Global Alliance for Vaccines and Immunization (GAVI)

PROPOSAL

For Support to

Health System Strengthening

in the

Kyrgyz Republic

20 October 2006

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1. Executive Summary

Manas Taalimi Sector Strategy, Kyrgyz Health SWAp and GAVI HSS Proposal

The Kyrgyz Republic has entered a new phase of health system reform with its recently developed five-year health sector strategy, Manas taalimi, covering the period of 2006-2010. The first reform phase (Manas Health Sector Reform Program 1996-2005) brought about many achievements particularly in the efficiency of service delivery and in the quality of primary health care but did not sufficiently improve population health status (including infant, child and maternal health), financial protection and equity. These became the priority goals of the second phase of health system reform with the Manas taalimi sector strategy.

The Manas taalimi health sector strategy is implemented using a sector wide approach (SWAp) which is the first large scale sector-wide approach in the Former Soviet Union. The Manas taalimi sector strategy is supported by pooled budget support from Joint Financiers (World Bank, DFID, KfW, SDC, SIDA) and through parallel financing from other development partners (USAID, UNICEF, WHO). The Manas taalimi sector strategy is viewed by the Government of the Kyrgyz Republic as a key instrument to contribute to the reduction of high poverty rates, estimated at 41% of the population in 2004. Although the Kyrgyz health SWAp is an early-stage SWAp, it already has brought about many gains in the policy environment including greater engagement and ownership of MOH staff in policy design and implementation at the departmental level, greater harmonization of health system strengthening activities, and exemplary implementation of funding commitments in 2006 for the health sector both in terms of budget allocation and budget execution. As a result, the SWAp is becoming an effective approach for the design and implementation of health system strengthening activities.

The GAVI HSS proposal was prepared to seamlessly fit into this wider policy context. Proposed GAVI HSS strategies and activities have been fully harmonized with the Manas taalimi sector strategy including proposed policy decisions, programmatic steps, funding allocations, and monitoring instruments. Proposed implementation arrangements rely on existing institutions and mechanisms to the extent possible. At the same time, the HSS Program Proposal seeks to ensure focus on those health system strengthening activities that are particularly relevant for immunization and have a potential impact on maternal and child health outcomes. This approach allows maximizing the leverage of the GAVI HSS support within the broader reform context, without compromising program impact on maternal and child health outcomes.

The GAVI HSS proposal was prepared by a multi-stakeholder working group representing the Ministry of Health, Mandatory Health Insurance Fund, Sanitary and Epidemiology System (SES), Republican Centre for Immunoprophylaxis (RCI), and the Centre for Health System Development. Technical input and advice was provided by WHO, UNICEF, and ZdravPlus funded by USAID on behalf of the wider group of Development Partners. The proposal was discussed at the Intersectoral Coordinating Committee for Immunization and approved by the Policy Council of the Ministry of Health.

Assessment of Barriers, GAVI HSS Goals, and Components

Assessment of health system barriers relevant for immunization identified four main barriers:

a. Access barriers remain for timely use of primary care services due to lack of providers in remote areas, low salaries and motivation of health care personnel, migration of health care workers leading to an acute human resource problem, and low awareness of entitlements, especially among poor and vulnerable populations.

b. Poor quality of primary health care remains a problem despite improvements, particularly at the level of feldsher-midwife points (known by the Russian acronym FAPs), due to poor conditions of facilities, lack of functioning equipment, and insufficient training/qualifications of staff.

c. Although general immunization coverage is high, 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 and with quality issues.

d. While the immunization program has been strengthened in the past, the overall public health service delivery system and surveillance capacity remain under-developed due to low salaries, weak coordination mechanisms with other health improvement structures, under-investment in transportation and the cold chain, and outdated monitoring mechanisms.

Thus, the goal of the GAVI HSS proposal is to remove health system barriers in order to improve population health status, particularly for children from rural areas, poor families and vulnerable groups, through enhancing the effectiveness of primary care and public health services to provide high quality preventive and curative services and to improve and maintain immunization coverage.

To achieve this goal, planned GAVI HSS support for the Kyrgyz Republic has five components:

1. Strengthening political commitment to immunization and financial sustainability;

2. Improving the physical infrastructure and working conditions of primary care and public health services;

3. Improving access to high quality primary care through capacity building, improved management, and introduction of economic incentives;

4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health; and

5. Social mobilization and active involvement of the population in prevention and health promotion.

The GAVI HSS Program Proposal reflects a balanced approach between traditional investments with known effectiveness and policy innovations requiring learning during the implementation process itself. Traditional investments with known effectiveness in the HSS Program Proposal include 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.

The policy innovation in the GAVI HSS Program Proposal is the development and introduction of performance-based payment incentives for primary care providers, an enduring aspiration of the Kyrgyz MOH. The recently emerging human resource crisis in rural areas brought the need for this policy instrument into sharp focus and the GAVI HSS window creates an opportunity for its realization. The successful experience of the Kyrgyz MOH and MHIF with output and population-based purchasing mechanisms (all primary care providers are paid on a capitation basis and all hospitals are paid on a per-case basis) and past investments into information technology create an enabling environment for successful implementation of performance-based payment. As the attached Program Proposal and Plan of Work illustrate in detail (Document #8, #9), GAVI funds are proposed to be used as a catalyst to the process. The government will contribute its own funds already in Year 2 of implementation, increasing the share of domestic financing for this component annually and achieving full financing after 2011.

In the allocation of funds to activities, rayon (district) level structures were emphasized where possible. Past investments into the health system have often focused on strengthening oblast (region or state) and national structures. Channelling resources predominantly to the rayon level is

one of the defining features of the GAVI HSS proposal distinguishing it from other health system strengthening initiatives.

Overall, it is expected that the GAVI HSS support, implemented in concert with other health system strengthening activities of Manas taalimi, will contribute to strengthened primary care and public health services with an ultimate impact on child mortality and morbidity.

Proposed Implementation Arrangements

GAVI HSS activities will be implemented by existing governmental structures in the MOH, MHIF, SES, and RCI as indicated in the Plan of Work to ensure full harmonization with implementation arrangements of Manas taalimi. It is proposed not to establish a separate project management unit but rather create a post of Technical Coordinator. The GAVI HSS Technical Coordinator will work closely with all structures implementing the activities of the GAVI HSS Program, will take part in committee meetings, provide information about progress of implementing activities, seek the support of committees where needed, and ensure appropriate information flows within the country as well as between the country and the GAVI Secretariat.

To facilitate this harmonized implementation, it is proposed that the GAVI HSS funds would flow into the state budget of the Kyrgyz Republic and its distribution to programmed activities would use the existing allocation and procurement mechanisms of the Kyrgyz state budget as specified in the context of the SWAp. Thus, GAVI would become one of the Joint Financiers providing budget support in addition to the World Bank, DFID, SDC, KfW, and SIDA. Management and accountability mechanisms that have been specified for the purpose of the SWAp will be applicable to the GAVI HSS funds unless there is a separate agreement reached in the context of negotiations. While the GAVI funds will be included in the overall budget pool, appropriate assurances will be made by the Ministry of Health and Ministry of Finance that GAVI funds will be used as planned to carry out the activities proposed in this application. As the bi-annual health summits serve as the highest forum for coordinating and monitoring health system support both at the policy and programmatic level, GAVI will be invited to take part in the health summits and the preceding joint reviews.

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2. Signatures of the Government and National Coordinating Bodies

Government and the Health Sector Strategy Committee (for HSS only)

The Government of Kyrgyz Republic commits itself to developing national immunization services on a sustainable basis in accordance with the multi-year plan presented with this document.

