Impact evaluation of the Community Action for Health (CAH) project in Kyrgyzstan

Phase I-VII (April 2002 - March 2017)

Report

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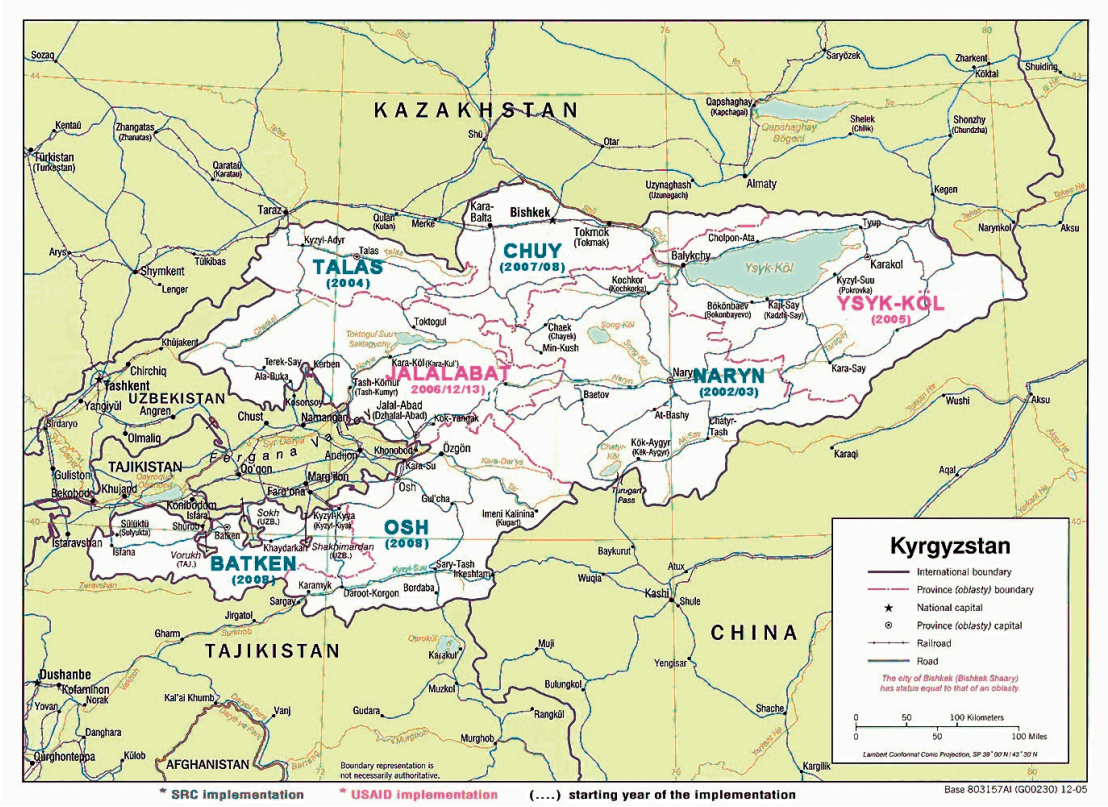
February 2017

MAP OF KYRGYZSTAN WITH OBLASTS AND YEARS OF INCLUSION INTO CAH PROGRAMME[1]



[1] Source: Community Action for Health Project Document, Phase VII, April 2014 – March 2017

ACKNOWLEDGMENT

The evaluation team wishes to record its grateful appreciation to the many people who gave time from their busy schedules to inform the evaluation team of their views, experiences and knowledge. The meetings were open and provided a wealth of insights.

We also want to express our gratitude to national partners, both from Ministries and local institutions, Development Partners who met with the evaluation team and answered its questions, and to all the stakeholders, who made themselves available and showed interest in the evaluation.

Special words of appreciation are due to the Project Coordinator at the time of the evaluation, Tolkun Jamangulova, for going to great lengths to respond to the questions and needs of the team. The evaluation team was impressed by her efficiency and expertise and enjoyed her pleasant company.

DISCLAIMER

ACRONYMS

AVHC	Association of Village Health Committees
CBO	Community Based Organization
CAH	Community Action for Health
DAC	Development Assistance Committee
DR	Desk Review
EF	Evaluation framework
ET	Evaluation Team
FAP	Feldsher Accoucher Point
FGD	Focus Group Discussions
FGP	Family Group Practices
FMC	Family Medicine Centres
GDP	Gross Domestic Product
HPU	Health Promotion Unit
HPU	Rayon Health Promotion Units
IC	Infection control
IDI	In-depth Interviews
KSHRSP	Kyrgyz-Swiss Health Reform Support Project
KYSSHP	Kyrgyz-Swiss-Swedish Health Project
LF	Logical Framework
MCH	Mother and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
OECD	Organization for Economic Co-operation and Development
PHC	Primary Health Care
RCHP	Republican Center of Health Promotion
RHC	Rayon Health Committee
RHC	Rayon Health Committees
RHCP	Republican Center of Health Promotion
SDC	Swiss Agency for Development and Cooperation
SIDA	Swedish International Development Cooperation Agency
SRC	Swiss Red Cross
SV	Site Visits
SWAp	Sector Wide Approach
TOC	Theory of Change
TOR	Terms of Reference
UHC	Urban Health Committee
UNEG	United Nations Evaluation Group
VHC	Village Health Committee

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EXECUTIVE SUMMARY

Since 1999 the Swiss Government is supporting the health sector reform in the Republic of Kyrgyzstan. In 1999, the Swiss Red Cross (SRC) was mandated by the Swiss Agency for Development and Cooperation (SDC) to assess the health care situation, facilitate the planning platform and implement the designed project – the Kyrgyz-Swiss Health Reform Support Project (KSHRSP). In early 2000 the SDC was approached by the MoH to design a program in the area of health promotion in rural areas. As a response to this request, since 2002, SDC has been supporting health promotion activities through the project "Community Action for Health" (CAHP). The project was implemented by the SRC in 7 phases with a total budget of CHF 24'500'000. The CAHP began with a pilot in one rayon and today is replicated countrywide.

CAH model: The Community Action for Health (CAH) model was designed to facilitate communities to gain more control over their health and wellbeing, through the formation and capacity development of Village Health Committees (VHCs). The VHCs are community-based organizations without legal status, elected by their communities, that engage in voluntary activities aimed at improving the health of their communities. At the rayon level, VHCs are organized into Rayon Health Committees (RHCs), which are registered as non-profit organizations. The RHCs in turn form the national Association of VHCs (AVHC), which represents the interests of VHCs in their dealings with the Ministry of Health (MoH) and other government agencies, partners and donors, and is the contractual agency for the cooperation of VHCs with the MoH and other interested parties. It supports VHCs in their organizational development and provides a forum for exchange, discussion and decision-making on guidelines and policy within the VHC movement.

The model is implemented through a partnership between the national health institutions, MoH, represented by the Republican Health Promotion Center (RHPC) and VHCs. The Health Promotion Units (HPUs) in rayons and oblasts are the key partners of the VHCs on the health system side. They regularly visit the VHCs, providing training and support. As staff of the Family Medicine Centers (FMCs) HPUs are part of the primary health care (PHC) system but are trained and guided by the RHPC. Apart from the health system, as independent civil society organizations, VHCs also collaborate with Local Self Governments (LSG) structures and other community-based organizations.

Health actions of VHCs cover a broad range of issues drawn from the analysis of community priorities and from additional public health priorities. Health actions are designed by the RHPC, and HPUs train the VHCs to implement the health actions. The VHCs members then visit people in their homes to discuss the health issue with the help of information material. The VHCs involve members of school parliaments[2] in all health actions and work with other organizations as appropriate (local primary care providers, local self-government structures, veterinary services, etc.). VHC members receive no remuneration for the time spent on any of these health actions.

The overall goal of the CAH project aimed to improve population health in rural areas of Kyrgyzstan through operationalization of VHCs. The Project had two overarching objectives: i) to enable rural communities to act on their own for the improvement of their health measured by improvement of the population knowledge and behavior and ii) to enable the governmental health care system to work in partnership with

[2] "School parliament" is a student representation body elected in all Kyrgyz schools.

communities for improving health.

With the nationwide network of citizen driven VHCs on micro level, RHCs on meso level and the AVHC on national level combined with the structure of the RHPC at national level and Oblast and rayon HPUs on meso level, the CAH model has a unique structure to achieve tangible impact in improved health of the population in Kyrgyzstan.

Impact of CAH model: The health promotion actions carried out by VHCs among rural population along with other reform actions of the Government, resulted in the decrease of Infant, under five child and maternal mortality rates, as well as lowering mortality rates due to the Cardiovascular diseases. The CAH project was effective in improving health awareness and promote behavior change among communities. Well planned and effectively implemented thematic health prevention campaigns by VHCs, contributed to the above stated improvements. VHCs educate community members on various health and nutrition topics, as well as promote good health care seeking behavior.

The CAH model had an impact on the strengthening of the Kyrgyz health system, particularly the health promotion. Capacity building interventions supported by the project played an important role in institutional establishment and enhancement of the health promotion sector. The latter has been strengthened at all, national, oblast and rayon levels, but less progress was observed in building PHC health personnel capacity in working jointly with VHCs and ensuring delivery of coherent health messages and quality health services to the population.

Of five governance dimensions, the CAH model focused on participation and non-discrimination. The CAH approach clearly works to increase the voice of citizens (participation) through the VHCs and deeper relations with the state governing system. Local health priorities are also determined through a participatory approach, though the project payed less attention to inclusion of the poor, elderly, young and disadvantaged (non-discrimination). The constant encouragement of VHCs to seek collaboration with local-self government agencies enhances participation of people in decisions of these bodies and can potentially improve accountability and transparency, as numerous examples suggest.

