensures free primary health care for the entire population, population awareness of entitlements is frequently low, especially among the poor and vulnerable populations, limiting timely use of primary care services. This is a particular problem among internal migrants settling in temporary settlements (novostroika) around the capital city with under-use of primary care services including immunization. These remaining and newly emerging access barriers may negatively impact on currently high immunization coverage, staff attended deliveries and compromise achievements in maternal and child health outcomes. Removing access barriers to primary care and ensuring appropriate supply of personnel is a key strategy in Manas Taalimi.

**Quality of primary health care, particularly at the level of feldsher-midwife points (FAPs), requires further improvement.** Although quality of care began to improve in early reform areas, these achievements are yet to be expanded and strengthened throughout the country with continued emphasis on training of medical and para-medical staff and reform of undergraduate and post-graduate medical education system. Detailed mapping of primary care providers unearthed that the conditions of providing care at FAPs – paramedical points staffed with feldshers, mid-wives and/or nurses in remote areas far from urban centers – are unexpectedly poor in terms of facilities, equipment, and training/qualifications of staff. Given the emerging human resource shortage in these areas, investment in FAPs in terms of equipment and training is a key strategy for providing primary care and a key focus of Manas Taalimi.

**Although general immunization coverage is high, as noted earlier, there are pockets of under-coverage**. These are particularly relevant for follow-up vaccines such as DPT-3, for children in rural areas and from poor families, and among urban migrants. These pockets of under-coverage are directly connected with access barriers identified under (1) and with quality problems in primary care described under (2).

**Public health reforms less advanced.** While the immunization program has been strengthened in the past, the overall public health service delivery system and surveillance capacity remains under-developed. Salaries are low and there is little motivation for staff to improve their work. Mechanisms for improved coordination and collaboration between public health and individual health services, and between public health and health promotion activities, are needed. Investments in transportation and continuing to improve the cold chain would contribute to increased effectiveness of delivery and monitoring of vaccine provision.
Source HSS proposal

## 2. 2. The GAVI HSS Proposal

### 2.2.1 Mapping of inputs

GAVI awarded the Kyrgyz Republic a total of $1.15m in round 1. As shown in **table 2** the support is spread over 4 years and complements support from other donors accounting for just over 10% of total HSS support related to immunisation

**Table 2: Sources of Funding for All HSS Activities Relevant to Immunization**

| Funding Sources | Cost per year (US$) | | | | |
|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 | Year 4 | TOTAL FUNDS |
| | 2007 | 2008 | 2009 | 2010 | |
| Domestic Sources[1] | 412,000 | 500,000 | 582,500 | 1,021,000 | 2,515,500 |
| SWAp Joint Financiers[2] | 3,017,000 | 1,366,400 | 1,250,000 | 450,000 | 6,083,400 |
| WHO[2] | 40,000 | 10,000 | 40,000 | 10,000 | 100,000 |
| UNICEF[2] | 9,000 | 4,500 | 9,000 | 4,500 | 27,000 |
| USAID/ZdravPlus[2] | 139,000 | 162,400 | - | - | 301,400 |
| KSPHSS/SDC[2] | 341,200 | 242,000 | 1,200 | 1,200 | 585,600 |
| **GAVI (HSS proposal)** | **423,684** | **255,088** | **255,462** | **219,511** | **1,153,745** |
| **TOTAL FUNDING** | **4,381,884** | **2,540,388** | **2,138,162** | **1,706,211** | **10,766,645** |

[1] Does not include operational expenditures of the health system; only investment funds

[2] Only a sub-set of financing provided by the Joint Financiers and other Development Partners

### 2.2.2 Proposal development process

The two bodies that are responsible for coordinating immunisation activities functions in the health sector are:

- t**he Intersectoral Coordination Committee on Immunization issues (ICCI): ICCI** was established in December 2000, is chaired by the Deputy Minister for Health (since April 2008) and meets quarterly or more regularly if needed. The secretary position is held by the deputy head of the RCI and the committee is also made up of representatives from the DSSEC; MHIF, other departments and centre within the MoH USAID; WHO; UNICEF; WB; Soros Foundation; Association for Health Promotion; Kyrgyz-Swiss-Swedish Project (KSSP); ZdravPlus (USAID); ADB. Key roles include advocacy and resource mobilisation, coordination, policy development and analysis and monitoring and evaluation

- **the Health Policy Council (HPC)**. HPC is the high level decision making body. It is chaired by the Minister of Health and made of up departmental heads both within

MoH and organs for which MoH is responsible. Its activities are coordinated by the Department of Strategic Planning and Reform Implementation.

Both organs were operating before development of the GAVI application.

The application process was led by the ICCI and the Deputy Minister with RCI and MHIF being actively involved and leading the work of the working group. CHSD provided research input and technical assistance.

The decision to develop an application was made by the Minister of Health through a ministerial order which established a working group to develop the proposal.

The working group was established on 18th August 2006 and included representation from MoH, MHIF, SES, RCI and CHSD with technical advice and input by WHO, UNICEF and ZdravPlus (USAID). A smaller sub group of the working group actually wrote the proposal met several times weekly between August and October 2006 WHO and Zdrav Plus (USAID), provided substantial amounts of high quality technical assistance to the working group.

The full working group met three times during the application process. A key issue discussed was whether the proposal should focus on narrow immunisation specific activities, or broader health system strengthening activities (which has broader implications for GAVI HSS as a whole – raising questions of what HSS actually is, whether it is supposed to focus on broader HSS and, if it doesn't who should?).

The proposal was reviewed by the ICCI on two occasions. On 10th October 2006 the ICCI was familiarised with the conditions and processes related to the GAVI HSS grant and a first draft was discussed. On 23rd October 2006 a revised proposal was reviewed at a meeting involving around 60 participants, including international organizations, donors and UN-organisations for a final discussion. The proposal was subsequently endorsed by the HPC and submitted to GAVI Secretariat in early November 2006.

The presence of the Manas Taalimi strategy was found to be extremely helpful in guiding the content of the proposal. Different agencies led on different components with the national immunization programme taking a key role in formulating components 1 and 2 and parts of component 3. MHIF has been responsible for the design and implementation of the performance based incentives component The Republican Center for Health Promotion helped develop the proposal to support Village Health Committees (VHC).

In 2007, after approval of the Kyrgyz application was approved a Kyrgyz team was invited to Istanbul to share its proposal development experiences to other countries in the Central Asian and Asian region planning to develop applications for GAVI.

Key milestones in the process are shown in table 3.

**Table 3: Chronology of activities during GAVI HSS application process**

| Activity | Date |
|---|---|
| Invitation from WHO, offering TA | 7 August 2006 |
| Nomination of working group to develop application | 18 August 2006 |
| Round table discussion with ICC | 7 September 2006 |
| Second presentation and round table discussion of draft application with ICC and stake holders | 10 October 2006 |
| Submission of application to GAVI | End of October 2006 |
| GAVI approval | 1 March 2007 |
| Setting up processes for the GAVI HSS, organization and nomination of management, opening special bank account etc | March – August 2007 |
| MoH approval of methods, indicators for the salary bonus etc. | September 2007 |
| Start of planning for implementation | September 2007 |
| First funds disbursement | 7 September 2007 |
| Procurement plan for the HSS | October 2007 |
| Initiation of activities, training, method development etc | October 2007 |
| Submission of 2007 APR | May 2008 |
| Second disbursement of funds | July 2008 |

Source Tracking Study

### 2.2.3 Content of the Proposal

The proposal has five components:

- Strengthening political commitment to immunization and ensuring financial sustainability;
- Improving the physical infrastructure and working conditions of primary care and public health services;
- Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives;

- Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health; and
- Social mobilization and active involvement of the population in prevention and health promotion;

The proposal contains a mix of activities including **traditional interventions of proven effectiveness** such as equipment purchases for primary care providers and the public health system at the rayon (district) level, strengthening means of transportation at rayon level, organizing mobile immunization teams, introducing supportive supervision, improving information technology, and integrated training of primary care providers. It also includes more **innovatory activities** such as the development and introduction of performance-based payment incentives for primary care providers. The Kyrgyz MoH has been interested in such approaches particularly in the face of growing human resource shortages in rural areas. It also contains a balance of narrower immunisation focused activities and broader health systems strengthening activities. Key components are summarised in Box 2.