Districts' performance on immunization will be reviewed annually through a transparent monitoring system. The Government requests that the Alliance and its partners contribute financial and technical assistance to support immunization of children as outlined in this application.

Ministry of Health: Mr. Niyazov Sh.

Signature:

Title: Minister of Health

Date: 26.10.06

Ministry of Finance: Mr. Djaparov A.

Signature:

Title: Minister of Economics and Finance

Date: 26.10.06

National Coordinating Body: MOH Health Policy Council

We, the members of the **Health Policy Council** met on the 23.10.06 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. (Document #3)

Agency/Organisation	**Name/Title**	**Подпись**
Ministry of Health	Mr. Nyazov Sh.N. – Minister of Health, Chairman	
	Mr. Mambetov K.B. – State Secretary, Vice Chairman	
	Mr. Imanbaev A.S. – Director of Department for Strategic Planning and Reform Implementation, Responsible Secretary	
	Mr. Karataev M.M. – Deputy Minister	
	Ms. Ibraimova A.S. – Deputy Minister, Director General of MHIF	
	Ms. Shteinke L.V. – Deputy Minister, Chief State Sanitary Doctor	
	Mr. Kutukeev T.S. – Director of Treatment and Prevention Department	
	Mr. Koshmuratov A.G. – Director of HR Policy and Organization Department	
	Ms. Oskonbaeva G.T. – Director of Economics and Financial Policy Department	
	Mr. Akmatbekov K.A. – Chief of Public Health Unit	
Trade Union of Health Professionals	Mr. Saaliev N.S. – Chairman of Central Committee	
Hospital Association	Mr. Djemuratov K.A. - Chairman	
FGP Association	Ms. Mukeeva S.T. - Director	

In case the GAVI Secretariat has queries on this submission, please contact:

Name: Mr. Imanbaev Almaz Sulaimanovich Title: Director of Department for Strategic Planning and Reform Implementation, MOH

Tel No.: + 996 312 66 37 07 Address: 148 Moskovskaya Str., Bishkek

Fax No.: + 996 312 66 04 93

Email: a_imanbaev@med.kg

Government and the Inter-Agency Coordinating Committee for Immunization

The Government of the Kyrgyz Republic commits itself to developing national immunization services on a sustainable basis in accordance with the multi-year plan presented with this document.

Districts' performance on immunization will be reviewed annually through a transparent monitoring system. The Government requests that the Alliance and its partners contribute financial and technical assistance to support immunization of children as outlined in this application.

Ministry of Health: Mr. Niyazov Sh. **Ministry of Finance:** Mr. Djaparov A.

Signature: Signature:

Title: Minister of Health Title: Minister of Economy and Finance

Date: 26.10.06 Date: 26.10.06

National Coordinating Body: Inter-Agency Coordinating Committee for Immunization

We, the members of the ICC met on the 10.10.06 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. (Document #4)

Agency/Organisation	Name/Title	Signatures
Ministry of Health	Ms. L. Shteinke (Deputy Minister of Health)	
	Mr. S. Abdikarimov (General Director of State Sanitary and Epidemiological Department)	
	Mr. J. Kalilov (Head of the Republican Center of Immunoprophylaxis)	
	Mr. S. Kuttukeev (Head of Department of Curative Care and Licensing)	
	Ms. G. Oskonbaeva (Head of Economics and Finance Policy Department)	
	Ms. O. Safonova (Deputy Head of the Republican Center of Immunoprophylaxis)	
	Mr. R. Kurmanov (General Director of Department of medical supplies and equipment)	
WHO	Mr. O. Moldokulov (Head of Country Office) Ms. M. Jakab (Resident Policy Advisor)	

	Mr. N. Cakmak (WHO EURO)	
UNICEF	Ms. I. Moldogazieva (Health Program Coordinator)	
ADB	Ms. G. Kojobergenova (Project Coordinator)	
World Bank	Ms. A. Sargaldakova (Project expert)	
USAID	Ms. D. Bibosunova (Project Coordinator) Mark McEuen (USAID-funded ZdravPlus Project Director)	
Family Group Practitioners	Ms. S. Mukeeva (Head of Family Group Practitioners Association)	
Swiss Coordination Office	Ms.E.Muratalieva (Health Programs Coordinator)	
JICA	Ms. S. Yakhontova (Representative)	

In case the GAVI Secretariat has queries on this submission, please contact:

Name: Mr. Kalilov Joldosh

Title: National Immunization Programme Manager, Head of the Republican Center of Immunoprophylaxis

Tel No.: 996 312 66 11 43

Fax No.: 996 312 66 02 24

Email: olgarci@elcat.kg

Address: 535 Frunze Str
Bishkek 720033
Kyrgyz Republic

The Inter-Agency Coordinating Committee for Immunization

Agencies and partners (including development partners, NGOs and Research Institutions) that are supporting immunization services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC). The ICC are responsible for coordinating and guiding the use of the GAVI ISS support. Please provide information about the ICC in your country in the spaces below.

Profile of the ICC

Name of the ICC: Inter-sectoral Coordination Committee on Immunization issues

Date of constitution of the current ICC: 17 December 2000

Organisational structure (e.g., sub-committee, stand-alone): Committee

Frequency of meetings: Once per quarter

Composition:

Function	Title / Organization	Name
Chair	Deputy Minister of Health	Ms. Shteinke L.
Secretary	Deputy Head of the Republican Center of Immunoprophylaxis	Ms. Safonova O.
Members	• General Director of State Sanitary and Epidemiological Department • UNICEF Health Program Coordinator • WHO Liaison Officer • WB Project Expert • ADB Project Coordinator • Head of the RCI • Head of Department of Curative Care and Licensing • USAID Project Coordinator • JICA representative • Head of Economics and Finance Policy Department • General Director of Department of medical supplies and equipment • Head of Family Group Practitioners Association • Swiss Coordination Office	• Mr. Abdikarimov S. • Ms. Moldogazieva I. • Mr. Moldokulov O. • Ms. Sargaldakova A. • Ms. Kojobergenova G. • Mr. Kalilov J. • Mr. Kutukeev T. • Ms. Beibosunova D. • Ms. Yakhontova S. • Ms.Oskonbaeva G. • Mr. Kurmanov R. • Ms. Mukeeva S. • Ms. Muratalieva E.

Major functions and responsibilities of the ICC:

1. Integration of government and international structures for strong partnership through coordination of contributions and resources provided from internal and external sources;
2. Assistance in development and approval of the national immunization policy, multy-year working plans on immunoprophylaxis in conditions of health system reforming.
3. Coordination of technical and financial support of available partners, development of key principles of collaboration of international organizations to ensure the most effective resource using, fundraising for support and improvement of the immunization service;
4. Monitoring and evaluation of economical effectiveness and expediency of activities undertaken for better implementation of target immunization programs;
5. Discussion of issues, reflecting the status of immunoprophylaxis in the country along with development of recommendations on situation improvement.

Three major strategies to enhance the ICC's role and functions in the next 12 months

1. Identification of necessary resources and provision of assistance to strengthen the immunization service to ensure realization of the new National Immunization Program as well as control and elimination of certain infections.
2. Coordination of financing in the sphere of immunization between existing partners through ICC to ensure an appropriate support.
3. Fundraising to ensure immunization needs in the country.

3. Immunization Programme Data

Please complete the immunization fact sheet below, using data from available sources.