CAH model was replicated nationwide with the support of externally funded projects and used as a vehicle for local community development. Empowered community members, especially women, got new opportunities for realization of their rights. CAH model created jobs in rural communities. Community and VHC members were employed through the income-generation projects supported by the small grants component of the project. Income generation experience motivated to remain a member of VHC, but negatively influenced renewal of VHC membership.

Effectiveness: There are well documented results of the health actions undertaken by the VHCs in terms of improved health awareness and behaviour of people; increased women's roles in community management and official public affairs as well as on greater civil society involvement in local self-government affairs.

The CAH model proved its effectiveness early in implementation and encouraged the MoH to promote country wide replication and introduction of the model in urban areas. The CAH programme has been endorsed by the Ministry of Health and is part of the health reform programme (Manas Taalimi and Den Sooluk) since 2005. The model presently (at the end of SDC support) covers 1700 Village Health Committees

(VHCs) or 87% of rural communities in Kyrgyzstan, representing about 75% (more than 5 million) of the total Kyrgyz population and approximately 18000 village level volunteers. The volunteers operate through the VHCs that are grouped within a district (rayon). A demonstration of their level of organizational development is that 58 Non-Government Organizations (NGOs) have been established to cover the 1700 VHCs.

An urban model of CAH, already introduced in rayon centres and towns of the country and in the capital, are yet in early years of its formation and has been modified according to the urban context. Urban Health Committees (UHC) are a group of volunteers from public institutions such as education institutions, public offices, production sector etc. and community representatives from condominiums.

The population plays an active role in health promotion. This is demonstrated by their involvement in health campaigns including school parliaments and households at the community level, which helps the population to improve their knowledge and to retain information on various health issues. The project made attempt to ensure equal inclusion of women and men into the health promotion activities by addressing high-risk behaviour. Male/female involvement varied by topic of the health promotion campaign. Male involvement was active in such health actions as brucellosis, malaria, alcohol and tobacco control, whereas women dominated in the health actions related to nutrition, danger signs of pregnancy and etc.

The CAH model enables communities to gain more control over the determinants of their health. Typically, this is achieved through addressing self-identified initiatives on most vulnerable population, for example, unemployment and migration, disability etc. There is evidence, that this is happening. However, the review concludes, that enabling individuals to gain more control over their lives is an under-developed aspect of the CAH and the main focus is on health, largely through the delivery of centrally planned health campaigns.

The CAH model was used as a driver for the introduction, capacity building and empowerment of public health structures from central to facility level. In the first phase of the project, there was no dedicated health promotion structure in the health system. VHCs displayed enthusiasm for this voluntary work and showed potential to become independent civil society organizations and a valuable partner of PHC staff for health promotion in the villages. With this proof of concept the MoH established Health Promotion Center (RHPC) at national level and Health Promotion Units (HPU) in PHC system of each rayon of the country and put the RHPC in charge of coordinating the extension. At present, the system employs 130 health promotion staff at rayon levels, majority of them without basic medical education. Most CAHP trainers have become HPU staff, preserving know-how. The RHPC received intensive capacity development from the SDC-funded project. The health promotion structure has been further supported and its capacity advanced by other development partners. During the extension, a number of health actions were developed on diseases that had been prioritized by the people and were major public health issues, including hypertension, iron deficiency anemia, iodine deficiency, alcohol consumption, nutrition in pregnancy and early childhood, brucellosis, sexual-reproductive health, hygiene/sanitation, dental health, acute respiratory infection.

VHC is seen as an additional resource for the PHC, albeit not used at its full potential. In the absence of well-functioning PHC system, the VHC has been seen as main means to work with population, and to improve the health of rural population. However, creating community demand for health services through health promotion and awareness rising activities must be adequately matched with the availability of

improved services within health facilities. CAHP promoted close collaboration of VHCs with the PHC staff and HPUs at the rayon level, Family Doctors (FD), nurses and Feldshers were the ones, who have been used by the project to enter into the community and encourage them to form VHCs. However, over the time collaboration weakened, particularly with the FDs and Nurses, whereas collaboration remained relatively effective with Feldshers at the village level. Identification and resolution of issues related to health system barriers, have been ignored by the communities and the project. VHCs to certain extend are disregarded by the formal health services and hence represent a missed opportunity in terms of harnessing their potential for health promotion. Absence of concrete interventions, either by the project or the MoH, resulted in the failure to ensure responsiveness of the supply side.

The project was instrumental in institutional and financial development of the CAH model. Organizational development of VHCs was supported with a series of seminars devoted to planning and knowledge sharing, the formation of 58 federations on rayon level (Rayon Health Committees (RHCs), registered as NGOs), and the formation of a national Association of VHCs (AVHC). AVHC capacity has been supported to strengthen organizational development and sustainability of VHCs. The project was also successful to define financial sustainability of AVHC. At present the association, as well as RHCs and VHCs have financial resources collected through income-generating funds.

The project promoted VHC collaboration with government and other non-governmental structures at community level. The VHCs show increased collaboration with women' and youth committees at community level. The VHC/CBO cooperation remains largely undefined and varies between communities. In some communities, CBO representatives are members of the VHC, but in others CBO/VHC cooperation has random character. The project encouraged the VHCs to seek support from and collaborate with the local self-government bodies, which meant to have another local partner besides the FGP/FAPs and HPUs. At the time of evaluation, majority of VHCs enjoy a good working relationship with the local self-government bodies. CAHP provided small grants to VHCs aiming at improving health related infrastructures through local municipalities, who in partnership with VHCs apply for the grants and implement them. Several committees have implemented significant improvements in health services as well as investments in other sectors, such as education, waste management, electricity, with an impact on health using the small grant. LSGs supported many VHC self- initiatives by providing organizational assistance, resources or funding. In support of VHC small grant programs only in 2015, LSGs contributed 22% of projects' funding.

Efficiency: The project design was largely informed by the VHCs and HPUs in pilot districts and was based on the lessons learned from the pilots. Resources were adequate and inputs and outputs were designed correctly to meet project objectives. The CAHP has been implemented in the most efficient way compared to its potential alternatives. The project ensured close coordination and collaboration of key stakeholders involved in health promotion. Effective coordination and division of responsibilities with other development partner supported projects, aided good policy/advocacy leverage as well as allowed more efficient use of available resources in support of CAH model. CAH project was also successful to pursue synergy and complementarities with other SDC supported projects.

Sustainability of CAH model: The government accepts the CAH model as an effective and efficient model of Primary Health Care and is part of the health reform strategy. Currently CAH is replicated country wide and represented by 1700 VHCs,

covering 87% of rural areas of the country and more than 5 million population. VHCs/RHCs and AVHC show sustainability prospects, but room for further improvements remain. The independence and sustainability of VHCs have grown over the course of the project. By 2017, only 4% of VHCs discontinued their activities. 74% of VHCs have their own resources “revolving health fund” and finance self-initiatives. AVHC is a legally established non-governmental organization, owns office space purchased by the CAH project and holds financial resources through membership fees and income generating fund (10% of income generation fees paid by RHCs). AVHC is a well-recognized partner of MoH and a member of Public Health Council under Prime Minister Administration. Similar to AVHC, RHCs are also legally established non-governmental organizations possessing own resources through membership fees and income generation projects.

The sense of ownership built by the CAH model amongst the health promotion professionals and policy makers is commendable. MoH continues to provide political support and despite financial constraints, finances the yearly training for three health actions and the annual VHC assessment and planning exercises. HPU, being a part of the PHC, is financed through PHC budget. All of these allows donor agencies to work with VHCs and HPUs on additional health issues.

Lessons Learned:

1. Well designed and effectively implemented CAH model can contribute to health gains through improving population knowledge and changing perceptions about public health related issues and influencing their health and health care seeking behavior over the time.
2. Thorough analysis of political and economic context along with social norms, beliefs and cultural peculiarities should inform the design of appropriate strategies that ensure wide community representation in VHCs, their engagement in identification of health determinants and implementation of health promotion activities.
3. Successfully establishing a VHC takes time to gain acceptance and generate community participation and ownership and there are complex local socio-political issues that may need to be addressed. PHC, as an entry point to the village community used by the project, proved to be effective strategy for mobilization of communities and formation of VHCs.
4. The composition of a VHC is critical for a successful outcome. The VHC should have wide representation from different sections of the village population, including women and men, different ethnic groups and classes, and adolescents to ensure responsiveness to the various health needs in the village. Furthermore, VHC members should be influential people within the community who are respected and who are able to represent the interests of all the different community sections.
5. CAH model design has to adequately address demand and supply side determinants of health and to avoid any potential tension that can arise from placing too much emphasis on the role of the VHCs to address the social determinants of health.
6. Generation of political support at national level and inclusion of CAH model in the reform of the national care system is vital for timely scale up of the CAH model and its sustainability.
7. To strengthen the partnership between those key stakeholders that are expected to continue enhancement of the organizational structure and delivery of the CAH model, identified as the AVHC/RHC and the MoH/RCHP, is an important lesson to be learnt.
8. Strengthening organizational capacities and empowerment of VHCs contribute to sustainability.

9. Tackling the environment fostering improvement of health literacy at institutional (policymakers, local self-government, PHC facilities), community, family, and individual level, thus improving health literacy responsiveness at all levels and in different settings (family, schools, workplaces (i.e. salt retailers).
10. Long-term commitment is crucial to induce structural changes, to change attitudes and behavior at individual level, and to support the development of new organizational values.

Recommendations

Policy Level:

- MoH to establish enabling environment for introduction of shared responsibility of PHC health professionals, HPUs and VHCs on the final health outcomes. This would require well formulated operational procedures for collaborative effort of Family medicine teams, HPUs and VHCs;
- MoH to elaborate methodology/guidance for identification and targeting of most vulnerable and disadvantaged;
- RHPC/HPU/RHCs to build capacity of VHCs, Family doctors, nurses and HPU staff in utilization of methodology/guidance for identification and targeting of most vulnerable and disadvantaged;
- RHPC to develop effective M&E system that tracks population health literacy, behavior change and access to health services;
- MOH to ensure mobilization of adequate public funding for sustainability of Health Promotion activities and CAH model.