**Box 2: Overview of Key Components**

**Component 1: Strengthening political commitment to immunization and ensuring financial sustainability;**

- conducting advocacy activities targeted at policy makers in the health system and in related sectors relying on strengthened analytical activities and application of their results in the political process
- ensuring financial sustainability of immunization by strengthening the budgetary process

**Component 2: Improving the physical infrastructure and working conditions of primary care and public health services**

- investment in the physical infrastructure of primary care and public health with a focus on strengthening the cold chain and enhancing mobility of public health services
- strengthening surveillance based on improving the equipment base of laboratories

**Component 3 "Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives"**

- training health professionals on immunization and MCH topics,
- introducing supervisory visits to oversee and support health workers on fields,
- supporting epidemiologists in investigating vaccine-preventable infection cases,
- introducing performance-based payment mechanism for PHC

**Component 4 "Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health"**

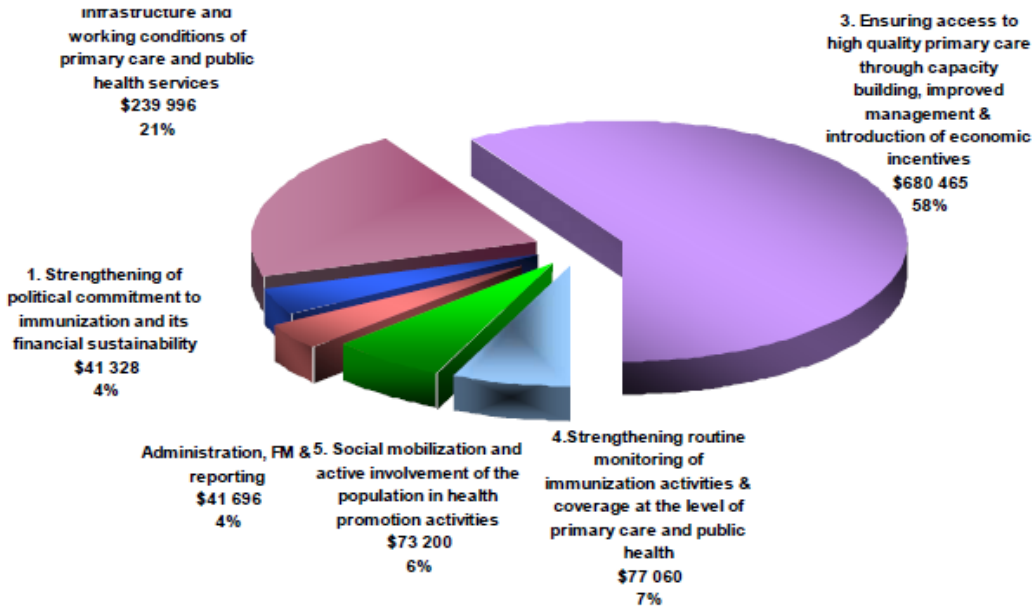
- development of the vaccine status register with individual immunization calendar
- Revision of the Indicator Package for Manas Taalimi to include the agreed GAVI HSS Indicators
- Maintenance of Health Information System
- Monitoring of timeliness and quality of immunization within the National Vaccination Calendar

**Component 5 "Social mobilization and active involvement of people in health promotion and disease prevention"**

- implementation of the Jumgal Model of community involvement in health promotion activities through establishing village health committees
- development of technical guidelines and informational material to train civil society organizations on public health issues, particularly among urban migrants and in remote areas
- creation of incentives for NGOs and public associations to conduct health promotion activities among urban migrants and in remote regions
- training for health workers on communication methods

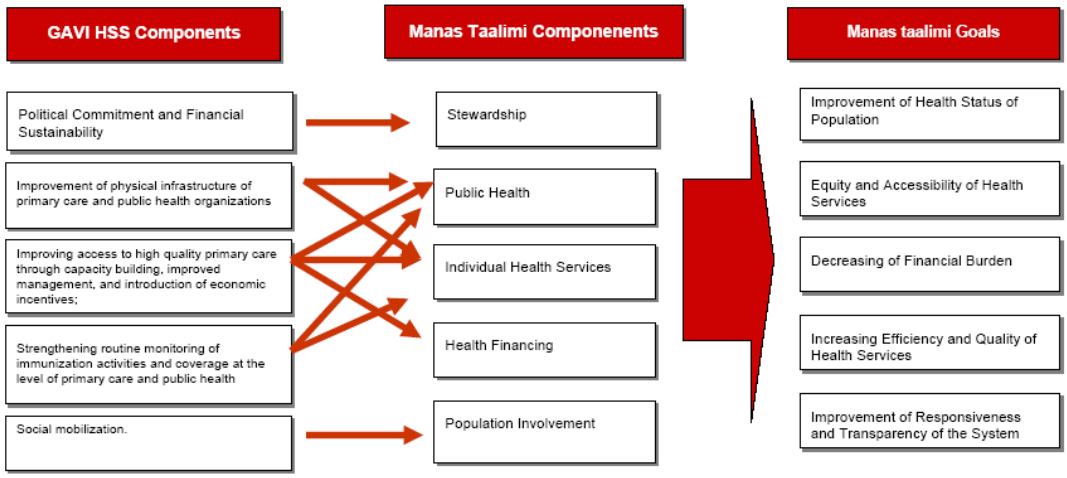
As shown in Figure 1 a large share of funds is allocated towards improving the quality of PHC and in particular, the performance incentives scheme

**Figure 1: Allocation of GAVI HSS Resources by Component**




The proposal clearly relates the GAVI HSS components with the Manas Taalimi and its overall goals.

**Figure 2: Links between activities and Manas Taalimi**



# 3 Analysis of Progress against Key GAVI Principles

## 3.1 Country Driven

As noted above, the GAVI HSS approach is guided by overarching Government priorities as set out in Manas Taalimi. The processes for developing the proposal used pre existing Government mechanisms and a wide use of appropriate Government staff making selective use of technical assistance as necessary

## 3.2 Alignment (with National Plans and Systems) and Harmonisation

The approach is fully aligned with Manas Taalimi. The proposal included a fully-costed Programme of Work (POW) for *all HSS activities* related to immunisation setting out proposed activities, timing, estimated cost, as well as the availability of financing from other sources. Crucially it is possible to link each activity in the POW to the corresponding Manas Taalimi programme so that each activity can be cross-referenced to activities in the Manas Taalimi strategy. Such an approach makes it easy to see the overall thrust of Governments approach to HSS and the role of different funders – it should also highlight synergies between activities and avoid duplication. POW activities were costed using the same unit prices as were used for costing the Manas Taalimi sector strategy to ensure consistency between the two.

In terms of alignment with Government financial systems the original intention was that GAVI HSS should use the existing allocation, procurement management and accountability mechanisms of the Kyrgyz state as used by the joint financiers (WB, DFID, SDC, KfW, and SIDA). GAVI HSS funds were to have flowed directly into a foreign currency-designated account at the National Bank. These funds would then be converted and deposited into the same local currency account used for the other joint funders with the GAVI Secretariat signing the Memorandum of Understanding covering the management of joint donor funds. Thereafter funds were to have been allocated to their end users – either MoH or MHIF. The same planning approach would be adopted as that of other components of Manas Taalimi involving the drafting of a annual Plan of Work (supported by the Technical Coordinator), review by the Department of Strategic Planning with endorsement form the HPC and presented for funding at the September Health Summit

The aim of this was to harmonise GAVI support with that of other joint funders, to reduce transactions costs by using the same Joint Annual Review processes and to adopt the same fiduciary risk mitigation measures used in the SWAp.

Rather than establishing a full blown, separate project management unit. The GAVI HSS Technical Coordinator post was created (using project funding). The role is to coordinate and support the GAVI HSS activities, ensure appropriate information flows within the country as well as between the country and the GAVI Secretariat.