Immunization Fact Sheet

Table 1: Basic facts for the year 2005 (most recent; specify dates of data provided)

Population	5,138,700 (2005)	GNI per capita	440 $US (2004)
Surviving Infants*	98.043 (2005, JRF) (covers only registered)	Infant mortality rate	29,7 / 1000 (2005)
Percentage of GDP allocated to Health	2.35 % (2005)	Percentage of Government expenditure on Health	10.5 % (2005)

* Surviving infants = Infants surviving the first 12 months of life

Table 2: Trends of immunization coverage and disease burden
(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

Trends of immunization coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2004	**2005**	**2003(*)**	**200…**		**2004**	**2005**
BCG		98.5	96.2	97.0		Tuberculosis*	5735	5794
DTP	DTP1	99.4	98.4			Diphtheria	2	1
	DTP3	99.3	98.1	94.2		Pertussis	44	91
Polio 3		98.4	98.5	96,8		Polio	0	0
Measles (first dose)		99.3	98.9	94.3		Measles	8	53
TT2+ (Pregnant women)		n.a.	n.a.			NN Tetanus	0	0
Hib3		n.a.	n.a.			Hib **	0	0
Yellow Fever		n.a.	n.a.			Yellow fever	0	0
HepB3		99.2	97.4	95,7		hepB sero-prevalence*	762	641
Vit A supplement	Mothers (<6 weeks post-delivery)	18.0	97.4					
	Infants (>6 months)	98.5	98.2					

* If available ** Note: JRF asks for Hin meningitis

If survey data is included in the table above, please indicate the years the surveys were conducted, the full title and if available, the age groups the data refers to:
In 2003, an Audit of Immunization Data Quality was conducted in all oblasts of the Republic by national specialists. Totally 21 rayons out 54 were covered by the research. The target group included children of 13-24 months, total number of the surveyed children was over 5 000.

Comprehensive Multi-Year Immunization Plan

A complete copy (with an executive summary) of the Comprehensive Multi-Year Plan for Immunization is attached. (Document #2) The following tables record the relevant data contained in the cMYP.

Table 3: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunization services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
BCG, HepB1, OPV0	At birth	X		
DTP1, OPV1, HepB2	2 months	X		
DTP2, OPV2	3.5 months	X		
DTP3, OPV3, HepB3	5 months	X		
MMR1	12 months	X		
DTP 4	2 years	X		
MR, DT	6 years	X		
Td	11 and 16 years	X		
Vitamin A	> 6 months	X		Twice a year, through campaigns

Summary of major action points and timeframe for improving immunization coverage identified in the cMYP

Major Action Points	**Timeframe**
1. Identification of priority districts and groups of population in terms of service delivery	2006 – 10
2. Establishing additional mobile teams at district level to serve to difficult to reach	2006 – 10
3. Identifying migrating populations	2006 – 10
4. Providing vehicle, fuel and supplies to mobile teams	2006 – 10
5. Strengthening Government's commitment to Programme	2006 – 10
6. Involvement of Health Insurance Agency and local governments in Programme financing	2006 – 10
7. Establishing buffer stock of vaccines	2006
8. Improving human resource capacity for the Programme	2006 – 10
9. Training of Programme staff	2006 – 10
10. Improving reporting system	2006 – 10
11. Improving data management system	2007
12. Conducting coverage surveys	2006 – 10
13. Improving social mobilization and advocacy	2006 – 10
14. Preparation of social mobilization and advocacy materials	2006 – 10
15. Conducting social surveys to assess public perception	2006 – 10
16. Purchasing new cold chain equipment	2006 – 08
17. Renovation of national cold store	2006 – 07
18. Procurement of generators	2007
19. Maintaining cold chain infrastructure	2006 – 10
20. Providing cold chain supplies to monitor temperature	2006 – 10

Table 4: 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[1] 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

Please indicate the method used for calculating TT and coverage:

……
……
……

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table α** after Table 7.1.

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Table 5: Estimate of annual DTP drop out rates

Number	Actual rates and targets					
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
Drop out rate [(DTP1 - DTP3)/DTP1] x 100	0,3	0,3	0,25	0,25	0,2	0,2

Table 6: Summary of current and future immunization programme budget

	Estimated costs per annum in US$ (,000)				
Budget chapter	**Current Year and Year 1 (2006)**	**Year 2 (2007)**	**Year 3 (2008)**	**Year 4 (2009)**	**Year 5 (2010)**
Vaccines	750,5	857,5	739,2	748,5	758,4
Supplies	142,7	144,5	146,3	148,3	150,2
Personnel cost (salaries)	81,5	101.0	123,7	151,2	184,1
Transportation of vaccines and supplies	2,6	2,9	3,2	3,5	3,9
Operational costs and maintenance	43,2	44,7	45,6	47,9	50,2
Training	119.0	87,8	98,5	110,5	124,0
Social mobilization	68,8	70,1	71,5	73,0	74,4
Surveillance	2,3	2,6	2,9	3,2	3,5
Programme management	11,3	12,8	14,3	16,2	18,1
Cold chain equipment	107,1	13,1	0	27,1	27,6
Supplementary immunization	759,6	112,2	0	0	0
Other expenses	102,6	117,7	0	0	0
GRAND TOTAL	2.160,0	1.566,8	1.380,4	1.484,5	1.572,3

Table 7: Summary of current and future financing and sources of funds

		Estimated financing per annum in US$ (,000)				
Budget chapter	**Funding source (*)**	**Current Year and Year 1 (2006)**	**Year 2 (2007)**	**Year 3 (2008)**	**Year 4 (2009)**	**Year 5 (2010)**
Vaccines	Govt, ADB	635,4	857,5	605,4	737,8	758,4
Supplies	Govt, GAVI	60,0	93,5	0	0	0
Personnel cost (salaries)	Govt	81,5	101.0	123,7	151,2	184,1
Transportation of vaccines and supplies	Govt	2,6	2,9	3,2	3,5	3,9
Operational costs and maintenance	Govt	43,2	44,7	45,6	47,9	50,2
Training		0	0	0	0	0
Social mobilization		0	0	0	0	0
Surveillance	Govt	2,3	2,6	2,9	3,2	3,5
Programme management	Govt	11,3	12,8	14,3	16,2	18,1
Cold chain equipment	ADB	94,3	0	0	0	0
Supplementary immunization	Govt, local governments	106,4	0	0	0	0
Other expenses	Health Insurance Fund	102,6	117,7	0	0	0
GRAND TOTAL		1.139,5	1.232,5	930,1	1.114,7	1.196,1
(*) Only secured funding sources indicated						

4. Health Systems Strengthening Support (HSS)

Assessment of health system barriers

[see next page]

Recent assessments, reviews and studies of the health system				
Title of the assessment	**Participating agencies**	**Areas / themes covered**	**Dates**	**DOCUMENT NUMBER**
Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Health Care Financing	Lead agency: WHO With support and contributions from: MOH, MHIF DFID USAID World Bank	→ Summary of health financing reforms with particular emphasis on changes in pooling arrangements and population entitlements through the State Guaranteed Benefit Package and co-payment policy; → Impact of reforms on household financial burden and equality of utilization patterns; → Impact of reforms on efficiency of resource use through linkages to facility restructuring; → Impact of reforms on transparency of resource flows and on the practice of informal payment.	Issued: 2005 Covers: 1996-2005	#7.a
Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Restructuring of service delivery	Lead agency: WHO With support and contributions from: MOH, MHIF DFID USAID World Bank	→ Summary of reforms in the area of restructuring health service delivery to address inefficiencies inherited from the Soviet Union characterized by (a) an over-sized inpatient provider network, (b) weak and under-funded primary care – a structure ill-suited to the disease burden and resource envelop of the Kyrgyz Republic experiencing economic decline and significant increase in poverty rates throughout the 1990's; → Documenting the extent of downsizing in hospital care and the development of autonomous primary care providers; → Assessing the efficiency, quality, and access consequences of restructuring	Issued: 2005 Covers: 1996-2005	#7.b
Evaluating the Manas Health Sector Reforms (1996-2005): Focus on Primary health care	Lead agency: WHO With support and contributions from: MOH, MHIF DFID USAID World Bank	→ Summary of primary care reforms in financing, organization, and HR development; → Impact of reforms on practice patterns of primary care personnel regarding task profile, first-contact and gate-keeping functions; → Impact of reforms on utilization and access to primary care and identification of access barriers.	Issued: 2005 Covers: 1996-2005	#7.c