AVHC/RHCs/VHCs:

Further enhance organization capacity of AVHC/RHCs/VHCs through:

- Organization capacity assessment of AVHC/RHCs and provision of needs and competency based trainings
- Refinement of self-assessment methodology and design of measurable results oriented indicators
- Capacity building of AVHC/RHCs/VHCs/UHCs in proposal writing, project implementation, M&E and reporting
- Development of PR and Fundraising strategy
- Elaboration of mechanisms for Urban Health Committees sustainability and institutional integration into the AVHC
- Develop/refine existing mechanism to ensure periodic renewal of VHC membership and attraction of younger members

RHPC/HPUs:

- Development of integrated M&E system enabling collection of quantitative and qualitative data, specifically measuring population's health literacy and behavior change and staff analytical capacity building
- Development of HP human resource planning and development plan
- Mobilization of public and external resources for intensification of HPU interaction with VHCs and implementation of additional health promotion activities

CHAPTER 1: INTRODUCTION

1.1 COUNTRY BACKGROUND

Since acquiring independence in 1991, following the collapse of the Soviet Union, Kyrgyzstan has been facing multiple state building challenges in the political, economic and social domains. The land locked Central Asian country has a territory of 195,000 square km and borders Uzbekistan, Kazakhstan, Tajikistan and China. The country's 5.5 million population is predominately rural (62%) and maintaining access to health services is a challenge. The main ethnic group is Kyrgyz (69%) followed by Uzbeks (14.5%) and Russians (9%)[3]. Islam is the dominant religion of Kyrgyzstan. The complex ethnic structures of Kyrgyz society, the fragile political system and the chronic tensions between North and South continue to be decisive factors of the country's politics. However, after the second revolution in 2010 with ethnic clashes in its wake a new constitution with a parliamentary democracy was instituted and the country has been relatively stable since.

The country's overall economic performance over the last decade has been volatile, reflecting several domestic and external shocks. The economy is still characterized by significant informality, reliance on a few sectors, and remittances. The global recession of 2008/2009 and later the 2010 domestic crisis made Kyrgyzstan a country with the highest budget deficit in the Europe and Central Asia region (averaging more than 5% of GDP). Nevertheless, in the last decade the country has been considered to be a champion of socio-economic reforms and has been enjoying the highest per capita donor support in the former Soviet Union. Reducing the level of poverty with promoting good governance remains the overriding development challenge for Kyrgyzstan.

Traditionally, the Kyrgyz are semi-nomadic pastoralists. Seasonal migration is still a feature of life of rural population involved in agriculture. Agricultural processing is a key component of the industrial economy. Women are still underrepresented in politics on all level, as cultural and social attitudes persist that women are less able to act in decision-making roles than men and are weaker or passive. The position of women in the Kyrgyz society differs between urban and rural communities and North and South. In urban areas women are more engaged in economic activity than in rural areas; in the more Islamic influenced South they are more restricted to house and family than in the North. Women's role in entrepreneurship activities and in the economic domain is still very weak in rural areas. On the other side, there is clearly also a broad support for an increased role of women in public affairs and many women take increasing advantage of the relative openness of the Kyrgyz society and political system.

1.2 MAIN ACHIEVEMENTS OF THE HEALTH SYSTEM REFORM

After independence in 1991 the health status of the Kyrgyz population deteriorated alarmingly, associated with severe cuts in health expenditures, a drop of life expectancy at birth, increase in maternal and infant mortality rates, rise in morbidity and coronary heart disease and stroke-related mortality rates, spread of communicable diseases (tuberculosis, diphtheria and hepatitis), growth of sexually transmitted and vaccine-preventable diseases, and the highest level of respiratory disease mortality in the region. The situation was further exacerbated by the deterioration of infrastructure and services not only in the health sector but also in water and sanitation, housing, electricity supply, waste disposal, etc.

[3] World Population Review, 2017, accessed on January 21

The MANAS Health Care Reform Programme launched in 1996 by the Government of Kyrgyzstan with the support of the international donor community aimed at the re-orientation of the system towards primary health care (PHC), rationalization of hospital services, introduction of new finance mechanisms on the background of preserving taxation as a main source of funding and the improvement in efficiency and effectiveness of services. The PHC system was restructured into a network of Family Group Practices (FGPs) with doctors and paramedical outpatient clinics (so called Feldsher Accoucher Points - FAPs) that are administered by rayon Family Medicine Centres (FMC).

Since 2006, the health reform programme "Manas Taalimi" 2006-2010 included the involvement of population and community into health protection and promotion as one of its main component. This was a direct result of the successful development of the CAH model. This reform phase also saw the introduction of a sector wide approach (SWAp), aligning the country's budget with donor support under a unified programme that includes both, direct budget support and bilateral programmes. Thus, the CAH project became part of the SWAp action plan. The Kyrgyz SWAp was recognized to be exemplary worldwide.

Health financing reforms, (introduction of single payer system, official co-payments for hospital treatment, etc.) promoted in the country resulted in the increase of the share of public funding of the health sector. Health sector funding increased from below 9% of total government expenditure in 2006 to about 13% in 2016 thanks to the Budget support received from donors[4]. The increase has contributed to a reduced financial burden on patients, although out-of-pocket payments remain high, particularly for medicines.

Despite all these reforms, the service delivery sector offers limited access /coverage, is still curative and hospital centered, inefficient and of poor quality and fails to ensure continuity of care. PHC system, which has been reformed to deliver family centered health services, lacks responsiveness, is poorly managed and technically inefficient.

Availability of professionally sound health workforce is a continuous problem faced by the health sector. Geographical maldistribution, especially staff shortage in rural areas, along with increasing brain drain, absence of effective human resource planning and development policy, hampers service availability and delivery to the population in general and to the rural residents in particular.

1.3 CAH MODEL DESCRIPTION

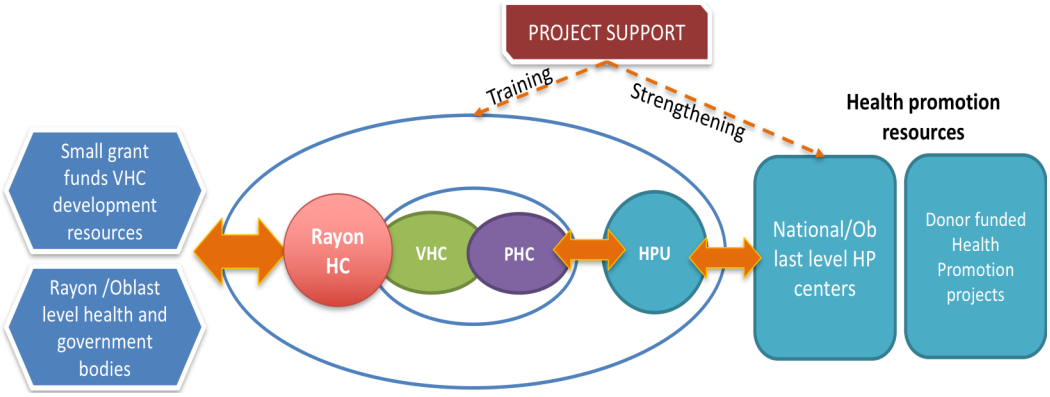
1.3.1 BRIEF CAH MODEL DESCRIPTION

Since 1999 the Swiss Government is supporting the health sector reform in Kyrgyzstan. In 1999, the Swiss Red Cross (SRC) was mandated by the Swiss Agency for Development and Cooperation (SDC) to assess the health care situation, facilitate the planning platform and implement the designed project – the Kyrgyz-Swiss Health Reform Support Project (KSHRSP). In early 2000 the SDC was approached by the MoH to design a program in the area of health promotion in rural areas. As a response to this request, since 2002, SDC has been supporting health promotion activities through the project "Community Action for Health" (CAHP). The project was implemented by the Swiss Red Cross in 7 phases with a total budget of CHF 24'500'000. The CAHP began with a pilot in one rayon and today is replicated

[4] WHO, Observatory Database, http://data.euro.who.int/hfadb/ accessed on January 9, 2017

countrywide.

Figure 1: Community Action for Health in Kyrgyzstan



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1.3.2 INTENDED RESULTS OF THE CAH PROJECT

The overall goal of the project changed through the phases, but in all phases the

[5] "School parliament" is a student representation body elected in all Kyrgyz schools.

program aimed to improve **Health in rural areas of Kyrgyzstan through operationalization of Village Health Committees.** The Project had two overarching objectives: i) to enable rural communities to act on their own for the improvement of their health measured by improvement of the population knowledge and behavior and ii) to enable the governmental health care system to work in partnership with communities for improving health.

With the nationwide network of citizen driven VHCs on micro level, RHCs on meso level and the AVHC on national level combined with the structure of the RHPC at national level and Oblast and Rayon HPUs on meso level, the CAH programme has a unique structure to achieve tangible impact in improved health of the population in Kyrgyzstan.

1.3.3 KEY PROJECT BENEFICIARIES

Key program beneficiaries vary by outcomes. For the first outcome, the key beneficiaries are the partner organizations and their staff (RHCP, HPUs, AVHC) and all VHC and RHCs. The target group for the second outcome varies according to the health action (e.g. pregnant mothers, mothers with small children in the MCH-related health action, the adult population in the hypertension health action). But in each of the subgroups the target are all people belonging to that subgroup in either rural areas or all of Kyrgyzstan, depending on the health action.