In the face of problems the Ministry of Health has faced in disbursing resources a decision was taken to take GAVI out of the joint funding arrangements to avoid negative consequences to the HSS programme. Funds are not co-mingled with those of other joint financiers – rather they are place in a separate account. Organisations implementing GAVI HSS activities make applications for funds to the MoH who send a payment order to the Central Treasury which sends funds to the implementing agencies. This procedure is felt to have worked well – the major constraint has been the initial transfer of GAVI funds to the special account. Although a step back from the original approach the approach still uses Government systems but GAVI HSS is now a parallel financier (the SWAp is seen as synonymous with joint or pooled financing in the Kyrgyz context). In effect GAVI HSS is still part of the SWAp as it tends to be defined internationally and its approach – as a parallel funder – is similar to that employed in Cambodia and Nepal. The real questions are when and whether GAVI HSS may become a joint financier itself

## 3.3 Predictability of Funding

Support is consistent with the current planning cycle and GAVI HSS support is for four years which is longer than the planning cycle for many in country donors. In principle, approval of the following years tranche of GAVI HSS support should be approved following receipt of the APR in May and funding agreed at the September Health Summit. In practice, releases of GAVI tranches to the country level have been delayed which has led to a knock on effect in terms of lack of budget execution according to the original timetable and a delay in the completion of activities

## 3.4 Inclusive and Collaborative Processes

The GAVI HSS proposal was prepared by a multi-stakeholder working group made up of the Ministry of Health, Mandatory Health Insurance Fund, State Sanitary and Epidemiological System, Republican Centre for Immunoprophlaxis (RCI), and the Centre for Health System Development with technical support and advice provided by the WHO, UNICEF, and ZdravPlus funded by USAID. The proposal was discussed at the Intersectoral Coordinating Committee for Immunization (including at an extended meeting involving around 60 participants) and approved by the Health Policy Council. However, there was no formal

external review and there has been no input from civil society though component 5, does include activities aimed at increasing community involvement in health promotion supporting Village Health Committees and mainly focusing on rural health. Despite good intentions – implementation appears to have been slow. Although progress under GAVI HSS is reported to key stakeholders at the May Health Summit given the range of issues to be discussed the timetable does not allow for detailed discussion

## 3.5 Catalytic Effects of GAVI HSS Funding

One of the key pillars of reform under Manas Taalimi has been the move away from input based norms for resource allocation and the introduction of more appropriate financing mechanisms particularly the introduction of output and population-based purchasing mechanisms. All primary care providers are paid on an adjusted capitation basis and all hospitals are paid on a per-case basis. A key shortcoming of capitation is that whilst good at promoting equity and cost containment it does little to promote efficiency as it can encourage providers to *reduce* their efforts. MoH has, for some time, been interested in applying the concept of performance based funding. (The approach differs from cost per case in the payments are related to assessed performance against a range of criteria rather than just delivery of a particular service). Past investments in information technology and the interest (and indeed encouragement) from GAVI have created a platform for introducing a performance-based payment system. The approach is being piloted in Issyk-Kul and Chui districts. It will be introduced in Naryn and Talas in the second half of 2009 with MHIF funding and by 2010 all oblasts will receive support – two from GAVI HSS the rest from MHIF. From 2011 MHIF will assume responsibility for all oblasts. Details on how the approach will be implemented is discussed below.

The Kyrgyz Republic will also be the recipient of much larger funds from the World Bank-led Results based Financing Initiative. The experience under GAVI HSS could therefore represent a useful learning exercise which may help guide and improved the effectiveness of future investments in this area.

GAVI funds are proposed to be used as a catalyst to the process and then the government will contribute its own funds starting from the second year of implementation, increasing the share of domestic financing for this component annually and achieving full financing after 2011. The extent to which this happens will be a clear indication of Government commitment to the approach and its likely sustainability.

Although undoubtedly catalytic in nature results based financing/performance based initiatives are yet to be proven as an effective instrument. International experience suggests they may work reasonably well in areas where performance measurement is rather simple. However, there is major scope for rent seeking. With this in mind it is extremely important that the approach is rigorously evaluated. In this respect it is reassuring to note that there are plans for studies to assess progress including:

- a baseline survey to monitor the indicators selected for calculation of bonus payments in the rayons targeted for early implementation using GAVI funds and in 3-4 control rayons selected for later implementation;
- a follow up survey after one year of implementation to assess the effectiveness of the implementation progress and looking at changes in the indicators in phase-1 rayons relative to control rayons and providing recommendations for improving the design of the program.
- a final survey after the second year of implementation taking into account longer reform history and assessing the wider impact of the program on staff retention and quality of care.

The 2012 evaluation will need to consider whether such studies took place, whether they were rigorously designed, whether the results were credible and whether appropriate action was taken on the basis of them

## 3.6 Results-oriented Approach

As noted in the previous section the performance based incentive component attempts to emphasise the importance of financial incentives as a means of increasing productivity. The approach aims to increase income by around 10% (compared to the capitation payment) but only for those providers who meet performance indicators. These indicators focus heavily on performance in terms of immunisation and access to health care for the U5s but also for a wider range of services provided at PHC level. The full list of selected indicators is shown below:

- proportion of infants under 1 who received duly preventive vaccines according to National Immunization Calendar.
- percentage of children under 5 who are regularly observed by FGP doctor (FAP Feldsher).
- changed number of visits of FGP doctors by children under 5 years old as compared to the same period of the previous year.

- proportion of women registered for the reason of pregnancy on term under 12 years.
- proportion of pregnant women who received potassium iodide medicines.
- percentage of women hospitalized for delivery with Hb level below 100 h/l.
- proportion of patients with bronchial asthma, who received drugs on SBP.
- rate of hospitalizations of patients with bronchial asthma.
- proportion of registered patients with hypertension out of adult population enrolled to FGP.
- rate of hospitalizations of patients with chronic obstructive lung diseases.

The results will be closely monitored (box below). The extent to which the findings were rigorously evaluated and incorporated into the broader results based financing approach is some thing the 2012 evaluation should pursue.

In terms of the programme as a whole the GAVI guidelines suggest that continued performance is conditional upon IRC endorsement of the APR but there seems to be little understanding or agreement on the extent to which funding would be reduced or withheld in the event of a lack of progress

## 3.7 Sustainability

The GAVI HSS proposal contains a range of activities some of which have obvious ongoing recurrent implications. These include investment in equipment and buildings and the performance based initiative. Government has committed to gradually take over the costs of the incentives for PHC providers (see above) but there are currently no identified funding sources for the other items. This would have to be funded through other sources and would depend on Government ability to raise domestic resources for health or from donors. This in turn will depend on the Kyrgyz Republic's long term fiscal prospects which like all countries will have been affected by the global financial turmoil and its commitments to the social sectors. This issue was given a high profile at the recent summit as Government's allocation to health fell below the agreed share suggesting that some mechanisms are in place to hold Government to account for its commitments.

Some activities are one off in nature and have no recurrent expenditure implications. The programme is, for example supporting the training of PHC providers on immunisation and MCH. The key question here is whether the way the training is being implemented will lead to sustainable benefits. The Tracking Study reports concerns that the courses, as designed, are too short to achieve its objectives. Those delivering the training also complained about the lack of incentives. This does raise questions as to whether intended benefits resulting fro

changes in behaviour and provider practices will take place and be sustained It also raises the broader question as to whether performance based incentives should be restricted to service delivery staff or should be employed more widely to staff producing intermediate outputs such as trainers

In its favour there has been a detailed costing of the GAVI HSS activities which at least create some basis for estimating ongoing costs. The programme is also placed within the context of overall efforts to support HSS for implementation. From this, it can be seen that the GAVI contribution is quite small as an overall share of total HSS costs (just over 10%). Other programmes by the very nature of their size – the Global Fund, Results Based Financing Initiative - are likely to pose greater sustainability challenges. GAVI HSS funds have also been frontloaded – allowing Government some time to identify alternative funding sources.

It is worth noting that the MoH has only limited control over sustainability. However, past experience, and the fact that Government already covers almost 70% of programmes costs gives, some grounds for comfort. However, the introduction of the pentavelant vaccine in 2009 will add further sustainability challenges

# 4 Monitoring

**Key Findings**

- GAVI HSS monitoring indicators are increasingly being integrated into the Manas Taliimi monitoring framework
- GAVI HSS does impose additional reporting requirements which are met through a "PIU-lite" approach led by a GAVI funded Technical Coordinator and Financial and Disbursement Specialist
- The proposal identifies a number of specific studies to supplement the reliance on routine monitoring systems.
- The APR provides a detailed analysis of progress – both physical and financial – against agreed activities. However, the links between inputs, outputs and the outcomes in the proposal are not always clear

The Manas Taalimi monitoring instrument was first developed in 2005 and covered a range of indicators related to health outcomes, equity and access to health care, financial risk protection, efficiency, quality and responsiveness of the system. A set of priority – Dashboard Indicators – had been defined as a mean of assessing overall progress. The instrument was last changed in May 2009 as some indicators had already been achieved. GAVI HSS indicators are increasingly being incorporated into this instrument

Quarterly financial management reports (FMRs) on GAVI HSS grant execution in accordance with both functional/economic and program classifications are prepared by the Financial Management and Disbursement Specialist hired under the Grant. The Specialist is located in the MOH Finance Department where similar reporting activities are conducted in the context of the SWAp.

Annual activity reports are prepared by the MOH with the support of the GAVI funded Technical Coordinator and provided to GAVI within 60 days of the End calendar year. This progress report is then presented as part of the progress report of Manas Taalimi at the spring health summit. In effect, these reports replace the standard GAVI Annual Progress Report (APR) and are prepared *earlier* than might be the case without GAVI requirement but are not an *additional* requirement

Within the context of the SWAp, detailed audit arrangements, both external and internal, have been developed. According to these arrangements, the Internal Audit Unit of the MOH is responsible for auditing at least once a year health facilities and other organizations that

are under the MOH and MHIF. The annual external audit will be conducted by the Chamber of Accounts. These are described in detailed in the Financial Management Operational Manual. All audit reports are to be provided to Joint Financiers, including GAVI, not later than six months after the reporting period.