Recent assessments, reviews and studies of the health system (cont'd)				
Assessing Human Resource Issues in the Kyrgyz Health System	Lead agency: WHO and ZdravPlus funded by USAID On behalf of the MOH and the community of development partners	In the first SWAp Health Summit in May 2006, the MOH and the development partners became alarmed by the accelerating pace migration of medical personnel from rural areas leaving entire areas without qualified medical assistance. A joint analysis was commissioned to review the main issues in the human resource situation focusing on: (a) Documenting the extent of migration and its impact on access to care; (b) Evaluating current policy proposals to address human resource problems.	2006	#7.d
Findings from the Multiple Indicator Cluster Survey, 2006	UNICEF National Statistical Committee	→ Survey-based estimates of child health and immunization coverage, and a number of other indicators relevant for meeting the MDG's	2006	#7.f
Review of "Manas 2": Public health component	WHO	Assessed the Manas Taalimi draft strategy and activities related to modernizing/strengthening public health services.	2005	#7.g
EURO-Travel Report Summary [*Re: reform of public health service system*]	WHO	Assessed progress in reforming public health services system and made recommendations for continued reform in the areas of (a) legislation and standards; (b) planning and management functions; (c) restructuring public health services with an aim toward integration of vertical structures; (d) financing; (e) issues in human resources and physical infrastructure	2006	#7h
Assessment of Health Information System	World Bank	Review of Health Management Information Systems including information flows, information networks and communication issues, and investments in hardware and their maintenance.	2004	#7.i
SWAp Joint Review Summary Statement → May, 2006 → September, 2006	MOH, MOF World Bank, DFID, KfW, SDC, SIDA, USAID, UNICEF, WHO	Review of implementation progress of Manas taalimi and SWAp in Year 1 with (a) identification of key policy and programmatic issues in each component (population involvement, health financing, service delivery, and stewardship), (b) assessment of implementation arrangements & capacity, and (c) progress towards mitigating fiduciary risks.	2006	#7.j
Health and access to health care among urban migrants	WHO DFID MOH	Qualitative study among the urban migrants living in informal settlements around Bishkek on their health problems and access to quality services	2005	#7.k

	Major strengths identified in the assessments relevant for immunization
1.	**Access to medical care improved.** Utilization rates among the poor increased relative to the non-poor for primary health care as well as hospital care between 200 and 2004. This is due to a number of successful reform steps that aimed to create a more efficient health system with better quality and reduced patient financial burden. Key reform steps included (a) introduced a successful health financing reform ending the fragmentation of resource allocation and introducing output/population-based payment methods (capitation, case-based payment); (b) downsized hospital capacity leading to efficiency gains through reduction in hospital fixed costs (utilities, maintenance, staff); (c) using efficiency gains, increased the share of public spending in hospitals devoted to direct medical care expenses such as medicines and supplies from 16% in 2000 to 37% in 2004, with an immediate beneficial effect on patient out-of-pocket financial burden (i.e. reduced need for patients to purchase these items informally); (d) using efficiency gains, increased the share of primary care in the overall resource envelop from 15% of public spending in 2001 to 33% in 2003; (e) clearly specified entitlements in the State-Guaranteed Benefit Package with an effective co-payment policy. These achievements had major implications for reducing household financial burden for deliveries and ensured high rates of deliveries attended by qualified medical staff.
2.	**Quality of primary care began to improve.** Quality of primary care began to improve, especially in areas where reforms had a longer history: the task profile of primary care physician has increased particularly for chronic diseases, pregnancies and childhood illnesses - conditions which used to have high rates of unnecessary hospitalizations with potential negative impact on health outcomes, patient satisfaction, efficient use of public resources, and household financial resources. A strong primary health care system with full integration of vertical programs is envisioned as the cornerstone of achieving high immunization coverage on a continuous basis, as well as to improve maternal and child health outcomes in the current resource poor environment.
3.	**Immunization rates continue to be high**. According to official data, vaccination coverage is greater than 98% against major childhood illnesses. The Multi Indicator Cluster Survey 2006 confirm high vaccination rates based on survey data for BCG (90%), DPT1 (89%), and measles (84%). These achievements are due to a strengthened national program of immunization fully integrated into primary health care with a relatively wide provider network.
4.	**Initial steps to strengthen public health services have been taken.** From 2000-05, (a) the national immunization program has been strengthened and further integrated into PHC; (b) health promotion activities have been enhanced through development of a Republican Health Promotion Center, extensive training in modern health promotion methodologies, and investment in infrastructure for republican and oblast levels; (c) computers and software have been provided throughout the public health system to improve monitoring and surveillance; and (d) a limited number of public health structures and laboratories (particularly duplicative ones at oblast and city levels) have been merged.
5.	**Investments in monitoring and evaluation and information systems have led to an emerging evidence-based policy-making environment**. A health system monitoring framework has been developed with annual assessment of performance monitoring indicators complemented with analytical products. The MOH regularly uses evidence from the monitoring instrument and analytical work for policy formulation. The MHIF regularly monitors performance of providers in order to improve service quality and patient satisfaction and ensure transparency of financial flows and feeds back the results to providers. These activities require high quality routine data which has been made possible by investments in information management systems at the level of providers, the MHIF, and the Republican Medical Information Center.

Problems (obstacles / barriers) with relevance to immunization coverage	
1.	**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.
2.	**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.
3.	**Although general immunization coverage is high, 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).
4.	**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.

	Recommendations
1.	**Further reduce barriers to access in order to ensure improvements in maternal and child health among the poor and vulnerable groups.** This would entail implementation of the following policies and activities: (a) implement commitments to funding the health sector as a priority sector for poverty reduction by allocating an additional percentage point of the government budget to health annually between 2006-2010 as specified in the SWAp negotiations; (b) centralize pooling of public expenditures at the national level in order to increase the potential of cross-subsidization from richer to poorer regions; (c) identify population points with no medical providers and create new FAPs, emergency care providers, and pharmacies in coordination with local governments; (d) develop incentive mechanisms to attract and retain medical staff in remote rural areas that experience rapid loss of staff; and (e) enhance population awareness of entitlements in the State Guaranteed Benefit Package with a particular emphasis on urban migrants.
2.	**Further increase the effectiveness of primary health care with special emphasis on FAPs.** (a) Improve the infrastructure and economic incentives at primary care level and ensure continuous training of family group practice (FGP) doctors and nurses in family medicine. (b) Strengthen FAPs by upgrading their equipment, ensuring means of communication with higher level medical centers and emergency services, training staff, and strengthening economic incentives; (c) Review the distribution of ambulance stations to improve access to emergency and specialist care; and (d) further improve population/output based purchasing mechanisms initiated under Manas by strengthening the role of contracts between the MHIF and providers to reward high quality efficient providers;
3.	**Targeted efforts are needed to further increase immunization coverage and remove pockets of under-coverage.** Although general immunization coverage is high, there are pockets of under-coverage in particular for follow-up vaccines such as DPT-3, for children in rural areas and from poor families, and among urban migrants. This requires reducing access barriers recommended under (1) and improving quality of primary care, particularly among FAPs, recommended under (2). To reach special populations, the health system should rely on the strong social mobilization processes taking place in the country through the village health committees and greater involvement of NGO's.
4.	**Create a sustainable public health service oriented toward the population's needs.** The public health program should be based on integration of health protection and promotion programs, wide inter-sectoral interaction, and active involvement of society in health protection and health promotion activities including strategies to: (a) Increase the effectiveness of epidemiological surveillance (disease control), health promotion, and government regulation (lab tests/control, sanitary inspection) through creation of sustainable integrated public health services. (b) Create a normative-legal base that would increase the efficiency of public health services; and (c) Further expand inter-sectoral collaboration and increased transparency for effective health promotion and protection activities; and (d) Reorient the work of the public health service to health priorities through better priority setting and coordination.