1.3.4 PROGRAM RESOURCES

The CAH Project was mainly financed by SDC. Funds for the program were also leveraged from Sida, USAID, LED, World Bank, DFID. Intended resourcing of the CAH Program, as set out in the original program documents, were as follows:

CHAPTER 2: INTRODUCTION

2.1 EVALUATION RATIONALE, OBJECTIVES AND SCOPE

Evaluation Rationale: As the CAH project is getting close to its end (March 2017), it is important to document the results, lessons learned and challenges, through the capitalization of experiences and measurement of impact at population level. The capitalization will aid to translate field experiences and tacit knowledge into explicit and documented knowledge and good practices that can be shared and used to improve performance in Kyrgyzstan as well as to benefit other countries trying to introduce similar models.

Evaluation Objectives: An impact evaluation examines the positive and negative, primary and secondary long-term effects produced by an intervention, directly or indirectly, intended or unintended. The report documents the impact of the CAH model since the beginning of the project implementation at institutional (HPUs, VHCs/RHCs/AVHC) and beneficiary levels (entire population); assesses its relevance, effectiveness and efficiency as regards to health promotion in rural areas of Kyrgyzstan; documents achievements of the project over all phases compared with its objectives as well as the population's behavior change towards healthier lifestyles. Furthermore, the evaluation also studies the organizational development of VHCs/RHCs and AVHCs and the sustainability of the CAH as a national model.

Evaluation Target Audience & Benefits: The target audience and key users of the impact evaluation findings are SDC and the main stakeholders involved in the project, including the implementing partner and selected national health institutions. The evaluation results will be mainly used for accountability, as well as transfer of best practices, capitalization and communication purposes.

2.2 EVALUATION METHODOLOGY[6]

The evaluation was conducted by an international and national consultant and was carried out in three phases between January – February, 2017. The data collection methodology (see Annex 5 for detailed methodology) comprised a mix of site visits, face-to-face in-depth interviews, desk-based research and review of existing reports, documents and available secondary data. Both quantitative and qualitative data were analyzed to assess evaluation domains and criteria. To ensure robustness of evaluation findings, the qualitative and quantitative data were triangulated across key informants, compared with available documentary evidence before drawing conclusions and formulating recommendations. The evaluation was conducted in a participatory way, involving policy makers, program staff, service providers and partners' staff, beneficiaries and their partners and other people directly or indirectly involved in the Programme at all phases of the evaluation. The evaluation ensured impartiality and independence at all stages of the evaluation process, which contributed to the credibility of evaluation and the avoidance of bias in findings, analyses and conclusions.

Evaluation Limitations: The evaluation was constrained by the absence of baseline and end-line quantitative data that limited impact and effectiveness evaluability. Due to time and budget constraints, the proposed evaluation did not include an extensive health literacy and behavior change assessment of the rural population, but largely relied on already available project related statistical and/or research data, as well as qualitative data collected through interviews and focus group discussions.

[6] Detailed evaluation methodology is provided in Annex 7: Evaluation Methodology and Framework

CHAPTER 3: ASSESSMENT FINDINGS

3.1 RELEVANCE

At the stage of project design, the CAH model was relevant to the local context and ensured that the needs and interest of target groups are addressed. The CAH model enables people to gain control over their health through analyzing the factors influencing their health. It aimed at empowerment of village communities to plan, implement and monitor actions directed at improving the population health in their communities.

Applied strategies were relevant to achieve the expected results. Harmonization and alignment with government policies were essential principles of the CAH Project from the very first pilot. It was designed to be implemented through the health system and to be open to collaboration with other projects. The CAH model also enables the health care system, especially the PHC and health promotion sector, to work in partnership with rural communities for improving health. Being a part of the health reform programme CAH it is aligned with health system policy. All project inputs were coordinated with the RHPC and through the RHPC with other donors.

The CAH model, as a rural health promotion model, is still relevant after 15 years of implementation to the needs of the population and is well aligned with Government priorities. The government health strategy 'Den Sooluk' (2012-2018) specifically refers to CAH in its plans to extend the health promotion services such that "The Community Action for Health will receive legal status and will be applied in all regions of the country".

3.2 EFFECTIVENESS

There are well documented results of the health actions undertaken by the VHCs in terms of improved health awareness and behaviour of people; recognized effects of the programme on women's increased roles in community management and official public affairs as well as on greater civil society involvement in local self-government affairs.

The CAH model proved its effectiveness early in implementation and encouraged the MoH to promote country wide replication and introduction of the model in urban areas. The CAH programme has been endorsed by the Ministry of Health and is part of the health reform programme (Manas Taalimi and Den Sooluk) since 2005. The model presently (at the end of SDC support) covers 1700 Village Health Committees (VHCs) or 87% of rural communities in Kyrgyzstan, representing about 75% (more than 5 million) of the total Kyrgyz population and approximately 18000 village level volunteers. The volunteers operate through the VHCs that are grouped within a district (rayon). A demonstration of their level of organizational development is that 58 Non-Government Organizations (NGOs) have been established to cover the 1700 VHCs.

An urban model of CAH, already introduced in rayon centres and towns of the country and in the capital, are yet in early years of its formation and has been modified according to the urban context. Urban Health Committees (UHC) are a group of volunteers from public institutions such as education institutions, public offices, production sector etc. and community representatives from condominiums.

The population plays an active role in health promotion. The review found that the rural population of Kyrgyzstan does play a role in health protection and promotion. This is demonstrated by their involvement in health campaigns including school parliaments and households at the community level.

All interviewed VHC leaders and community members reported that their communities had participated in health campaigns. There is evidence, that these campaigns are helping the population to improve their knowledge and to retain information in regard to danger signs of pregnancy and specific hygiene behaviors, alcohol, nutrition, etc.

Good practice: Results of Health Actions on Iodine Deficiency Disorders

Iodine Deficiency Disorder was one of the first health problem defined by the communities as a priority. The information campaign on this topic was conducted first in one oblast and then covered all oblasts in the country. During this campaign the VHC members disseminated information on impact of iodine deficiency and about rules of correct storing of salt to preserve adequate level of iodine in it. In addition, using rapid tests kits for monitoring salt iodization, allowed VHCs to measure iodine level in salt at households and at village grocery stores. Based on the results of massive salt iodization monitoring in their communities, VHCs prepared information about the quality of salt produced by different companies and disseminated among population as well as grocery shops. By doing so, demand on iodized salt increased that encouraged grocery shops to sell only the iodized salt in their communities.

The CAH model attempted to meet women's and men's differential health needs, but focus on most marginalized and disadvantaged was less evident. Where biological sex differences interact with social determinants health policy efforts must address these different needs. Not only must neglected sex-specific health conditions be addressed, but sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias. The project made attempt to ensure equal inclusion of women and men into the health promotion activities by addressing high-risk behaviour.

Good practice: Focus on vulnerable community members

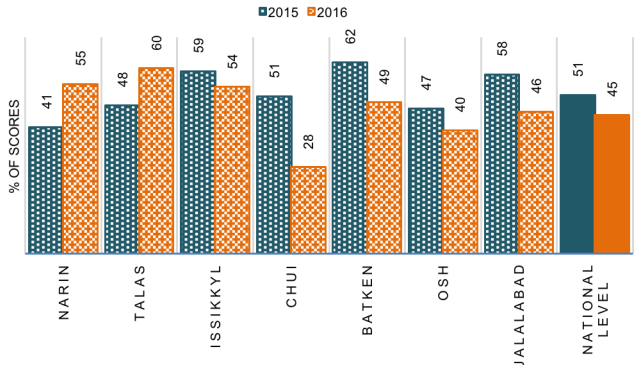
The VHCs initiated different income-generating activities using small grant funding made available by the CAH Project. One VHC bought sheep, cared for them and then got an offspring. Since the overall number of sheep increased, the VHC members decided to support poor families in their community and gave one sheep per each family. Part of the sheep was sold and the received money was transferred to the VHC's Health Revolving Fund.

CAHP has not specifically addressed the health needs of men, but these are partially covered in the MoH campaigns that address CVD, HIV, TB, brucellosis, alcohol and antismoking, etc. Male/female involvement varied by topic of the health promotion campaign. Male involvement was active in such health actions as brucellosis, malaria, alcohol and tobacco control, whereas women dominated in the health actions related to nutrition, danger signs of pregnancy and etc.

Good practice: Local competition promoting male participation

The VHC as part of self-initiative organized a local competition on the theme of "Responsible Fatherhood". Out of volunteers 12 males were selected and asked to answer questions on responsible parenting. Winners, who answered all questions of the competition, received certificates and gifts. The contest allowed to attract the attention of men to positive fatherhood issues in the community and promotion of the equal role of fathers and mothers in the stimulation of child development and growth.

Figure 2: Degree of VHC focus on most vulnerable population[7]



The CAH model enables communities to gain more control over the determinants of their health. Typically, this is achieved through addressing self-identified initiatives on most vulnerable population, for example, unemployment and migration, disability etc. There is evidence, that this is happening. For example, a poultry unit for income generation was provided to a single parent family in Naryn (Kochkor rayon) oblast. Nevertheless, the review concludes, that enabling individuals to gain more control over their lives is an under-developed aspect of the CAH and the main focus is on health, largely through the delivery of centrally planned health campaigns. In the absence of the consistent data across different phases, the evaluation examined the results of the VHC self-assessment of 2015 and 2016, and found that in only two oblasts, Naryn and Talas, focus on vulnerable is getting more attention by VHCs, but at national level it declined by 6% between 2015-2016 (Figure 2).