A total of 19 indicators were set out in the country application. They are set out in table 4 below – which also sets out progress against them. Some of these have been incorporated into the Manas Taalimi monitoring instrument which was revised in May 2009. Whilst the proposal does spell out the links between the objectives of the different components and the key Manas Taalimi objectives (as set out in Figure 2 above) the links between the GAVI HSS activities and expected outputs and outcomes are not always clear. In some cases there is a direct link between activities and expected outputs e.g. the establishment of supervisory teams and integrated supervisory visits taking place (though the quality of these visits is likely to be more important than the fact that they took place). In other cases the links are not clear. A detailed breakdown of progress in terms GAVI HSS funded activities is shown at **annex 2**

**Table 4: Progress and Impact Monitoring under GAVI HSS in Kyrgyzstan**

| | Indicator(s) | Target by 2010[2] | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|
| **HSS Inputs (year 1 and 2)** | # of vehicles purchased (and as % of planned) | 27 | Not in progress | Not in progress | 18 (67 %) | Completed |
| | # of planned cold chain equipment purchased (and as % of planned) | 10 | Not in progress | Not in progress | 30 (300 %) | Completed |
| | # of planned rayon level vaccine warehouses repaired (and as % of planned) | 16 | Not in progress | Not in progress | 36 (225 %) | Completed |
| **HSS Activities** | # of planned supervisory teams established and trained (and as % of planned) | 40 | Not in progress | Not in progress | Not in progress | In progress |

[2] Targets here refer to the Country Application to GAVI HSS, 2006

| | | | | | | |
|---|---|---|---|---|---|---|
| | # of trainers trained at the oblast and rayon level in immunization, IMCI, and other maternal and child health programs | 26 | Not in progress | Not in progress | 15 | In progress |
| | # of FAPs receiving training in "WHO Practice of Immunization" (and as % of planned) | 420 | Not in progress | Not in progress | 170 | In progress |
| | # of mobile teams established (and as % of planned) | 40 | Not in progress | Not in progress | Not in progress | In progress |
| | # of primary care providers receiving performance incentive (and as % of planned) | 85 | Not in progress | Not in progress | 8 | 35 |
| | # of NGO's working with urban migrants on health issues and which are in regular contact with the RHPC | 20 | Not in progress | Not in progress | 14 | 14 |
| **Outputs (Impact on the capacity of the system)** | % of rayons where at least 90% of facilities received integrated supportive supervision at least once during the year | 100 | Not in progress | Not in progress | Not in progress | Not in progress |
| | % of population points with no health facility that received 4 rounds of mobile services during the year | 100 | Not in progress | Not in progress | Not in progress | In progress |
| | % of measles and rubella cases that received lab confirmation | 90 | NA | NA | 100% | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| | % of rural FGP's with more than 2000 enrolled population (NB: Manas Taalimi dashboard indicator for staff retention) | 33 | - | | | |
| | % of government health spending allocated to primary health care | - | 25 | 25,6 | | |
| **Impact on immunization (year 3 and 4)** | BCG | 98,0 | 98,6 | 97,7 | 98,8 | NA |
| | DPT1 | 96,0 | 96,0 | 98,1 | 99,0 | NA |
| | DPT3 | 95,6 | 92,6 | 94,1 | 95,3 | NA |
| | MMR1 | 98,0 | 97,3 | 98,8 | 99,1 | NA |
| **Impact on child mortality (year 4)** | Under 5 child mortality | 0,8 annual decrease | 34,6 | 35,3 | 31,2 | NA |

Table 5 sets out expected progress against these indicators over time

**Table 5: Expected Progress in Indicators over Time**

| Indicator(s) | Indicators: baseline and targets | | | | | | |
|---|---|---|---|---|---|---|---|
| | Base-year | Year of GAVI application | Year 1 | Year 2 | Year 3 | Year 4 | |
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | |
| **HSS Inputs** | | | | | | | |
| # of planned vehicles purchased | 0 | 0 | 27 | 0 | 0 | 0 | |
| # of planned cold chain equipment purchased | 0 | 0 | 10 | 0 | 0 | 0 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| # of planned rayon level vaccine warehouses repaired | 0 | 0 | 8 | 8 | 0 | 0 | |
| **HSS Activities (3 main)** | | | | | | | |
| # of planned supervisory teams established and trained | 0 | 0 | 10 | 30 | 40 | 40 | |
| # of trainers trained at the oblast and rayon level in immunization, IMCI, and other maternal and child health programs | 0 | 0 | 26 | 26 | 0 | 0 | |
| # of FAPs receiving training in “WHO Practice of Immunization” (and as % of planned) | 0 | 0 | 210 | 0 | 210 | 0 | |
| # of mobile teams established | 0 | 0 | 10 | 20 | 40 | 40 | |
| # of primary care providers (Family Group Practice) receiving performance incentive | 0 | 0 | 0 | 15 | 45 | 85 | |
| # of NGO’s working with migrants on health issues and are in regular contact with the RCI | 0 | 0 | 10 | 15 | 20 | 20 | |
| **Outputs (Impact on capacity of the system)** | | | | | | | |
| % of rayons where at least 90% of facilities received integrated supportive supervision at least once during the year | 0% | 0% | 25% | 75% | 100% | 100% | |
| % of population points with no health facility that received 4 rounds of mobile services during the year | 0% | 0% | 20% | 50% | 80% | 100% | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| % of measles and rubella cases that received lab confirmation | 50% | 50% | 80% | 80% | 85% | 90% | |
| % of rural FGP's with more than 2000 enrolled population (NB: Manas taalimi dashboard indicator for staff retention) | 57% | 73% | 73% | 60% | 45% | 33% | |
| % of government health spending allocated to primary health care | 28% | n/a | 29% | 30% | 31% | 32.7% | |
| **Impact on Immunization** | | | | | | | |
| BCG | 92.0% | | | | 97.0% | 98.0% | |
| DPT1 | 90.5% | | | | 95.8% | 96.0% | |
| DPT3 | 90.3% | | | | 95.5% | 95.6% | |
| MMR1 | 90.8% | | | | 97.0% | 98.0% | |
| **Impact on Child Mortality** | | | | | | | |
| Under 5 Mortality (official data) | 29.7 | | | | | 28.0 | |

A number of studies are planned to contribute to understanding the impact of GAVI HSS support:

1. **Monitoring and evaluation studies:** (1) a baseline survey to monitor the indicators selected for calculation of bonus payments in the rayons targeted for early implementation using GAVI funds and in 3-4 control rayons selected for later implementation; (2) follow up survey should be conducted after one year of implementation assessing the effectiveness of the implementation progress and looking at changes in the indicators in phase-1 rayons relative to control rayons and providing recommendations for improving the design of the program. (3) the last survey are proposed to be conducted after second year of implementation taking into account longer reform history and assessing the wider impact of the program on staff retention and quality of care.
2. **Economic evaluation of immunization:** although it is widely known that immunization is one of the most cost-effective health interventions, the use of international data has little effect on Kyrgyz policy makers (outside the health sector

in the wider government and in parliament). During 2007, an economic evaluation of selected immunization activities are proposed to be conducted using a combination of national and international data. The objective is to demonstrate the degree to which mortality and morbidity are averted in Kyrgyzstan by investing in immunization and its cost implications.

3. **Study of primary care use and immunization coverage among urban migrants, 2007-2009:** a study is proposed to be conducted among urban migrants to better understand under-coverage and under-use of health care services. The study is built on an existing qualitative study looking at population perceptions among migrants of health problems and access to services including the quantitative estimates of service utilization and immunization coverage.