Recommendations	Progress with implementation of the recommendations of the assessment reports
1. Reduce access barriers	Excellent progress on meeting financial commitments to the sector but the emerging human resource crisis is a major threat. The government has met its commitments to funding the sector in an exemplary manner during the first year of the SWAp. This is a major achievement and is in part due to the strengthened effectiveness of the policy dialogue, demonstrated national ownership and improved accountability mechanisms in the framework of the SWAp. At the technical level, pooling of public funds at the national level has been implemented with an already demonstrable equalization of resource flows across the country. The State Guaranteed Benefit Package has been revised with co-payment reductions for pregnant women, children and the elderly. The sustainability of the co-payment reductions is under question and is being examined. However, attrition of medical personnel particularly in rural area has become a major concern identified at the May 2006 health summit as the major threat to implementation of Manas taalimi. Significant efforts are targeted to developing policy instruments both in the short- and long-term to mitigate the loss of medical personnel in rural areas. In part, the GAVI HSS application is targeted to this area to help implement an innovative incentive payment mechanism to increase staff retention in affected areas.
2. Further strengthen the quality of primary care, particularly of FAPs	Good progress has been made on taking the initial steps to make effective investments in primary care over the next four years. New FAPs have been built in the context of the village investment program and their equipment needs have been identified and included in the SWAp procurement plan for 2007. Mapping of service delivery and inventorization is under-way and will lead to the definition of equipment purchases for existing FAPs to be carried out in 2007. Training in family medicine continues, but the current training program needs to be strengthened with up-to-date material on improving the quality of immunization services in the context of primary care. This is a key activity included in the GAVI HSS application.
3. Targeted work on increasing immunization coverage	There has been good progress on strengthening immunization activities in general. However, several activities need to be implemented in order to reach specific target groups with under-coverage such as urban migrants and populations living in remote rural areas without medical assistance (FGP, FAP). Among urban migrants, the registration process needs to improve and population awareness needs to be enhanced on access to primary care (free and no need for registration documents to receive care). This requires active involvement of civil society. Among remote rural populations, mobile units need to be organized for delivering services in population points without medical points (FGP or FAP). Finally, regular monitoring needs to be conducted and surveillance needs to be improved. All these activities feature strongly in the GAVI HSS application.
4. Create a sustainable public health service	In the past year, a Public Health Unit of the MOH has been established to strengthen policymaking and stewardship in public health and a concept for further reform has been drafted. The concept states that restructuring will be guided by definition of modern public health functions, lead to improved integration of public health services (including health promotion), and increase quality and efficiency of delivery of public health services. A national workshop and round table have been conducted with WHO and other donors to review and finalize the public health reform concept and identify concrete next steps.

Proposed GAVI Health Systems Strengthening Support

Objectives

The goal of the GAVI HSS proposal of the Kyrgyz Republic is to remove health system barriers in order to improve population health status, particularly for children from rural areas, poor families and vulnerable groups, through enhancing the effectiveness of primary care and public health services to provide high quality preventive and curative services and to improve and maintain immunization coverage.

Main Areas of HSS Support and Their Link to GAVI Themes

To achieve the above objectives, five components are proposed for the GAVI HSS support:

1. Strengthening political commitment to immunization and financial sustainability;
2. Improving the physical infrastructure and working conditions of primary care and public health services;
3. Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives;
4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health; and
5. Social mobilization and active involvement of the population in prevention and health promotion;

The table below maps these five components to the three themes identified in the GAVI proposal guidelines.

Five components of HSS support	GAVI HSS themes
1. Strengthening political commitment to immunization and ensuring financial sustainability	While this activity does not map directly to any of the GAVI themes, strong political commitment and awareness is a critical to create an enabling environment for successful health system reform and successful implementation of the GAVI HSS activities in the framework of the SWAp.
2. Improving physical infrastructure and working conditions of primary care and public health services	**Theme #2**: Supply, distribution and maintenance systems for drugs, equipment, and infrastructure for primary health care
3. Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives	**Theme #1**: Health workforce mobilization, distribution, and motivation targeted at those engaged in immunization and other health services at the district level and below. **Theme #3**: Organization and management of health services at the district level and below (including financial management)
4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health;	**Theme #3**: Organization and management of health services at the district level and below (including financial management)
5. Social mobilization and active involvement of the population in health promotion and prevention	**Theme #3**: Organization and management of health services at the district level and below (including financial management)

Major Action Points and Activities

The table below describes the main activities within each of the five components of the GAVI HSS proposal. The five components are described in greater detail in the attached GAVI HSS Program Proposal. (Document #8) The Program Proposal is complemented by a fully-costed Plan of Work (POW) listing proposed activities, timing, estimated cost, availability of financing from already programmed sources, and requested amount from GAVI. (Document #9) The GAVI HSS plan of work indicates the link of each activity to the corresponding Manas taalimi component identification number so that relevant sections can be easily found and cross-referenced in the Manas taalimi strategy, plan of work and costing. The POW/costing for the GAVI HSS proposal provides a comprehensive description of health system strengthening activities targeted to improving immunization and child health, including activities proposed for GAVI funding, as well as complementary activities for which financing has already been secured from other sources (government budget, joint financiers, or parallel financing). This approach allows highlighting synergies across activities funded from different sources and avoiding duplication.

Five components of HSS support (Correspond to component ID's in POW)	Activities and action points
1. Strengthening political commitment to immunization and ensuring financial sustainability	▪ Conduct analytical work with relevance for strengthening immunization and primary health care and channel to policy process in the health sector, wider government, and parliament ▪ Conduct advocacy activities targeting wider government, local governments, and the population ▪ Provide accurate and timely information to MOH on financing requirements for ensuring full immunization coverage for preparation of annual budgets and the MTBF
2. Improving physical infrastructure and working conditions of primary care and public health services	▪ Purchase 27 cars for surveillance and mobile team ▪ Purchase 10 refrigerating equipment ▪ Renovate 16 rayon-level vaccine warehouses
3. Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives	▪ Conduct training for feldsher-midwives in "Immunization in Practice" (WHO curriculum) ▪ Develop mechanism for "supportive supervision" of primary care staff for performance improvement including immunization coverage: develop manual, train supervisors, conduct joint supervision trips with MHIF in each of 40 rayons ▪ Organize mobile teams in each of 40 rayons that will visit population points without medical services 4 times year ▪ Train primary health care staff on integrated surveillance of infectious diseases and provide support for its implementation ▪ Develop mechanism and indicators for performance based pay for primary care providers, implement it in a phased approach and conduct evaluation of its effectiveness to improve quality and staff retention after Year 1 & Year 2. Contribute government funds to increase the number of recipient providers after Year 1 and move to full self-financing after 2010.
4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health;	▪ Develop and introduce vaccine status register and immunization calendar ▪ Create electronic reporting for immunization activities in primary care by revising the primary care reporting form of the Medical Information System ▪ Monitor the timeliness of immunization activities in line with immunization calendar
5. Social mobilization and active involvement of the population in health promotion and prevention	▪ Develop regular contact with NGO's working among urban migrants in Bishkek and Osh cities where under-coverage is significant ▪ Conduct capacity building for providers to work with civil society organizations to help conduct outreach and communication activities in order to generate demand for timely primary care and immunization

Expected Time-Frame for Success

The time-frame of the GAVI application corresponds to the time-frame of Manas-taalimi for the period of 2007-2010. A mid-term review is proposed for 2008 to coincide with the mid-term review of Manas taalimi and an end-program review is proposed for 2010 to coincide with the final program evaluation of Manas taalimi.