The CAH model was used as a driver for the introduction, capacity building and empowerment of public health structures from central to facility level. In the first phase of the project, the challenge was to develop a health promotion program in rural areas that involved communities and could become part of the national health reform program. There was no dedicated health promotion structure in the health system. The first health actions demonstrated to be successful, VHCs displayed enthusiasm for this voluntary work and showed potential to become independent civil society organizations and a valuable partner of PHC staff for health promotion in the villages. With this proof of concept the MoH established Health Promotion Center (RHPC) at national level and Health Promotion Units (HPU) in PHC system of each rayon of the country and put the RHPC in charge of coordinating the extension. At present, the system employs 130 health promotion staff at rayon levels, majority of them without basic medical education. Most CAHP trainers have become HPU staff, preserving know-how. The RHPC received intensive capacity development from the SDC-funded project. During the extension, a number of health actions were developed on diseases that had been prioritized by the people and were major public health issues, including hypertension, iron deficiency anemia, iodine deficiency, alcohol consumption, nutrition in pregnancy and early childhood, brucellosis, sexual-reproductive health, hygiene/sanitation, dental health, acute respiratory infection. The delivery of health education campaigns by the VHCs has been largely coordinated by HPU. The HPU also monitors VHC activities by interviewing community members, even using mobile phones to record questions that are asked regarding the health campaigns. The health promotion structure, established in the country, has been further supported and its capacity advanced by

> "When I was recruited as a staff member of HPU, had no idea what the health promotion was and lacked skills to perform these functions. Being the lawyer, it was difficult at the beginning to comprehend all materials delivered during the training, but later, I gained confidence in working with VHCs and training them on the topic of upcoming health promotion campaign".
> ***Quote: In-depth interview with key informant***

[7] Source: VHC Self-assessment results, 2015 and 2016

other development partners in promotion of various public health issues.

VHC is seen as an additional resource for the PHC, albeit not used at its full potential. In the absence of well-functioning PHC system, the VHC has been seen as main means to work with population and to improve the health of rural population. However, creating community demand for health services through health promotion and awareness rising activities must be adequately matched with the availability of improved services within health facilities.

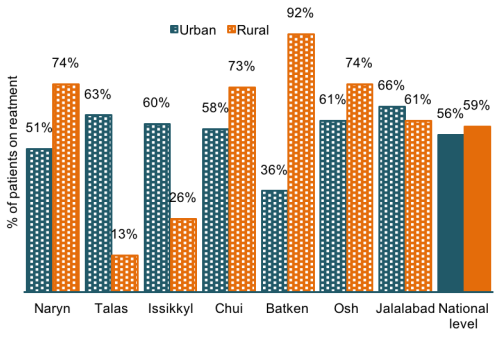
Good practice: Improving access to health care for pregnant women
During the PRA-discussions the VHC members identified the problem with timely transportation of pregnant women to health facilities in case of delivery or any other health emergency. The VHC and village representatives found joint solution of this problem: they defined the village representatives who have cars and can be responsible for timely transportation of women, and also collected funds for buying and ensuring a sufficient stock of fuel.

CAHP promoted close collaboration of VHCs with the PHC staff and HPUs at the rayon level, Family Doctors (FD), nurses and Feldshers were the ones, who have been used by the project to enter into the community and encourage them to form VHCs. However, over the time collaboration weakened, particularly with the FDs and Nurses, whereas collaboration remained relatively effective with Feldshers at the village level.

"Although there are some occasions when we inform PHC medical staff on planned activities, we do not have regular interaction with them". ***Quote: from HPU key informants***

"VHC is my right hand. They help to mobilize parents of the children for immunization, help to identify people with high blood pressure, and in general educate them on health-related issues…" **Quote: from FAP key informants**

Figure 3: Share of people with Hypertension on treatment, 2015[8]



"During national campaign, we identified people with increased blood pressure and handed over the list of people to the PHC facilities. However, our villagers were not able to receive adequate services. Firstly, when they visited the medical personnel at FAP/FMC, they delivered different messages to them regarding hypertension and secondly, immediately referred to specialists to the district PHC center. Only those villagers reached the district center, who was able to pay for transportation and medicines. Those who started treatment were not supervised by FD". ***Quotes: from VHC key informants***

The aim of Non-communicable diseases program is to strengthen the link between promotion and primary health care facilities. The Joint Annual Review (JAR) meeting of the National Program "Den Sooluk" in November 2014, concluded that new cases of hypertension, despite being effectively detected each year by the VHCs, are not always taken for observation and treatment to primary health care settings. They are neither professionally diagnosed nor registered. The substantial additional workload for family doctors related to the mandatory follow up of these patients which has to be documented together with the low wages for each newly registered case has been named as a is the reason for that. Patients with hypertension are routinely referred to a cardiologist for diagnosis or confirmation of diagnosis, adjustment of treatment, and at least once-yearly

[8] Source: CAHP monitoring results, RHPC, Kyrgyzstan, 2015

consultations. Cardiologists are typically located in FMCs at rayon level, so primary care providers are inclined to view the management of patients with CVD as the responsibility of cardiologists[9]. According to the CAHP monitoring results of 2015, the share of people with hypertension receiving treatment varies between regions and rural/urban settings (Figure 3). At national level, six out of ten diagnosed patients with hypertension receive treatment (urban 56% and rural 59%).

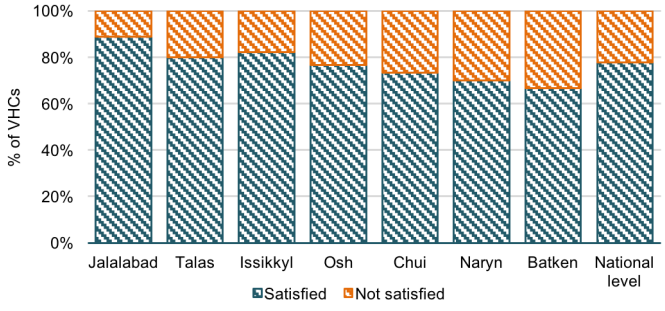
At the FMC level, HPUs have a mandate to focus on preventive activities and raise awareness of population on health issues. However, their work so far has primarily been to train and coordinate the activities of village health committees. As a result, the integration of health promotion units into primary health care has not yet achieved its full potential.

Source: M. Jakab et al., Better non-communicable disease outcomes: challenges and opportunities for health systems, Kyrgyzstan Country Assessment: Focus on cardiovascular disease, WHO, 2014

VHCs are disregarded by the formal health services and hence represent a missed opportunity in terms of harnessing their potential for health promotion. According to the results of the impact assessment of CAH project carried out in 2016, in some regions, there is a certain "tension" between health professionals and members of VHCs, particularly due to the fact that health workers seek to assert their superiority and legitimate right to work on health issues[10]. All of these resulted in a system that operated largely as a vertical system within the PHC sector oriented only towards awareness raising on health issues and consequently creation of demand for required services among population. Absence of concrete interventions, either by the project or the MoH, resulted in the failure to ensure responsiveness of the supply side. Identification and resolution of issues related to health system barriers, have been largely ignored by the communities and the project. A comprehensive, integrated approach to a multidimensional health program helps to ensure that communities ultimately access the services they need.

The project was instrumental in institutional development of the CAH model. Organizational capacity of VHCs is enhanced allowing them to manage their affairs as independent CBOs, i.e. to gradually define their own agendas and take initiatives designed to tackle determinants of health beyond the suggested health actions. Self-assessment of VHCs performed once a year allows HPU/RHC to identify weak VHCs and act upon for their institutional development. VHCs learn to mobilize resources and collaborate with other organizations in the village, the rayon and beyond. The project has offered a small grant for income generation activities to VHCs. The profit adds to the resources for own initiatives and helps cover administrative expenses.

Figure 4: VHC satisfaction with AVHC performance



Organizational development of VHCs was supported with a series of seminars devoted to planning and knowledge sharing, the formation of 58 federations on rayon level (Rayon Health Committees (RHCs), registered as NGOs), and the formation of a national Association of VHCs (AVHC). AVHC capacity has been supported to strengthen

[9] M. Jakab et al., Better non-communicable disease outcomes: challenges and opportunities for health systems, Kyrgyzstan Country Assessment: Focus on cardiovascular disease, WHO, 2014

[10] Impact assessment of the Community Action for Health Project, 2017, unpublished

organizational development and sustainability of VHCs. About 70% of all VHCs are satisfied with AVHC performance (Figure 4). The project was influential to define financial sustainability of AVHC. At present the association has income-generating fund. Albeit institutional set-up of rural CAH model is well defined, the urban model has yet to be framed.

Improved collaboration with other non-governmental structures at community level are observed. The VHCs show increased collaboration with women' and youth committees at community level. In few cases, representatives of these organizations are members of VHCs. VHCs are successful to work through school youth parliaments in promotion of healthy lifestyle (smoking, alcohol, sexual and reproductive health etc.) among adolescents. Health promotion campaigns often are implemented in close collaboration with community based organizations (CBO), but the research failed to obtain robust evidence of joint problem identification and planning practices.

The VHC/CBO cooperation remains largely undefined and varies between communities. In some communities, CBO representatives are members of the VHC, but in others CBO/VHC cooperation has random character. Particularly worrisome is VHC cooperation with Youth Committees. The latter possibly limits effectiveness of the VHC efforts to address the generational gap/ differences in knowledge, attitude and practice of different generations in the community.

"We try to coordinate our activities and involve women' and youth Committees during campaigns, but mode of collaboration is not well developed and varies from campaign to campaign …"
"We included representatives of Women' Committee as a member of VHC"
"We rarely meet and discuss community problems with Youth Committees…"
Quotes: from VHC member interviews

CAH model promoted increasing role of LSGs and engagement in addressing health determinants. The project encouraging the VHCs to seek support from and collaborate with the local self-government bodies which meant to have another local partner besides the FGP/FAPs and HPUs. At the time of evaluation, majority of VHCs enjoy a good working relationship with the local self-government bodies. LSGs supported many VHC self- initiatives by providing organizational assistance, resources or funding. In support of VHC small grant programs only in 2015, LSGs contributed 22% of projects' funding. Constant stimulation of the VHCs collaboration with the

Good practice: Rehabilitation Center for Children
Establishing of the Rehabilitation Center for children with disabilities on the basis of rural kindergarten is an example of successful collaboration of VHC, with the education sector and Local Self-Government. This idea came from the fact that children with different type of disabilities usually stay at home without the qualified care and support due to the lack of access to qualified care as well as stigma associated to disability. To address this issue, VHC members prepared proposal for opening the rehabilitation center on the premises of the kindergarten. The organization of the Center was mostly funded by the small grants component of CAHP and 10% of total funding was contributed by the LSG. In-kind contributions were made by the parents of children with disabilities. Mobilized resources were used for facility renovation; buying furniture, inventory, books. Currently the Center serves 13-15 boys and girls of different ages, some of them from the neighborhood villages. Children spend a half day five times per week in the Center and have classes according to the special program. To date, the caregivers and parents have noted the progress. Two children have already been successfully socialized: one child was transferred to general group in the kindergarten, and another child was moved to the specialized school. The parents are highly satisfied with the services provided by the Center. The Center is fully funded by the LSG, except expenses for lunch which is covered by families.

local self-government bodies, increased peoples' participation in the decision-making process and contributes to enhanced accountability and transparency of local governance.