**Overview of results/ assessment of progress**

Progress to date has been hampered by a number of factors:

- late receipt of GAVI funds
- slow procurement – as SWAp financiers rely on World Bank procurement rules
- a failure to fully account for all costs – social security costs were not included in the budget for performance incentives
- inflation combined with delays has meant some of the activities have had to e scaled back
- spending has been low as much of the effort to date has involved preparatory work – especially for the performance based incentive initiative – which has involved little expenditure

The Tracking Study reported that there were no mechanisms in place to allow deviations from the original plan and it was not clear to implementers whether they need to consult with GAVI before making changes. Experience in other countries suggests that flexibility is there and countries such as Cambodia has gone ahead and made quite substantial changes to their approach. It would appear therefore that the Kyrgyz Republic has not taken advantage of the flexibility offered by the GAVI HSS window suggesting that although flexibility is there the fact it is there need to be fully communicated and that flexibility is not automatic and highly dependant on how it is interpreted at the country level.. It is not clear what role the Technical Coordinator had in this discussion. The result of this is that the Ministry ordered less vehicles but more fridges that it would otherwise have chosen to

**Progress against conceptual framework**

Actual spending is shown in **table 6**. Although funds have flown when in country the late receipt of tranches (funds were received in September 2007, June 2008 and March 2009) delays have occured As a result activities expcted to take place in 2007 were conducted from October 2007 to April 2008

**Table 6: GAVI HSS financing flows**

| | YEAR | | | |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 |
| Amount of funds approved | $ 424 000 | $ 255 500 | $ 255 500 | $ 220 000 |
| Date the funds arrived | September 2007 | June 2008 | March 2009 | |
| Amount spent | $ 308 710 | $ 28 000 | - | |
| Balance | $ 113 290 | $ 221 700 | $ 255 500 | |
| Amount requested | $ 424 000 | $ 255 500 | $ 255 500 | $ 220 000 |

Amount spent in 2007-2008: $ 336 710

Remaining balance from total: $ 342 790

# Annex 1: Summary of Methodology

In February 2009, HLSP Ltd was awarded the contract to undertake the 2009 GAVI Health Systems Strengthening Support (HSSS) Evaluation.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants will spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009 will be undertaken. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and to gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit, we anticipate any outstanding stakeholder interviews being conducted, and the data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and appropriateness of conducting an end-of-mission 'validation workshop' to provide countries with feedback on the in-depth case studies, and seek validation/confirmation of their findings and conclusions

Specific issues to be addressed as part of the country case studies include the following:

## Priority Questions for the Evaluation

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)?
- If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed?
- Do they measure the right things?
- Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?

- What do we know about outputs and outcomes?
- How realistic is it to try and attribute improved outputs and outcomes to GAVI support?
- What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?

Qualitative and quantitative information will be collected and analyzed, both retrospectively as well as prospectively. Typically the period covered will be from the time the GAVI HSS application process commenced in country, then through the implementation process and it will also cover the monitoring and evaluation of the project to date.

In addition, the five in-depth case studies will be **complemented by the addition of on-going GAVI HSS Tracking Studies** currently being conducted by the JSI-InDevelop-IPM research group in a further six countries. Additional data collection will be undertaken by the HSSS Evaluation to bring these studies to the same point as the five in-depth case studies. Finally, the HSSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions outlined above.

# Annex 2: HSS Activities – APR 2008

| HSS Activities in reporting year (activities and resources HSS for 2007) | | | | | |
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| **Planned Activity for reporting year** | **Report on progress[3] (% achievement)** | **Available GAVI HSS resources for the reporting year (2008)** | **Expenditure of GAVI HSS in reporting year (2008)** | **Carried forward (balance) into 2009)** | **Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements** |
| **1. Strengthening political commitment to immunization and its financial sustainability** | | | | | |
| A. Conduct advocacy activities for evidence-based policies targeted at policy makers in the health system and related sectors | | | | | |
| A1.Annual analysis of impact of Immunization programs on Health status | 100 % | $ 100 | $ 100 | - | According to the results of 2007 all kinds of preventive inoculation were made than 94%. Owing to high coverage level of children´s preventive inoculation the number of infectious diseases is on the low level. The cases of diphtheria, tetanus and poliomyelitis are not registered in 2007. The sickness rate is on the low level of such diseases as: whooping cough (71 cases), measles (40 cases) and rubella (3 cases). |
| A2. Public awareness campaigns about the impact of Immunization programs on health status | 100 % | $ 4 110 | $ 4110 | - | From April 21 to April 27 2008 the European Immunization week was conducted. The main purpose is to attract attention of population to the issues of immunization and to increase political commitment of heads who define public health policy. |

[3] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

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| | | | | | In April 22, 2008 round-table discussion together with Republic Centre of Immunoprophylaxis was conducted on the national level with the participation of heads of the public health service organizations.<br>During the European Immunization week round-table discussions on the urban and oblast level were conducted where the heads of the public health service organizations took part. |
| A4. Broadening of ICC membership to involve all stakeholders | 100 % | - | - | - | The staff of Inter-Agency Coordinating Committee for Immunization (ICC) is expanded. The specialists Ministry of Health and Public Health Organizations are included into ICC staff. |
| A7.Dissemination of results of analytical work conducted in the framework of the GAVI HSS activities and within other immunization and public health programs | 100 % | $ 500 | $ 500 | - | A competition on dissemination of Immunoprophylaxis issues was conducted from April 1 to May 1, 2008. The purpose of competition is to improve knowledge level of population of the Kyrgyz Republic concerning vaccine prevention issues. |
| **2. Improving the physical infrastructure and working conditions of primary care and public health services** | | | | | |
| A. Improve the physical infrastructure of primary care and public health services with a focus on improving the cold chain and enhancing mobility of public health services | | | | | |
| A2. Purchase of vehicles for vaccines transportation and supervisory visits | 67% | $ 189 000 | $ 189 000 | - | 18 vehicles (VAZ 21214) for vaccines transportation and supervisory visits purchased and distributed to health care organizations. 27 |

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| | | | | | vehicles were foreseen to purchase in the application but in the connection of price increase 18 vehicles were purchased. |
| A3.Purchase of refrigerators for vaccine warehouses | 100% | $ 12 000 | $ 12 000 | - | 30 refrigerators NORD DX 245-010 brand for vaccine warehouses were purchased in February 2008. Refrigerators were distributed according to equipment inventory data taking into account the number of target groups, refrigerators volume which are in vaccine warehouses and available deficiency. |
| Repair of Stores for Vaccines | 100% | $ 16 000 | $ 16 000 | - | Repair-building work of Central Vaccine Store of the Republican Center for Immunoprophylaxis and current repairs of 35 regional vaccine warehouses was conducted. A great amount of rayon vaccine stores are required to be conducted a current repair. |
| A4. Development and adoption of a software for monitoring refrigerators and other equipment in the cold chain | 90 % | $ 12 000 | $ 12 000 | $ 11 020 | The software on cold equipment accounting is being developed. The development will be finished in June 2009. The implementation of software is planned after finishing its development. |
| A5. Maintenance of cold chain equipment | 30 % | $ 2 100 | $ 400 | $ 1 700 | The repair brigade of cold chain equipment of immunization service was organized. Regulations, functional duties and repair brigade departure schedule were |

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| | | | | | developed. Maintenance crew departures and cold equipment revision were conducted in Health care organization in 2 oblasts. |
| **3. Ensuring access to high quality primary care through capacity building, improved management & introduction of economic incentives** | | | | | |
| A. Build capacity of health workers in primary care, particularly FAP's, to achieve & maintain high immunization coverage | | | | | |
| A1. Training of FAPs, FGPs and ambulance staff on specific issues in MCH, immunoprophylaxis in addition to general training envisioned under the HR component of Manas Taalimi | 100 % | $ 11 750 | $ 11 750 | - | 15 trainer-medical assistants were trained on motherhood and childhood health issues, the basis of urgent help and immunoprophylaxis was conducted. 145 medical assistants of FAP were trained by trainer-medical assistants in regions. |
| A2. Training for FAP personnel - Immunization in practice (WHO curriculum) | 85 % | $ 29 820 | $ 27 820 | $ 2 000 | Training for FAP personnel – Immunization in practice was conducted in 6 oblasts for FMC immunologist, medical assistants and vaccination nurses. 170 people were trained. |
| B. Provide technical guidance and material support to primary health care facilities to increase efficiency and quality of activities on immunoprophylaxis and child health | | | | | |
| B1. Development of Manual on supervisory visits and comprehensive monitoring (immunologist, FMC specialist) to improve the quality of immunoprophylaxis | 100 % | $ 3 300 | $ 3 300 | - | The manuals on immunoprophylaxis for curatorial visits of medical organizations, the manuals on immunoprophylaxis at schools, the questionnaire on conducting curatorial visits of inoculation points (order of Ministry of Health from 19.12.2008 № 664) were developed and approved. In March 2009 manual test was |