Justification

Five components of HSS support	Justification of components
1. Strengthening political commitment to immunization and ensuring financial sustainability	The immediate risk to financial sustainability is past success in achieving high immunization coverage. Thus, immunization may receive less political support as it is no longer viewed as a problem area. This component will contribute to keeping immunization consistently high on the political agenda by highlighting benefits from investing in immunization and more generally in primary care. **Thus, the component will contribute to more effective health system stewardship where immunization activities receive high priority in the context of a unified approach to health system strengthening.**
2. Improving physical infrastructure and working conditions of primary care and public health services	A key area to improve the quality of immunization services is to ensure appropriate conditions for transportation and storage of vaccines especially at the rayon level. Insufficient investments at the rayon level so far have led to poor conditions in the quality of transport and storage conditions. **This component will channel investments to strengthening rayon level transportation and storage conditions and will contribute to improved quality of the cold chain, and thus, to improved quality and sustainability of immunization services.**
3. Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives	Lack of trained medical personnel, particularly in rural areas, is a key a barrier to high immunization coverage and to access to effective primary care services. A key activity of this component is the development of incentive payments for primary health care providers targeted to under-served areas with poor child health and high social risks. This component will increase the potential of the Kyrgyz health system to mitigate the effects of health worker migration and improve staff retention. GAVI funds will serve as the catalyst to launch this component, government funds will be added from Year 2 and its share increased annually until complete self-financing from 2011. In addition, in areas that will not be covered with health care providers over the next four years, mobile teams will be organized under the component to conduct immunization as an outreach activity. **Thus, the component will contribute to improved access to primary care services, particularly in under-served areas and among poor populations.** In addition to improving access, the component will place a great emphasis on capacity building at the level of FAPs, FGP's, and rayon Family Medicine Centers (FMCs) and in the rayon public health system. The current training programs in family medicine will be strengthened on immunization practice. Regular supervisory visits to primary care providers will be organized under the component in order to identify and discuss problems and potential solutions appropriate for local circumstances and conditions. Capacity building for improved surveillance of infectious diseases at the rayon level and below will be organized. This will improve the quality of disease surveillance, monitoring of immunization activities, and management. **Overall, the component will contribute to improved quality of immunization services in the context of family medicine and stronger disease surveillance.**

Five components of HSS support	Justification of components (cont'd)
4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health;	The reporting system for immunization was introduced in 1997 and provides basic information about immunization activities. However, reporting continues to be paper-based and heavy investments in information technology in the health system overall have by-passed the reporting mechanisms for immunization. The component will invest in developing an electronic system of reporting that provides information about immunization activities and their timeliness with special mechanisms to be developed to keep track of migrant populations where immunization coverage is lagging behind. This database will be connected to other already existing databases (e.g. primary care database) for analytical purposes. This information, once aggregated and analyzed, will be directed back to rayon level supervisory teams and providers. **Thus, the component will contribute to improved quality of immunization services through better information at the national and rayon level and increased use of information to improve management decisions.**
5. Social mobilization and active involvement of the population in health promotion and prevention	The component will contribute to generating demand for immunization and timely primary care services in general through social mobilization and well-targeted communication. Involving civil society is an effective way to implement social mobilization activities. Since social mobilization activities in rural areas are a current focus of several other donors, the component will focus on urban areas and in particular, on new urban settlements with registered and unregistered migrants. At the same time, capacity building activities will be conducted for all providers (urban and rural) to work with civil society organizations to help conduct outreach and communication activities in order to generate demand. **Thus, the component will contribute to improving immunization coverage among populations with under-coverage and improve the quality of primary care services overall.**

HSS Monitoring and Evaluation

The proposed indicators below will allow tracking implementation progress and program impact of the GAVI HSS support.

As part of the SWAp, great efforts have been made to reduce the number of overlapping monitoring mechanisms. As a result, a Joint Monitoring Instrument was developed and approved by the MOH and development partners. (Document 5.b) The Monitoring Instrument is composed of 3 sections: (a) implementation progress monitoring (mostly, input, process and output indicators) matching the components of Manas taalimi; (b) performance impact monitoring instrument (outcome indicators) matching the goals/objectives of Manas taalimi; and (c) "Dashboard" indicators, a selection of the 25 most important indicators (mostly outcome) for high level policy attention.

Once agreement is reached on the GAVI HSS indicators, the Manas taalimi monitoring instrument will be revised to fully include all indicators agreed with GAVI. Thus, the GAVI HSS indicators will be part of the Joint Monitoring Instrument annually collected and presented by the MOH at the spring health summits.

Table 9: Progress and Impact Monitoring

	Indicator(s)	Data source(s)
HSS Inputs (year 1 and 2)	# of vehicles purchased (and as % of planned)	MOH
	# of planned cold chain equipment purchased # of vehicles purchased (and as % of planned)	MOH
	# of planned rayon level vaccine warehouses repaired # of vehicles purchased (and as % of planned)	MOH
HSS Activities	# of planned supervisory teams established and trained (and as % of planned)	RCI
	# of trainers trained at the oblast and rayon level in immunization, IMCI, and other maternal and child health programs	MOH
	# of FAPs receiving training in "WHO Practice of Immunization" (and as % of planned)	RCI
	# of mobile teams established (and as % of planned)	RCI
	# of primary care providers receiving performance incentive (and as % of planned)	MHIF
	# of NGO's working with urban migrants on health issues and which are in regular contact with the RHPC	RHPC
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	RCI
	% of population points with no health facility that received 4 rounds of mobile services during the year	RCI

	% of measles and rubella cases that received lab confirmation	RCI
	% of rural FGP's with more than 2000 enrolled population (NB: Manas taalimi dashboard indicator for staff retention)	RMIC
	% of government health spending allocated to primary health care	MOH
Impact on immunization (year 3 and 4)	BCG	RCI
	DPT1	
	DPT3	
	MMR1	
Impact on child mortality (year 4)	Under 5 Mortality	RMIC

These indicators will be complemented by a number of in-depth evaluation studies to understand causal factors behind trends in indicators, and to assess the effectiveness of program implementation.

1. **Evaluation of performance based pay in primary health care**. This evaluation product will consist of a series of studies contributing to understanding the impact of GAVI HSS support in this area. Specifically:

a. The first study will be conducted to take a baseline of 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 (2007, Q4)

b. The second study will be conducted after Year 1 implementation assessing the effectiveness of the implementation progress and looking at changes in the indicators in phase-1 rayons relative to control rayons. The study will lead to recommendations for improving the design of the program. (2009, Q1)

c. The third study will be conducted after Year 2 implementation to take into account longer reform history and be able to assess the wider impact of the program on staff retention and quality of care. (2010, Q3)

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 will be conducted using a combination of national and international data. The objective will be to demonstrate deaths and morbidity averted concretely in the Kyrgyz Republic by investing in immunization and its cost implications.