The CAH project stimulated cross sectoral collaboration in communities. Several committees have implemented significant improvements in health services as well as investments in other sectors, such as education, waste management, electricity, with an impact on health using the small grant. CAHP provided small grant to VHCs aiming at improving health related infrastructures through local municipalities, who in partnership with VHCs apply for the grants and implement them.

The project disbursed small grants to the account of local municipality, which was responsible for financial management and conduct a tender locally to ensure the cost-effectiveness of the interventions. Since 2003, the project financed 229 small scale projects identified as apriority by the communities. Small grants funds were used by communities to: i) improve sanitation and hygiene by establishing community baths (43%), ii) rehabilitation /construction of FAPs (32%), iii) improvement of water supply (9%), iv) construction of rehabilitation center for children and provision of inventory for kindergartens (1%) and other projects (10%). Small grants programs fueled cross sectoral collaboration and improved community access to services beyond health sector.

The most effective elements of the CAH model promoted by the project were:

- The formation and first years of organizational capacity building of the AVHC was a long but good learning experience about democratic procedures, governance and the essence of a membership organization, which was entirely in the hands of the members and board of the AVHC. The process had its lengths and hurdles but ultimately resulted in valuable lessons for the VHC leaders out of own experience rather than from teaching, and it confirmed the guiding thematic approach of the project – partnership on an equal level with all involved, respect and trust in people's capabilities.
- In phase VI the project added to its long list of innovations the development and installation of a system, "Rapid Assessment with Mobile Phones" (RAMP) system, for collecting health promotion survey data with mobile phones. The phones send the data via internet to a server where they can be viewed and analyzed instantly, without the need for data entry. RAMP offers the RCHP and MoH a much more cost-effective way of using this principle. The system is currently being prepared to be offered for a fee also to other organizations working in Kyrgyzstan.
- A policy dialogue between VHCs/AVHC, MoH and donors contributes to a strategy development based on population needs. A consultative forum exists consisting of RCHP, AVHC and donors with health promotion programmes. It is convened by RCHP at the end of each year to plan the activities of the CAH programme for the coming year. In addition, CAH issues can be discussed in the Health Policy Council of the MoH where RCHP is a member and which meets quarterly. CAH activities are included in the yearly planning of MoH and in particular support for CAH is included in the Den Sooluk health sector strategy (2012-2018).

3.3 EFFICIENCY

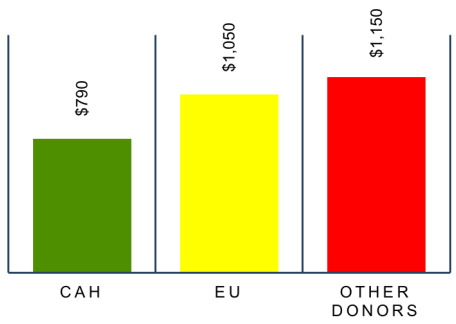
This section of the evaluation report examines whether project resources have been used efficiently in order to achieve the project outputs. In addition, analysis was carried out to conclude whether project outputs justified costs incurred and whether

there were more efficient alternative ways and means to deliver better and more outputs with available inputs.

Project resources were adequate and inputs and outputs were designed correctly to meet project objectives. The evaluation found that resources were adequate to attain desired results. This has been confirmed by majority of key informants interviewed. The inputs and outputs were designed correctly. In initial phases of the CAHP the focus was mainly on capacity building and expansion. Later the project design entailed elements and inputs of CAH model sustainability.

The CAHP has been implemented in the most efficient way compared to its potential alternatives. With help of the small grant component and contributions from villages, 56 health infrastructure objects have been built (31 health care posts and 12 bathhouses, 11 sport places/halls, and 2 drinking water systems repaired).

Figure 5: Comparison of FAP construction costs per square meter of different projects



The small grant objects are efficiently constructed, given that health care posts (Feldsher Accousher Point, FAPs) constructed by the project with highly modern technology (floor heating, highly advanced insulation techniques) cost 790 USD per square meter in 2013 in Batken. This compares very favorably with two other FAPs built in 2013 in Batken oblast, financed by other donors: a FAP financed by government funds cost 1150 USD/m^2 and one financed by the European Union cost 1050 USD/m^2.[11] The fact that none of these FAPs has the level of heating/insulation technology, FAPs constructed by the project makes this comparison even more favorable.

Another example of efficient use of resources is the development of a system for digital surveys using mobile phones, as data input devices. In this system, the interviewer no longer uses paper and pen but enters the answer into a mobile phone. The data is sent via internet to a central server. This annual survey is carried out by HPU staff. The system has its advantages in being virtually free of costs and that VHCs are involved in producing their own monitoring data. The first national survey, using new electronic system was done in the first half of February 2013 by all HPUs with about 10,000 interviews.

The project ensured beneficiary involvement in the design of CAHP activities. The first phase of the CAHP, was mainly designed without involvement of primary and secondary beneficiaries, but after the pilot phase, VHCs and HPUs were largely consulted during the project design phase. Active participation of VHCs and HPUs informed the project design and allowed to address weaknesses of the pilot and expand on the positive lessons learned.

The CAHP ensured close coordination and collaboration of key stakeholders involved in health promotion. The effectiveness of CAH model, documented at the end of the pilot phase, increased development partner interest to use the CAH model for the implementation of projects related to health promotion. Strong coordination efforts were made available through Health SWAp during the Joint Annual Reviews

[11] Information from the Office for Architecture and Town Planning, Batken Oblast

and Thematic Meetings. The latter aided good policy/advocacy leverage as well as allowed more efficient use of available resources in support of CAH model. The complementarity and effective coordination was attained by effective division of the roles and responsibilities between key actors by:

- **Geographical location:** For example, the GIZ project on Sexual Reproductive Health for students and with Tuberculosis Centre on tuberculosis among migrants helped RCHP to develop a model of collaboration with communities in urban contexts in and around Bishkek. The ICCO financed project on the promotion of migrants' rights to health supported one RHC meeting and one HPU visit to VHCs in Osh oblast. The Quality Health Care Project/ USAID financed one RHC meeting countrywide as part of the tuberculosis health action and Swiss Red Cross financed one RHC meeting in the Northern oblasts in the frame of an income generating project for female headed households. UNICEF's "micronutrient supplementation pilot project so called "Gulazyk" was implemented in Talas Oblast with active involvement of PHC staff and VHCs.

Good practice: Effective coordination and complementarity
The collaboration with other projects on health action resulted in cost-sharing (e.g. the printing of tuberculosis information material was covered by the Quality Health Care Project/USAID); the collaboration in developing that material reduced costs for both projects (designers, specialists).

- **Project inputs/thematic areas:** Several partners financially contributed to the execution of the health promotion actions through VHCs. To name the few, USAID financed educational material on tuberculosis. MoH financed two health actions and visits of HPU specialists to the villages for training of VHC members. Besides that, UNICEF financed health actions on information about danger signs during pregnancy/labor/after birth and newborn care in three Southern regions. More specifically, UNICEF supported RPHC in the development, printing of informational materials and training of HPU staff and VHCs. The Finnish Association of Lung Health financed actions on smoking prevention in three Northern regions of the country. UNDP financed HIV related health promotion activities in various parts of the country. The World Bank's project on improving transparency, contributes to strengthening connections between VHCs and local self-government bodies.

CAH project was successful to pursue synergy and complementarities with other SDC supported projects. The SDC's budget support project "SWAP" directed towards improving public health in the country with the focus on vulnerable groups, promotes equal access to the health services through effective and reliable health financing. The SWAP acknowledges and supports CAH model as a priority component of the government's health program. Within the "Health Facility Autonomy" project, Rayon Health Councils (RHC) have been established in three pilot rayons of Issyk-Kul oblast. These RHCs includes representatives from different sectors/organizations, such as representatives from LSG, health facilities, education institutions, veterinary services, NGOs, CBOs, including VHCs/RHCs and others. The given approach allowed to address health issues and determinant of health through better coordination and multi-sectoral cooperation in urban areas. As part of the "Reform of the Medical Education System" project, technical assistance is made available for the reform of the undergraduate and postgraduate medical education and ensures integration of health promotion/CAH model into the education programs. It is expected that renewed medical education programs will further advance cooperation between VHCs and PHC staff, particularly family doctors and nurses of FMCs and FAPs. Another SDC supported project, "Budget Transparency and Accountability", promotes active participation of citizens in budget formation and

monitoring of execution by active involvement of VHCs. This project will further advance CAH cooperation with LSGs.

3.5 IMPACT

This section of the report examines the overall impact of the project on the target group. More specifically, it presents impact of the CAHP on health outcomes, including in terms of disease prevalence, health perceptions, knowledge of health issues. It also examines reach of beneficiaries and looks at changes in equality.