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| | | | | | conducted in 4 rayons. |
| B2.Training of supervisors (immunologist, FMC specialist) and experts of MHIF TD to conduct comprehensive supervisory visits | 0 % | $ 6 700 | - | $ 6 700 | Curator and expert training (specialists of Territorial Department of Mandatory Health Insurance Fund, Center of State Sanitary Epidemiological Surveillance, Family Medicine Center) on conducting curatorial departures, complex monitoring of activities quality on immunoprophylaxis is planned for June 2009. |
| B3. Joint comprehensive supervisory visits (immunologist, FMC specialist) to monitor quality of activities on immunoprophylaxis and programs on MCH | 0 % | $ 13 460 | - | $ 13 460 | To conduction of compatible complex curatorial departures will be after curators and experts training. |
| B4. Support to the work of mobile immunization teams in remote villages | 15 % | $ 29 400 | - | $ 29 400 | The mechanism of mobile immunization teams in remote villages is being developed. |
| C. Improve surveillance efficiency of infectious diseases at the level of primary care and public health services | | | | | |
| C3. Training PHC staff on integrated surveillance of infectious diseases | 0 % | $ 6 000 | - | $ 6 000 | General regulation systems of surveillance efficiency of infectious and parasites diseases were reconsidered and improved in November 2008 (order of Ministry of Health from 26.11.2008 № 610).<br>It is planned to conduct zone seminars for epidemiologists, immunologists, infectiologists and other PHC specialists and integrated surveillance of infectious diseases in |

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| | | | | | 2009. |
| C4. Epidemiological investigations of detected cases of infectious diseases | 100 % | $ 6 000 | $ 6 000 | - | 224 sick people under suspicion on measles and rubella were revealed and laboratory examined for 2007. Out of them 40 cases with the measles diagnosis and 3 cases with rubella were confirmed.<br>Also during 2007, 37 cases sharp flaccid paralyses were revealed and laboratory examined. The poliomyelitis virus wasn't found. |
| D. Develop mechanism and indicators for performance based pay for primary care providers working in districts with high U5MR, MMR and related social risks. | | | | | |
| D1.Establishment of a technical working group to develop: (i) the exact financial and institutional mechanisms for performance-based payments and (ii) a system of indicators that will serve the basis of calculating performance payments. | 100 % | $ 2 540 | $ 500 | $ 2 040 | A technical working group to develop mechanism for performance based payments for primary care providers was established.<br>The method of stimulate mechanism and indicators for performance based payments for primary care providers is developed and approved. |
| D2. Presentation and discussion of the developed mechanisms for performance based pay to primary care providers at a multi-stakeholder Round Table Discussion | 0 % | $ 6 250 | | $ 6 250 | The discussion of stimulate methods for performance based payments for primary care providers will be conducted after monitoring the results of mechanism introduction of payment for primary care providers. |
| **4. Strengthening routine monitoring of immunization activities & coverage at the level of primary care and public health** | | | | | |
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| A. Improve quality of data collected through the existing health information system and integrate this with the immunization program information system | | | | | |
| A1. Development of the vaccine status register with individual immunization calendar | 90 % | $ 6 700 | | $ 6 700 | The software on vaccine status register with individual immunization calendar is being developed. The development will be finished in June 2009. The implementation of software is planned after finishing its development. |
| A2. Development and installation of a software for registering immunization status of individuals and providing information about vaccine sensitive diseases | 0 % | $ 7 000 | | $ 7 000 | It is supposed to change registration-accounting documentation on immunization due to applying new vaccine (in April 2009) and changing into qualitative working indicators.<br>Development and installation of software for registering immunization is being planned to work out after approval of new registration-accounting forms. |
| A4. Automatization of collection and processing of information on immunization through PHC facilities using the standard clinical informational forms | 90 % | $ 14 500 | $ 2 280 | $ 12 220 | The software on automatization of collection and processing of information on immunization through PHC facilities using the standard clinical informational forms is being developed.<br>The development will be finished in June 2009. The implementation of software is planned after finishing its development. |
| A6. Monitoring of timeliness and | 0 % | $ 10 800 | - | $ 10 800 | The technical support in training national |

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| quality of immunoprophylaxis within the framework of the National Vaccination Calendar | | | | | specialists on methods of conducting cluster coverage research of inoculations and qualitative researches of lot method is necessary. After getting technical support it is planned to conduct modern researches and qualitative immunization. |
| **5. Social mobilization and active involvement of the population in health promotion activities** | | | | | |
| A. Enhance the effectiveness of NGO's and civil society organizations working in the area of public health, particularly on issues related to immunization, nutrition and mother and child health | | | | | |
| A2. Development of technical guidelines and informational material to train civil society organizations on issues related to public health particularly among urban migrants and in remote areas | 100 % | $ 1 000 | $ 1 000 | - | Informational materials on immunoprophylaxis issues for NGO and Public Training Issues were developed. |
| A3.Creation of incentives for NGOs and public associations to conduct health promotion activities among urban migrants and in remote regions | 100 % | $ 16 800 | $ 16 800 | - | Grants for 14 Civil Society Organizations (Rayon Health Committee) were given to conduct the activities on health strengthening of population in the regions, which include such activities as issues on immunoprophylaxis, improvement of nutrition in schools, prophylaxis on infection diseases, and popularization of healthy life style. |
| B. Improvement of communication and relationship between health system workers and population | | | | | |
| B2. Implementation of activities under the framework of European initiative | 100 % | $ 500 | $ 500 | - | Informational materials (posters) were printed out for implementation of activities under the framework of European |

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| "Immunization Week" | | | | | initiative “Immunization week” from April 21 to 27, 2008 |
| **Support Functions** | | | | | |
| Management<br>M&E<br>Technical Support | | $ 14 370 | $ 14 370 | - | |
| **Total** | | **$ 424 000** | **$ 308 710** | **$115 290** | |

| HSS Activities in reporting year (activities and resources HSS for 2008) | | | | | |
|---|---|---|---|---|---|
| **Planned Activity for reporting year** | **Report on progress[4] (% achievement)** | **Available GAVI HSS resources for the reporting year (2008)** | **Expenditure of GAVI HSS in reporting year (2008)** | **Carried forward (balance) into 2009)** | **Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements** |
| **1. Strengthening political commitment to immunization and its financial sustainability** | | | | | |
| A. Conduct advocacy activities for evidence-based policies targeted at policy makers in the health system and related sectors | | | | | |
| A1.Annual analysis of impact of Immunization programs on Health status | 100 % | $ 100 | $ 100 | - | According to the results of 2008 all kinds of preventive inoculation were made than 94%. Owing to high coverage level of children´s preventive inoculation the number of infectious diseases is on the low level. The cases of diphtheria, tetanus and poliomyelitis are not registered in 2008. The sickness rate is on the low level of such diseases as: whooping cough (45 cases), measles (16 cases) and rubella (6 cases), viral hepatitis B among children under 1 (4 cases). |
| A2. Public awareness campaigns about the impact of Immunization programs on health status | 100 % | $ 4 200 | $ 4 200 | - | From April 20 to April 26 2008 the European Immunization week was conducted. In April 20, 2008 round-table discussion together with Republic Centre of Immunoprophylaxis was conducted on the national level with the participation of heads of the public health service organizations. |

[4] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

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| | | | | | During the European Immunization week round-table discussions on the urban and oblast level were conducted where the heads of the public health service organizations took part. |
| A5. Survey on economic efficiency of immunization programs | 0 % | $ 15 000 | - | $ 15 000 | The group was created and research program on immunoprophylaxis efficiency was prepared.<br>The research on immunoprophylaxis efficiency will be conducted in 2009. |
| A7.Dissemination of results of analytical work conducted in the framework of the GAVI HSS activities and within other immunization and public health programs | 0 % | $ 500 | - | $ 500 | |
| **2. Improving the physical infrastructure and working conditions of primary care and public health services** | | | | | |
| A. Improve the physical infrastructure of primary care and public health services with a focus on improving the cold chain and enhancing mobility of public health services | | | | | |
| A4. Development and adoption of a software for monitoring refrigerators and other equipment in the cold chain | 0 % | $ 1 300 | - | $ 1 300 | The software on cold equipment accounting is being developed. The development will be finished in June 2009. The implementation of software is planned after finishing its development. |
| A5. Maintenance of cold chain equipment | 0 % | $ 2 100 | - | $ 2 100 | |
| **3. Ensuring access to high quality primary care through capacity building, improved management & introduction of economic incentives** | | | | | |

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| A. Build capacity of health workers in primary care, particularly FAP's, to achieve & maintain high immunization coverage | | | | | |
| A1. Training of FAPs, FGPs and ambulance staff on specific issues in MCH, immunoprophylaxis in addition to general training envisioned under the HR component of Manas Taalimi | 10 % | $ 11 800 | $ 1 800 | $ 10 000 | Medical assistant of FAPs training handout is developed and printed out. The training will be conducted in the 3rd quarter in 2009. |
| B. Provide technical guidance and material support to primary health care facilities to increase efficiency and quality of activities on immunoprophylaxis and child health | | | | | |
| B3. Joint comprehensive supervisory visits (immunologist, FMC specialist) to monitor quality of activities on immunoprophylaxis and programs on MCH | 0 % | $ 13 500 | - | $ 13 500 | To conduction of compatible complex curatorial departures will be after curators and experts training. |
| B4. Support to the work of mobile immunization teams in remote villages | 0 % | $ 29 500 | - | $ 29 500 | The mechanism of mobile immunization teams in remote villages is being developed. |
| C. Improve surveillance efficiency of infectious diseases at the level of primary care and public health services | | | | | |
| C3. Training PHC staff on integrated surveillance of infectious diseases | 0 % | $ 6 000 | - | $ 6 000 | General regulation systems of surveillance efficiency of infectious and parasites diseases were reconsidered and improved in November 2008 (order of Ministry of Health from 26.11.2008 № 610).<br>It is planned to conduct zone seminars for epidemiologists, immunologists, infectiologists and other PHC specialists and integrated surveillance of infectious diseases in |