3. **Study of primary care use and immunization coverage among urban migrants, 2007-2009**. A study will be conducted among urban migrants to better understand under-coverage and under-use of health care services. The study will build on the existing qualitative study looking at population perceptions among migrants of health problems and access to services and will complement this study with quantitative estimates of service utilization and immunization coverage. The study will be conducted in 2007 and in 2010 to assess change and the effects of increased efforts on this population group.

Table 10: 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[1] (official data)	29.7					28.0	

[1] The official infant and child mortality data under-estimates the true mortality as is shown by survey estimates such as the DHS-1997 and the MIC's 2006. In part, this is due to the different definition of live-birth used in Soviet times. The new live-birth criteria has been introduced in the Kyrgyz Republic and as a statistical artefact of this change, the indicator is still showing an increase and is expected to show an increase over the next 1-2 years.

The components of HSS have been broken down into sub-components and activities as shown in the plan of work. Input requirements for these activities have been estimated and costed out using the same unit prices as were used for costing the Manas taalimi sector strategy. The full details of the costing exercise can be found in the attached Document #9 and Table 11 below shows the summary of the costing estimates by component and year.

The base year for the costing of these activities is 2007. There are a number of activities funded by the budget and/or non-GAVI donor funds that started earlier than 2007. These costs are not shown for simplicity of presentation but can be easily found by using the cross-references of each activity to Manas taalimi strategy and plan of work to obtain a full picture.

Table 11: Cost of Implementing All HSS Activities Relevant to Immunization

Component	Cost per year (US$)				
	Year 1	Year 2	Year 3	Year 4	TOTAL COSTS
	2007	2008	2009	2010	
Component#1. Strengthening political commitment to immunization and financial sustainability	44,707	29,707	52,207	14,707	141,328
Component #2. Improving the physical infrastructure and working conditions of primary care and public health services	3,599,398	1,819,698	1,602,100	552,100	7,573,296
Component # 3. Ensuring access to high quality primary care through capacity building, improved management and introduction of incentives	131,165	188,869	396,191	691,740	1,407,965
Component # 4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health	100,940	70,240	58,990	418,990	649,160
Component # 5. Social mobilization and active involvement of the population in prevention and health promotion	491,500	422,700	19,500	19,500	953,200
Management costs (included TA and IOC for program administration)	14,174	9,174	9,174	9,174	41,696
Technical support					
TOTAL COSTS	**4,381,884**	**2,540,388**	**2,138,162**	**1,706,211**	**10,766,645**

The table below shows the available financing to meet the costs of the five components in the HSS including government budget, joint financiers in the SWAp, WHO, UNICEF, USAID-funded ZdravPlus Project and the Kyrgyz-Swiss Health Reform Project funded by SDC.

The GAVI HSS plan of work and costing includes only those activities and costs that are most relevant for immunization and mother and child health. There are many other health system strengthening activities in Manas taalimi with less relevance for immunization and mother and child health and these were not included in the costing exercise (e.g. restructuring hospital capacity, strengthening evidence based medicine, reform of medical education, etc.) This approach to

planning the GAVI HSS funds was taken for the sake of simplicity and better focus as the complete plan of work and costing of Manas taalimi is a 400 page document. Correspondingly, the available funding highlighted below from various sources is only a sub-set of the total funding programmed for the health sector for the period 2008-2010.

Table 12: 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

The GAVI HSS Program Proposal (Document #8) and the costed Plan of Work (Document #9) provide a detailed analysis of the distribution of total costs as well as proposed GAVI financing by component. It also provides a mapping of these funds to Manas taalimi components and provides an analysis of how much the GAVI HSS funds contribute to the funding of these components.

When looking across sources of funding for all planned HSS activities relevant to immunization, domestic sources contribute 23% of the total costs even though this is an underestimate of the true significance of domestic financing as it does not include regular operational expenditures such as salaries of medical personnel, utilities, drugs, other supplies, etc. The Joint Financiers in the SWAp contribute 56% of the total program costs. The GAVI funds make up 11% of the program costs. While these may seem low, these funds will be allocated mostly at the rayon level where this level of funding will make a significant difference. Second, by including activity 2.A.1 Renovation and equipment of FAPs, both the government's and the Joint Financier's share of program costs increased significantly by US$1.4 million and US$5.7 million respectively. Without the costs of FAP renovation and equipment, the share of GAVI funding in the total program cost is 32%.

Management and Accountability of GAVI HSS Funds

If the Kyrgyz Republic becomes a recipient of the GAVI HSS grant, it is proposed that the GAVI HSS funds would flow into the state budget of the Kyrgyz Republic and its distribution to programmed activities would use the existing allocation and procurement mechanisms of the Kyrgyz state budget as specified in the context of the SWAp. Thus, GAVI would become one of the Joint Financiers providing budget support in addition to the World Bank, DFID, SDC, KfW, and SIDA. Management and accountability mechanisms that have been specified for the purpose of the SWAp and described in the Operational Manual will be applicable to the GAVI HSS funds unless there is a separate agreement reached in the context of negotiations. These arrangements are described below. Additional features are described in 5 volumes of the SWAp Operational Manual and further details can be provided upon request. While the GAVI funds will be included in the overall budget pool, appropriate assurances will be made by the Ministry of Health and Ministry of Finance that GAVI funds will be used as planned to carry out the activities proposed in this application.

There are four main advantages of this arrangement. First, this arrangement ensures full and automatic harmonization of the annual programming of the GAVI HSS funds with implementation of the Manas taalimi health sector strategy increasing their effectiveness. Second, issues related to implementation progress and program impact can be highlighted at the bi-annual Joint Health Summits which provides a high level powerful forum for policy and programmatic decisions (e.g. budget issues, counterpart funds, concerns for duplicate activities, identifying synergies with other organizations, etc…). Third, a complex system of fiduciary risk mitigation measures are being put in place for the SWAp fund-flow mechanisms which are monitored closely by the Joint Financiers. Thus, pooling of the GAVI HSS funds will ensure proper financial management of the Grant funds. Fourth, this arrangement will decrease administrative costs associated with management and accountability arrangements related to the GAVI HSS Grant.

a) Who is responsible for approving annual plans and budgets for use of GAVI HSS?

In line with forming and approving annual plans and budgets for Manas taalimi, the following process is proposed for the GAVI HSS activities and funds:

1. The GAVI HSS Working Group will make a draft annual plan of work and budget. The Working Group will be coordinated by a Technical Program Coordinator who will be the primary point person for all activities included in the HSS program proposal and the contact person for communication with the GAVI Secretariat. For the annual plan of work and costing, review and recommendations of the ICC will be sought.

2. The draft POW and budget will be submitted to the MOH Department of Strategic Planning and Reform Implementation in charge of compiling an overall annual plan of work and budget for Manas taalimi on time for the September SWAp joint review.

3. Approval will be provided by the MOH Health Policy Council, the highest organ of policy approval.

4. Agreement with the development partners will be sought at the September Health Summits whose purpose is to approve program activities and corresponding funding for the following year. GAVI representatives will be invited to take part in the bi-annual health summits and approve annual plans of work and budget in the context of the overall Manas taalimi plan of work.

As a result of this process, the agreed annual Plan of Work for GAVI HSS will be approved by a resolution of the MOH. The annual GAVI HSS budget will form part of the budget of the Kyrgyz Republic discussed and approved by the Parliament.

b) Which financial year is proposed for budgeting and reporting?

Calendar year is used for budgeting from January 1 to December 31.

c) How will HSS funds be channelled into the country?[2]

If there is an agreement reached between the GAVI Secretariat and the Ministry of Health of the Kyrgyz Republic, it is proposed that the funds provided by the GAVI HSS window flow into and be co-mingled with the state budget of the Kyrgyz Republic. Thus, GAVI would become one of the Joint Financiers and the funds would flow in the same manner as the funds provided by the other Joint Financiers supporting Manas Taalimi Health Reform Program on the basis of budget support. (World Bank, DFID, SDC, KfW, SIDA).