Table 1: Impact Indicators as per Project Logical Frame[12]

Indicators	2000	2005	2010	2015
Infant Mortality Rate	22.6	29.7	22.8	18.0
Under five child Mortality Rate	33.2	35.2	26.5	21.5
Maternal Mortality Rate	46.5	61	50.6	38.5
Cardiovascular Mortality Rate	46.2 (2004)	47.3	51.5	50.8

The project contributed to the improved health outcomes. The health promotion actions carried out by VHCs among rural population along with other reform actions of the Government, resulted in the decrease of Infant, under five child and maternal mortality rates. Furthermore, lowering of mortality rates due to the Cardiovascular diseases is observed since 2010, the year when the Hypertension campaign was initiated through VHCs. The increased awareness on hypertension may have contributed to the recent decrease in CVD mortality, besides the improvements that were achieved in the quality of primary and hospital care.

The CAH project was effective in improving health awareness and promote behaviour change among communities. "The population lacks knowledge about health issues…" – this is a usual statement in many discussions about health in Kyrgyzstan. But the fact is, that population's health awareness and behaviour have been improving considerably as a result of the CAH project and the partnership for health promotion between VHCs and the government public health system (detailed list of indicators can be found in Annex 5).

VHCs are seen as having a pivotal role to play in health promotion activities by all stakeholders interviewed including direct beneficiaries. The VHCs are the main point of contact between the population and the delivery of health education campaigns in rural areas. Well planned and effectively implemented thematic health prevention campaigns by VHCs contributed to the above stated improvements. VHCs educate community members on various health and nutrition topics, as well as promote good health care seeking behavior. For example, in

Good practice: Results of Health Actions on Alcohol

During PRA-sessions community members selected increased alcohol consumption as a priority health problem in their community. In order to improve the situation in this area the VHC members undertook multiple activities. At the first stage, they calculated on average how much money family spends on alcohol during one year. Then, the VHC members with the support of CAH project and HPU staff conducted the information campaign among village population on alcohol consumption and its negative consequences for health as well as economic effect on family budget. At the same time VHC members worked closely with small shops in villages persuading them not to sell alcohol to persons under 18. In case of observed violation cases, VHC members attempted to close the shops. As a consequence of these activities the situation in villages has been changed. Currently, the overall alcohol consumption has decreased, especially among young people, and vodka is no longer used during funerals, and as a present or payment for work.

[12] National Health Statistics Department, MoH

2016, 12% of interviewed people stopped smoking and the prevalence of smoking among young people (20-24 years old) decreased by 5.6% between 2015-2016[13].

The CAH model had an impact on the strengthening of the Kyrgyz health system, particularly the health promotion. Capacity building interventions supported by the project played an important role in institutional establishment and enhancement of the health promotion sector. Health promotion sector has been strengthened at all, national, oblast and rayon levels. The project focused on strengthening skills and capacities of RHPC/HPU staff in health promotion, including communication capacities. Less progress was observed in building PHC health personnel capacity in working jointly with VHCs and ensuring delivery of coherent health promotion messages and quality health services. Whilst at the beginning PHC medical staff were trained along with VHC members, later this practice has discontinued by HPU staff.

> "There were cases when we identified people with high blood pressure and sent them to the primary health care, but medical staff when measured blood pressure informed the patients that it was within normal range and one time increase does not necessarily indicate about existence of hypertension. By doing so, they negatively affected our reputation in the community. We think, that trainings should be also provided to the health personnel to avoid similar cases and ensure that they take appropriate care of people with high blood pressure". ***Quote: from VHC member interview***
>
> "If in the first phases of the project we trained jointly PHC staff and VHC members before each campaign, later due to the limited funding trainings were targeted only at VHC members". ***Quote: from HPU member interview***

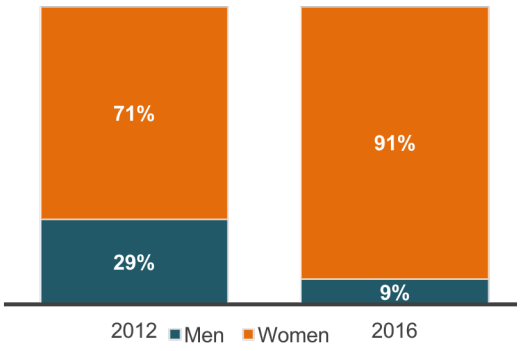
The project promoted good governance. Of five governance dimensions, the project focused on participation and non-discrimination. The CAH approach clearly works to increase the voice of citizens (participation) through the VHCs and deeper relations with the state governing system. Local health priorities are also determined through a participatory approach, but the project payed less attention to inclusion, including the poor, elderly, young and disadvantaged (non-discrimination)[14]. The constant encouragement of VHCs to seek collaboration with local-self government agencies enhances participation of people in decisions of these bodies and can potentially improve accountability and transparency, as numerous examples suggest. For example, the new project on participatory budgeting financed by the World Bank and SDC will further strengthen the link of VHCs with LSGs and the transparency of local government agencies.

> **Good practice: *HIV infection preventing measures***
> A round table on HIV was organized by the initiative of the RHC's chairmen with participation of the heads of the rayons and other stakeholders due to the rapid increase of infected individuals (16 new cases within six months of 2014). The round table resulted in a decision to organize a five-months campaign devoted to HIV prevention actions in the Issykkul region. VHC members took the lead to attract people for voluntary HIV testing, and also for conducting educational work amongst the local population on HIV preventing measures and transmission routes. The FMCs kept for all results strict confidentiality. Heads of village LSGs committed themselves to support the initiatives of VHCs aimed at raising the awareness of the local population with the focus around the workers returning from foreign countries. The five-months action resulted in voluntary testing for HIV of 10'000 people in the region. In November 2014, a summarizing round table was organized related to the World AIDS Day. The chairmen of all the RHCs, AIDS centers, HPU specialists, and representatives of different government bodies took part in this event and at the end of this cross-sectorial action VHCs were awarded with special recognition presents.

[13] Impact assessment of the Community Action for Health Project, 2017, unpublished

[14] See "Effectiveness" section of the report

Figure 6: Gender representation at VHCs 2012-2016



Gender representation in VHC membership was constrained by economic and socio-cultural context. CAH model aimed at 70%/30% representation of female/male members in the VHCs. While in 2012 gender parity was maintained, male participation decreased over the time (Figure 6). Obviously, VHCs will remain women-dominated organizations.

In the absence of well documented research on the reasons of this phenomena, the evaluation mostly relies on the feedback received from female and male members of VHCs. Key factors determining male participation named by informants are: i) female members elected by the communities as VHC members are above the middle-aged women. Most of them are either unemployed or pensioners who can dedicate spare time to voluntary work, whereas male population either have a paid job or are busy with husbandry works, restricting their ability to volunteer; ii) increasing male seasonal migration to other regions of the country as well as in neighbouring countries is another factor defining males ability to be engaged in community activities; and iii) given the gender norm that men should go out to work for pay, men who were unemployed might find it unacceptable to heavily devote themselves to nonmarket activities, especially those outside the family.

The CAHP had unintended positive and negative results.

CAH model was replicated nationwide with the support of externally funded projects. CAH model, was eagerly replicated by other development partners in different parts of the country that enabled prompt scale up. CAH model was also used for the formation of youth committees by youth projects. CAH model was used by different projects/donors as a mechanism for health promotion campaigns (HIV, TB, Malaria, Iodine Deficiency, National Immunization days, Hand Washing, UNICEF Quality project in Osh, etc.).

VHCs were used as a vehicle for local community development. Increased interest of donor financed projects in VHCs resulted in their involvement in sectors beyond health such as agriculture, food production, electricity etc. While this can be considered as a positive result proving VHC effectiveness, overstretched VHC capacity due to increase donor interest to use as a vehicle for the delivery of different services resulted in diversification of the VHC activities and diversion from

Good practice: Example of own initiative
Jalalabat oblast, Susak rayon, town of Kok-Jangak with 4 VHCs. People in this area complained about high land taxes (higher than neighbouring areas) and asked the VHCs to help. On VHC leader first approached the Ail Okmotu, to no avail. She then went to Bishkek, for the first time in her life, contacted the member of parliament for her district, explained what the VHCs are and the issue of too high taxes and the parliamentarian solved the problem.

"Over the time we were involved in number of donor financed projects beyond the health and had less time to continue our regular activities devoted to health education of villagers…"
"The project empowered our members. One of our VHC member became a member of the local council, but still remains as a member of VHC".
"I also wanted to apply for local council candidate, but the Head of the LSG asked me to lead the election process…"
"We were asked by LSG to help them during the local election".
Quotes: from VHC member interviews

the main mission of improving health of the local population. VHC engagement in health promotion activities were maintained during campaigns but regular health promotion through home visits to households and/or community meetings were no longer practiced. Furthermore, increased interest of politicians to use VHC for political purpose were also reported by key informants.

Project empowered community members, especially women, and opened up new opportunities for realization of their rights. The CAHP empowered VHC members. According to VHC members interviewed, the project provided access to evidence and new information gave them credibility within their communities. Some of them became local council members, leaving less time to work on HP activities.

> "In total around 45 VHC members became a member of local councils…"
> ***Quote: from AVHC member interview***

CAH model created jobs. Community and VHC members were employed in the income-generation projects supported by the small grants component of the project. Income generation experience motivates to remain a member of VHC, but results in close committees not allowing membership renewal and/or new membership. Majority of VHC members interviewed reported to be a member of VHC for 10-13 years. Albeit election of VHC members is carried out once in every two years, renewal of membership is less evident.

> "12 of our VHC members now work in kindergarten, which we built using grant from the CAH project…"
> "We are members of the VHC for almost 13 years. We like to work on income generation project and it motivates us to remain as VHC members… We do have any intention to change members…"
> "Or committee was stablished 12 years ago. Since then, only two members changed, as former ones became older…."
> ***Quotes: from VHC member interviews***

3.6 SUSTAINABILITY

This section of the report examines the prospects of CAH model sustainability. In particular, it assesses whether the project included strategies that ensure sustainability, how the project influenced national decision-making and policies, and whether there is likelihood that the CAH model will have lasting results upon project termination without technical and financial support from SDC.