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| | | | | | 2009. |
| C4. Epidemiological investigations of detected cases of infectious diseases | 100 % | $ 6 000 | $ 2 000 | $ 4 000 | 254 sick people under suspicion on measles and rubella were revealed and laboratory examined for 2008. Out of them 16 cases with the measles diagnosis and 6 cases with rubella were confirmed.<br>Also during 2008, 34 cases sharp flaccid paralyses were revealed and laboratory examined. The poliomyelitis virus wasn't found. |
| D. Develop mechanism and indicators for performance based pay for primary care providers working in districts with high U5MR, MMR and related social risks. | | | | | |
| D3. Phase 1 of implementation of the performance based pay in pilot regions with high MMR and U5MR | 15 % | $ 114 600 | $ 15 600 | $ 99 000 | 23 seminar-meetings on introduction of payment for primary care providers were conducted in the pilot oblasts.<br>Since 3rd quarter 2008 economical stimulation have been introduced for 8 primary care providers (Issyk-Kul oblast – 5, Chui oblast – 3). |
| D4. Analysis of the effectiveness of performance payment in Phase 1 regions | 0 % | $ 3 200 | - | $ 3 200 | Analysis of the effectiveness of performance payment in Phase 1 regions will be conducted in the 3rd quarter in 2009. |
| **4. Strengthening routine monitoring of immunization activities & coverage at the level of primary care and public health** | | | | | |
| A. Improve quality of data collected through the existing health information system and integrate this with the immunization program information system | | | | | |
| A2. Development and installation of a software for registering immunization status of individuals and | 0 % | $ 11 200 | - | $ 11 200 | It is supposed to change registration-accounting documentation on immunization due to applying new vaccine (in April 2009) and |

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| providing information about vaccine sensitive diseases | | | | | changing into qualitative working indicators.<br>Development and installation of software for registering immunization is being planned to work out after approval of new registration-accounting forms. |
| A6. Monitoring of timeliness and quality of immunoprophylaxis within the framework of the National Vaccination Calendar | 0 % | $ 9 000 | - | $ 9 000 | The technical support in training national specialists on methods of conducting cluster coverage research of inoculations and qualitative researches of lot method is necessary. After getting technical support it is planned to conduct modern researches and qualitative immunization. |
| **5. Social mobilization and active involvement of the population in health promotion activities** | | | | | |
| A. Enhance the effectiveness of NGO's and civil society organizations working in the area of public health, particularly on issues related to immunization, nutrition and mother and child health | | | | | |
| A2. Development of technical guidelines and informational material to train civil society organizations on issues related to public health particularly among urban migrants and in remote areas | 100 % | $ 1 000 | $ 1 000 | - | Informational materials on immunoprophylaxis issues for NGO and Public Training Issues were developed. |
| A3.Creation of incentives for NGOs and public associations to conduct health promotion activities among urban migrants and in remote regions | 0 % | $ 16 800 | - | $ 16 800 | In June 2009 submitted application forms from public associations will be considered. According to the results of application forms the grants will be allocated. |

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| B. Improvement of communication and relationship between health system workers and population | | | | | |
| B2. Implementation of activities under the framework of European initiative "Immunization Week" | 100 % | $ 500 | $ 500 | - | In 2009 during of European Immunization Week from April 20 to 26 advertisement-informational materials on immunoprophylaxis issues were arranged on the National Television. |
| **Support Functions** | | | | | |
| Management<br>M&E<br>Technical Support | | $ 9 200 | $ 2 800 | $ 6 400 | |
| **Total** | | **$ 255 500** | **$ 28 000** | **$227 500** | |

| **Planned HSS Activities for current year (ie. January – December 2009)** | | | | |
|---|---|---|---|---|
| **Planned Activity for current year (ie.2009)** | **Planned expenditure in coming year** | **Balance available (To be automatically filled in from previous table)** | **Request for 2009** | **Explanation of differences in activities and expenditures from original application or previously approved adjustments**** |
| **1. Strengthening political commitment to immunization and its financial sustainability** | | | | |
| A. Conduct advocacy activities for evidence-based policies targeted at policy makers in the health system and related sectors | | | | |
| A1.Annual analysis of impact of Immunization programs on Health status | $ 100 | - | $ 100 | |
| A2. Public awareness campaigns about the impact of Immunization programs on health status | $ 4 200 | - | $ 4 110 | |
| A5. Survey on economic efficiency of immunization programs | $ 15 000 | $ 15 000 | - | The group was created and research program on immunoprophylaxis efficiency was prepared. |

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| | | | | The research on immunoprophylaxis efficiency will be conducted in 2009. |
| A7.Dissemination of results of analytical work conducted in the framework of the GAVI HSS activities and within other immunization and public health programs | $ 8 500 | $ 500 | $ 8 000 | |
| **2. Improving the physical infrastructure and working conditions of primary care and public health services** | | | | |
| A. Improve the physical infrastructure of primary care and public health services with a focus on improving the cold chain and enhancing mobility of public health services | | | | |
| A4. Development and adoption of a software for monitoring refrigerators and other equipment in the cold chain | $ 12 320 | $ 12 320 | - | The software on cold equipment accounting is being developed. The development will be finished in June 2009. The implementation of software is planned after finishing its development. |
| A5. Maintenance of cold chain equipment | $ 5 900 | $ 3 800 | $ 2 100 | |
| **3. Ensuring access to high quality primary care through capacity building, improved management & introduction of economic incentives** | | | | |
| A. Build capacity of health workers in primary care, particularly FAP's, to achieve & maintain high immunization coverage | | | | |
| A1. Training of FAPs, FGPs and ambulance staff on specific issues in MCH, immunoprophylaxis in addition to general training envisioned under the HR component of Manas Taalimi | $ 10 000 | $ 10 000 | - | Medical assistant of FAPs training handout is developed and printed out. The training will be conducted in the 3rd quarter in 2009. |
| A2. Training for FAP personnel - Immunization in practice (WHO curriculum) | $ 31 800 | $ 2 000 | $ 29 800 | |
| B. Provide technical guidance and material support to primary health care facilities to increase efficiency and quality of activities on immunoprophylaxis and child health | | | | |
| B2.Training of supervisors (immunologist, FMC specialist) | $ 6 700 | $ 6 700 | - | |

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| and experts of MHIF TD to conduct comprehensive supervisory visits | | | | |
| B3. Joint comprehensive supervisory visits (immunologist, FMC specialist) to monitor quality of activities on immunoprophylaxis and programs on MCH | $ 40 400 | $ 26 960 | $ 13 440 | |
| B4. Support to the work of mobile immunization teams in remote villages | $ 88 300 | $ 58 900 | $ 29 400 | |
| C. Improve surveillance efficiency of infectious diseases at the level of primary care and public health services | | | | |
| C3. Training PHC staff on integrated surveillance of infectious diseases | $ 18 000 | $ 12 000 | $ 6 000 | |
| C4. Epidemiological investigations of detected cases of infectious diseases | $ 10 000 | $ 4 000 | $ 6 000 | |
| D. Develop mechanism and indicators for performance based pay for primary care providers working in districts with high U5MR, MMR and related social risks. | | | | |
| D1.Establishment of a technical working group to develop: (i) the exact financial and institutional mechanisms for performance-based payments and (ii) a system of indicators that will serve the basis of calculating performance payments. | $ 2 040 | $ 2 040 | - | |
| D2. Presentation and discussion of the developed mechanisms for performance based pay to primary care providers at a multi-stakeholder Round Table Discussion | $ 6 250 | $ 6 250 | - | |
| D3. Phase 1 of implementation of the performance based pay in pilot regions with high MMR and U5MR | $ 208 500 | $ 99 000 | $ 109 500 | In 2009 economical stimulation have been introduced for 19 primary care providers of Issyk-Kul oblast and 16of Chui oblast. |
| D4. Analysis of the effectiveness of performance payment in Phase 1 regions | $ 6 990 | $ 3 200 | $ 3 790 | |
| D5. Implementation of Phase 2 of performance based pay | $ 6 790 | | $ 6 790 | |