Specifically, the funds would flow directly into a foreign currency-designated account that was opened at the National Bank of the Kyrgyz Republic (NBKR) in the name of the Ministry of Economy and Finance (MOEF) of the KR, it would thereafter be converted to Kyrgyz Som, which would be deposited in one of the local currency Budget accounts managed by the State Treasury. The foreign currency account has already been opened for the purpose of receiving funds from the donors that are providing budget support to Manas taalimi health reform strategy.

In terms of administrative arrangements, if the current Proposal is approved, the GAVI Secretariat similar to other development partners such as DfID, KfW, SDC and SIDA will be requested to conclude the Memorandum of Understanding with the World Bank that is responsible for managing the joint donor funds.

A detailed description of all the procedures, documentation and other operational issues is provided in the HSS Program Proposal (Document #8) and in the Financial Management Operational Manual that was approved by the MOEF and the Joint Financiers. The Manual is available at the following website http://manastaalimi.med.kg/

d) How will HSS funds be channelled within the country?

In the context of the SWAp, pooled funds are allocated to activities through two channels in an agreed and specified manner. The first channel is through the Ministry of Health and the other channel is through the Mandatory Health Insurance Fund. The GAVI HSS funds would flow in the same manner following the same rules. Specifically, once the HSS funds are deposited in a local currency account managed by the State Treasury, they will be sent to the Treasury accounts of (1) the Mandatory Health Insurance Fund for financing the activities envisioned under the Component 4.D on incentive payments for primary care providers and (2) the Ministry of Health for all the other activities under Components 1 – 5. The funds, once they are in the Treasury system, are managed according to the standard budgetary procedures of the country. The detailed description and evaluation of these mechanisms are provided in the Financial Management Operational Manual and the Health Sector Fiduciary Assessment of the SWAp.

d) How will reporting on use of funds take place (financial and activity/progress reports)?

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

[2]Countries are encouraged to use existing health sector accounts for Health System Strengthening System funds

SWAp. The reports will be furnished to the GAVI Secretariat within 60 days of the end of each quarter.

Annual activity reports will be prepared by the MOH with the support of the Technical Coordinator and will be furnished to GAVI 60 days after the end of the calendar year. The progress report will then be presented as part of the progress report of Manas taalimi at the spring health summit.

In addition, if the mechanism proposed in (C) is accepted by the GAVI Secretariat, these reports will be supplemented by the procedures for financial reporting put in place by Joint Financiers. These are described in detail in the Financial Management Operational Manual.

e) If procurement is required, what procurement mechanism will be used?

In the context of the SWAp, all procurement is conducted corresponding to the Kyrgyz public procurement law which corresponds to international requirements and best practices. All international competitive bidding and involvement of Technical Assistance requires approval from joint financiers.

Procurements under the current Proposal will be included into the Annual Procurement Plan of the Manas Taalimi Health Reform Program. The Plan is prepared by the MOH and reviewed by all participating donors, including GAVI in the future, during the fall Health Summit (September).

The Procurement Unit of the MOH will be responsible for all of the procurement-related activities. The procurement procedures have been agreed with the participating donors and are described in detail in the Procurement Manual and the Development Grant Agreement concluded between the Government of the Kyrgyz Republic and the International Development Association on March 10, 2006.

f) How will use of funds be audited?

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. Hiring of an international audit company is in the process in order to provide in-service training for the staff of the Unit. 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.

g) What is the mechanism for coordinating support to the health sector (particularly maternal, neonatal and child health programs)? How will GAVI HSS be related to this?

The bi-annual **health summits** serve as the highest forum for coordinating health system support both at the policy and programmatic level. The spring health summit (May) focuses on evaluating implementation progress and program impact while the fall health summit (September) focuses on forward planning through preparation and approval of the costed annual plan of work and the budget. The health summits are preceded by 1-2 week Joint Reviews conducted in partnership between the MOH and development partners, the results of which are channeled into the summit itself. On the side of the development partners, the joint review and the summit is inclusive of both joint financiers and parallel financiers of the program (e.g. USAID, UNICEF, WHO, etc.) GAVI will be invited to take part in the Joint Review and the bi-annual health summits.

In general, the **MOH Department of Strategic Planning and Reform Implementation** is responsible for coordinating all health system strengthening activities under Manas taalimi including coordinating and facilitating planning, implementation and reporting processes. Maternal and child health is a priority program in Manas taalimi and direct implementation responsibility is

assigned to the **MOH Department of Prevention and Curative Services**. This assignment of implementation responsibilities ensures maximum integration of maternal and child health activities in the health system at all levels. In addition, other departments and agencies are also involved in activities relevant for immunization such as the **Public Health Department, State Epidemiology Service, Center for Immunoprophylaxis**, etc. The **Technical Coordinator for the GAVI HSS** support will work closely with these two departments and others on a regular basis and will provide a link for the GAVI secretariat in between the summits as required.

The work of the MOH is aided by a number of standing committees to provide guidance and policy input. The **ICC** for immunization is one example and the **Inter-sectoral Coordination Commission** was created under the Manas Taalimi for broader issues that go beyond the health sector. The **Technical Coordinator for the GAVI HSS** support will take part in committee meetings, provide information about progress of implementing activities, seek the support of the committees where needed, and ensure appropriate information flows.

Involvement of Partners in GAVI HSS Implementation

The active involvement of many partners and stakeholders is necessary for HSS to be successful.

Please describe the key actors in your country and their responsibilities below. Please include key representatives from the Ministry of Health, Ministry of Finance, the Immunization Programme Manager, the key Bilateral and Multilateral partners, relevant co-ordinating committees and NGOs.

Main Implementing Agencies

Title / Post	Organisation	Roles and Responsibilities related to GAVI HSS
K.Akhmatbekov (Head of Public Health Unit)	MOH	• Policy development • Advocacy in government for health • Procurement
J. Kalylov (Director of RCI)	RCI	• Training • Supportive supervision • Organization of mobile teams • Surveillance (with SES)
A. Ibraimova (Director)	MHIF	• Performance based pay for primary care
G. Aitmurzaeva (Director)	RCHP	• Social mobilization
M. Madybaev (Director)	CHSD	• Monitoring, evaluation, and analysis (with RMIC and RCI) • Development of information technology

5. Additional comments and recommendations from the National Coordinating Body (Health Sector Strategic Committee / ICC)

The Health Policy Council of the MOH fully approved the GAVI HSS Program Proposal, plan of work and costing. The Health Policy Council expressed the importance of the proposed GAVI HSS Program to strengthen the health system and acknowledged its great potential contribution to Manas taalimi and the SWAp.

DOCUMENTS REQUIRED FOR EACH TYPE OF SUPPORT

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form	#1	
ALL	Comprehensive Multi-Year Plan (cMYP)	#2	
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed	#3	
If relevant	Endorsed minutes of the ICC meeting discussing the requested GAVI support	#4	
HSS	National Health Sector Strategic Plan (Manas taalimi) Manas taalimi Monitoring Instrument	#5.a #5.b	
HSS	Medium Term Expenditure Framework **	#6	
HSS	Recent Health Sector Assessment documents	#7 (a-k)	
HSS	Outline of HSS Programme with budget and Justification for support or HSS Relevant parts of National Planning Document	#8 (HSS Program) #9 (POW and costing)	
HSS	Other Health Systems Strengthening Plans / estimates	-	
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)	N/A	
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)	N/A	
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)	N/A	

** Please indicate the duration of the plan / assessment / document where appropriate*
*** Where available*