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| **4. Strengthening routine monitoring of immunization activities & coverage at the level of primary care and public health** | | | | |
| A. Improve quality of data collected through the existing health information system and integrate this with the immunization program information system | | | | |
| A1. Development of the vaccine status register with individual immunization calendar | $ 6 700 | $ 6 700 | - | |
| A2. Development and installation of a software for registering immunization status of individuals and providing information about vaccine sensitive diseases | $ 18 200 | $ 18 200 | - | |
| A4. Automatization of collection and processing of information on immunization through PHC facilities using the standard clinical informational forms | $ 12 220 | $ 12 220 | - | |
| A6. Monitoring of timeliness and quality of immunoprophylaxis within the framework of the National Vaccination Calendar | $ 28 790 | $ 19 800 | $ 8 990 | |
| **5. Social mobilization and active involvement of the population in health promotion activities** | | | | |
| A. Enhance the effectiveness of NGO's and civil society organizations working in the area of public health, particularly on issues related to immunization, nutrition and mother and child health | | | | |
| A2. Development of technical guidelines and informational material to train civil society organizations on issues related to public health particularly among urban migrants and in remote areas | $ 1 000 | - | $ 1 000 | |
| A3.Creation of incentives for NGOs and public associations to conduct health promotion activities among urban migrants and in remote regions | $ 33 600 | $ 16 800 | $ 16 800 | |
| B. Improvement of communication and relationship between health system workers and population | | | | |
| B2. Implementation of activities under the framework of European initiative "Immunization Week" | $ 500 | - | $ 500 | |
| **Support costs** | $ 15 580 | $ 6 400 | $ 9 180 | |

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| M&E support costs<br>Technical support<br>Management costs | | | | | |
| **TOTAL COSTS** | | **$598 290** | **$ 342 790** | **$ 255 500** | |

| Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments | | | | |
|---|---|---|---|---|
| **Planned Activity for current year (ie.2010)** | **Planned expenditure in coming year** | **Balance available (To be automatically filled in from previous table)** | **Request for 2009** | **Explanation of differences in activities and expenditures from original application or previously approved adjustments**** |
| **1. Strengthening political commitment to immunization and its financial sustainability** | | | | |
| A. Conduct advocacy activities for evidence-based policies targeted at policy makers in the health system and related sectors | | | | |
| A1.Annual analysis of impact of Immunization programs on Health status | $ 100 | | $ 100 | |
| A2. Public awareness campaigns about the impact of Immunization programs on health status | $ 4 200 | | $ 4 200 | |
| A7.Dissemination of results of analytical work conducted in the framework of the GAVI HSS activities and within other immunization and public health programs | $ 500 | | $ 500 | |
| **2. Improving the physical infrastructure and working conditions of primary care and public health services** | | | | |
| A. Improve the physical infrastructure of primary care and public health services with a focus on improving the cold chain and enhancing mobility of public health services | | | | |
| A5. Maintenance of cold chain equipment | $ 2 100 | | $ 2 100 | |
| **3. Ensuring access to high quality primary care through capacity building, improved management & introduction of economic incentives** | | | | |
| B. Provide technical guidance and material support to primary health care facilities to increase efficiency and quality of activities on immunoprophylaxis and child health | | | | |
| B3. Joint comprehensive supervisory visits (immunologist, FMC specialist) to monitor quality of activities on immunoprophylaxis and programs on MCH | $ 13 500 | | $ 13 500 | |

| | | | | |
|---|---|---|---|---|
| B4. Support to the work of mobile immunization teams in remote villages | $ 29 500 | | $ 29 500 | |
| C. Improve surveillance efficiency of infectious diseases at the level of primary care and public health services | | | | |
| C3. Training PHC staff on integrated surveillance of infectious diseases | $ 18 000 | $ 12 000 | $ 6 000 | |
| C4. Epidemiological investigations of detected cases of infectious diseases | $ 10 000 | $ 4 000 | $ 6 000 | |
| D. Develop mechanism and indicators for performance based pay for primary care providers working in districts with high U5MR, MMR and related social risks. | | | | |
| D3. Phase 1 of implementation of the performance based pay in pilot regions with high MMR and U5MR | $ 109 500 | | $ 109 500 | |
| D5. Implementation of Phase 2 of performance based pay | $ 12 000 | | $ 12 000 | |
| **4. Strengthening routine monitoring of immunization activities & coverage at the level of primary care and public health** | | | | |
| A. Improve quality of data collected through the existing health information system and integrate this with the immunization program information system | | | | |
| A6. Monitoring of timeliness and quality of immunoprophylaxis within the framework of the National Vaccination Calendar | $ 9 000 | | $ 9 000 | |
| **5. Social mobilization and active involvement of the population in health promotion activities** | | | | |
| A. Enhance the effectiveness of NGO's and civil society organizations working in the area of public health, particularly on issues related to immunization, nutrition and mother and child health | | | | |
| A2. Development of technical guidelines and informational material to train civil society organizations on issues related to public health particularly among urban migrants and in remote areas | $ 1 000 | - | $ 1 000 | |
| A3.Creation of incentives for NGOs and public associations to conduct health promotion activities among urban migrants and in remote regions | $ 16 800 | | $ 16 900 | |

| | | | | | |
|---|---|---|---|---|---|
| B. Improvement of communication and relationship between health system workers and population | | | | | |
| B2. Implementation of activities under the framework of European initiative "Immunization Week" | | $ 500 | | $ 500 | |
| **Support costs** | | $ 9 200 | | $ 9 200 | |
| M&E support costs<br>Technical support<br>Management costs | | | | | |
| **TOTAL COSTS** | | | | **$220 000** | |

## Annex 3: Baseline and annual targets

| Number | Baseline and targets | | | | | |
|---|---|---|---|---|---|---|
| | Base-year | Year of GAVI application and Year 1 of Program | Year 2 of Program | Year 3 of Program | Year 4 of Program | Year 5 of Program |
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| Births | 109.939 | 111.000 | 112.500 | 114.000 | 115.500 | 117.000 |
| Infants' deaths | 3.258 | 3.000 | 3.000 | 3.000 | 3.000 | 3.000 |
| Surviving infants | 106.581 | 108.000 | 109.500 | 111.000 | 112.500 | 114.000 |
| Pregnant women | 113.237 | 114.330 | 115.976 | 117.420 | 118.965 | 120.510 |
| Infants vaccinated with BCG | 101.120 | 104.340 | 106.875 | 109.440 | 111.475 | 113.490 |
| BCG coverage* | 92.0 | 94.0 | 95.0 | 96.0 | 96.5 | 97.0 |
| Infants vaccinated with OPV3 | 96.661 | 99.360 | 101.835 | 104.340 | 106.875 | 109.440 |
| OPV3 coverage** | 90.7 | 92.0 | 93.0 | 94.0 | 95.0 | 96.0 |
| Infants vaccinated with DTP3*** | 96.221 | 100.000 | 103.000 | 105.500 | 107.500 | 109.000 |
| **DTP3 coverage**** | 90,3 | 92,6 | 94,1 | 95,0 | 95,5 | 95,6 |
| **Infants vaccinated with DTP1***** | 96.542 | 100.440 | 103.477 | 106.005 | 108.000 | 109.440 |
| **Wastage[5] rate in base-year and planned thereafter** | 1,18 | 1,18 | 1,15 | 1,13 | 1,11 | 1,11 |
| **Infants vaccinated with 3rd dose of Hepatitis** | 95.516 | 99,360 | 102.382 | 105.450 | 108.000 | 110.580 |
| …… Coverage** | 89,6 | 92,0 | 93,5 | 95,0 | 96,0 | 97.0 |
| **Infants vaccinated with 1st dose of Hepatitis** | 103.551 | 105.000 | 107.000 | 110.000 | 112.000 | 114.000 |
| **Wastage[1] rate in base-year and planned thereafter** | 1,18 | 1,18 | 1,18 | 1,18 | 1,18 | 1,18 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Infants vaccinated with Measles | | 92.352 | 98.054 | 101.520 | 105.120 | 107.670 | 110.250 |
| Measles coverage** | | 90,8 | 92,0 | 94,0 | 96,0 | 97,0 | 98,0 |
| Pregnant women vaccinated with TT+ | | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| TT+ coverage**** | | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Vit A supplement | Mothers (<6 weeks from delivery) | 107.080 | 111.000 | 112.500 | 114.000 | 115.500 | 117.000 |
| | Infants (>6 months) | 426.088 | 429.800 | 432.375 | 435.740 | 437.910 | 439.715 |

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women