The government accepts the CAH model as an effective and efficient model of health promotion in rural settings. The principle of community participation is internationally accepted as a desirable feature of any health system. Since its inclusion in the Alma Ata Declaration thirty years ago (WHO, 1978), countries have attempted, with varying degrees of success, to incorporate this principle in their health systems. The concept goes beyond simply being involved in the curative services of the health system and extends to incorporate both promotional and preventative health strategies as well. Preventative health is generally seen as taking positive action on health, diet, exercise and lifestyle while promotional health refers to the process of enabling people to increase control over and improve their health. The primary care, which has a strong focus on health promotion and disease prevention, is identified as the essential foundation of the health system in the Republic of Kyrgyzstan. With this in mind, health reforms led by the Ministry of Health and supported by development partners have put emphasis on strengthening the primary care system through health promotion among population, thus increasing their responsibility for their own health. The CAH model is well recognized by the public health system and it is part of the health reform strategies 'Den Sooluk' (2012-

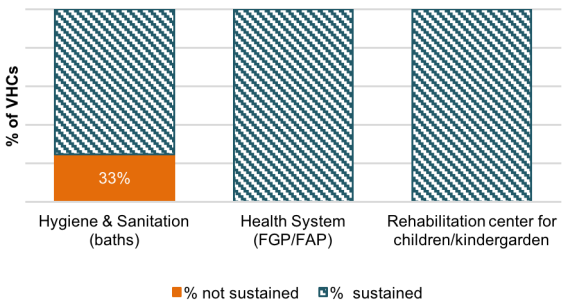
2018) as the main approach to improve quality of care. It is also an element of the National Sustainable Development Strategy 2013-2017 of the government and of the "Health Care Reforms 2020", and is ready to be fully integrated into the health system, by gradually handing over the project to the Republican Center for Health Promotion of the Ministry of Health.

VHCs/RHCs and AVHC show sustainability prospects, but room for further improvements remain. AVHC is a legally established non-governmental organization, owns office space purchased by the CAHP and possesses financial resources through membership fees and income generating fund (10% of income generation fees paid by RHCs). AVHC is a well-recognized partner of MoH and a member of Public Health Council under Prime Minister Administration. Similar to AVHC, RHCs are legally established non-governmental organizations possessing own resources through membership fees and income generation projects. The institutional development of VHC/RHC/AVHC has been largely supported by the CAHP and other donor financed projects. The technical support to the AVHC has reduced over the time in accordance with the growing ability to manage its affairs independently. Since AVHC establishment, the organization managed to leverage funding from different sources and implement number of donor financed projects (Annex 6). Nevertheless, a room for further capacity development has been identified with special focus on public relations and marketing, fund rising, proposal writing, monitoring and evaluation, data analysis and planning as well as reporting.

The independence and sustainability of VHCs have grown over the course of the project. Results of the VHC assessment in 2016 shows that only 4% out of all VHCs discontinued their operations. Notably, in comparison to CAHP 2015 assessment results, share of weak VHCs declined from 4% to 2% in 2016. As a VHC monitoring by HPUs, on average 12% of VHCs required further assistance and support from the HPUs/RHCs in enhancement of their capacities. 74% of VHCs have their own resources "revolving health fund" and spent on average 6000 Som on self-initiatives in 2016. The stimulation grants for income generation given by the project to VHCs contributed to their self-sufficiency. The other main source for newly generated money is interest rates from informal microcredit lending.

> Every year before the annual refresher training on self-assessment and planning, the HPU specialists define VHCs that are too weak for further independent and effective functioning. Instead of doing a self-assessment, those VHCs go through the process of recovery: HPU workers, with the help from FGP/FAP staff, facilitate the establishment of new VHCs' leadership, and involve previous members if they are still willing to participate.

Figure 7: Sustainability of the facilities constructed within the small grants



Facilities constructed within the small grants are sustainable and maintained by VHCs and local municipalities. Large majority of all supported grants are sustained and functional with the exception of community baths, 33% of which have been closed due to the difficulties of water and electricity supply.

The sense of ownership that has been built amongst the health promotion professionals and policy makers is commendable. The MoH is one of key

partners of the project at the central level and has endorsed the CAH Model as an approach to implement health reforms. MoH continues to provide political support to the model and despite financial constraints, supports measures to make the CAH model sustainable. The MoH finances the yearly training for three health actions and the annual VHC assessment and planning exercises. This amounts to one quarterly visit of HPU staff to all VHCs and ensures a basic level of collaboration and support. HPU, being a part of the PHC, is financed through PHC budget. All of these allows donor agencies to work with VHCs and HPUs on additional health issues.

The role of the RCHP is to coordinate CAH activities, in partnership with the AVHC and to guide and monitor the Health Promotion Units. The RHCP has gained sufficient experience in this and has been effective in lobbying changes in the MoH in favor of the CAH program. RHCP is capable of developing health actions in collaboration with specialized departments and donors. Encouragingly, the evaluation found that the RCHP is taking a leading role in steering CAH to address the MoH priority health areas and using its staff at oblast and rayon level to help deliver health campaigns in close collaboration with the VHCs. In summary, the MoH/RCHP provide the institutional structure through which CAH can be maintained at the national, oblast and rayon levels and funds to secure some running costs.

Notwithstanding, RHPC/HPU capacity yet remains insufficient and fragile to sustain CAH model without external support. The high staff turnover observed at HPUs, requires increased funding for staff capacity development which currently is predominantly externally funded. RHPC expressed a need for the development of the integrated M&E system and building staff capacity in data analysis and planning. Funding for health promotion information materials are yet financed by donors through SWAP, which has been extended till 2018. Prospects for continued public and/or donor funding are not clear thus rising sustainability risks.

Integration of health promotion education in the national continuous medical education program ensures continuous enhancement of human resource capacity. Health promotion education in Kyrgyzstan is guided by new graduate and post-graduate curricula. In 2013, RCHP has finalized the curricula on health promotion and on CAH that became a part of the continuous medial education program of PHC workers at the Institute for Continuous Medical Education. These courses were taught for the first time with the beginning of the academic year in September 2013. The project has initiated this development and provided occasional assistance.

CHAPTER 4: LESSONS LEARNED

This section of the report outlines lessons learned from this evaluation formulated based on the information obtained through desk review, key stakeholders, beneficiaries and programme staff. The lessons of CAHP in Kyrgyzstan can be shared and used to benefit other countries trying to introduce similar models.

Community Action for Health can contribute to the health gains: Well designed and effectively implemented CAH model can contribute to health gains through improving population knowledge and changing perceptions about public health related issues and influencing their health and health care seeking behaviour over the time.

In-depth assessment of local context (political, economic and social) has to be considered into CAH design: Thorough analysis of political and economic context along with social norms, beliefs and cultural peculiarities should inform the design of appropriate strategies that ensure wide community representation in VHCs, their engagement in identification of health determinants and implementation of health promotion activities.

Community orientation to the role of the VHC: The evidence from CAH interventions shows that successfully establishing a VHC takes time to gain acceptance and generate community participation and ownership and there are complex local socio-political issues that may need to be addressed. PHC, as an entry point to the village community used by the project, proved to be effective strategy for mobilization of communities and formation of VHCs.

Community Representation in the VHCs: The composition of a VHC is critical for a successful outcome. The VHC should have wide representation from different sections of the village population, including women and men, different ethnic groups and classes, and adolescents to ensure responsiveness to the various health needs in the village. Furthermore, VHC members should be influential people within the community who are respected and who are able to represent the interests of all the different community sections. If the committee reflects the narrow interests of only a small group of people, confidence may be lost in the entire programme, leading to failure. Ideally, the composition of the committee should reflect the gender balance of the community. While it may not be possible to have completely equal gender representation, because of cultural and social norms, women/men should be adequately represented to ensure that their concerns are taken into account and dealt with sensitively. The influential members of a community are not necessarily the people with administrative responsibilities within the community, rather people who are respected and act as opinion leaders, such as village chiefs, teachers, religious leaders and ordinary community members. It is best that committee members are elected by the community and have limited terms of office, to ensure that serving on the committee does not become a burden to key community members, or become a way for individuals to use the committee for personal gain. As the committee is expected to be the principal implementing body for health promotion programs, members must also have time to allocate to the committee and other health promotion activities.

CAH model design has to adequately address demand and supply side determinants of health: An important lesson to be learnt is to focus on the strengths of the CAH model to promote health in rural communities and to avoid any potential

tension that can arise from placing too much emphasis on the role of the VHCs to address the social determinants of health. The local 'health funds', for example, will not be sufficient to tackle these social key issues even at their projected rate of increase. Other solutions to address the broader social determinants are needed beyond the present scope of the CAHP which has demonstrated that its greatest success has been in addressing health education issues.

Generation of political support at national level and inclusion of CAH model in the reform of the national care system is vital for timely scale up of the CAH model and its sustainability. Documentation of evidence on the benefits, effectiveness and efficiency of CAH model should be used as an advocacy tool for generation of the political support at national level. Inclusion of CAH model in the reform of the national care system should be ensured early on to allow timely and smooth national scale up of the model. High involvement of health authorities at national, subnational and local levels in project design, implementation and M&E helps to obtain ownership and is a prerequisite for CAH sustainability.

Promote strong partnerships: To strengthen the partnership between those key stakeholders that are expected to continue enhancement of the organizational structure and delivery of the CAH model, identified as the AVHC/RHC and the MoH/RCHP, is an important lesson to be learnt. The viability and sustainability of the CAH model is especially dependent on a successful partnership between the AVHC and the RCHP because this is the relationship between a governmental and a non-governmental organization. It should be an equal and symbiotic relationship. The CAH programme in Kyrgyzstan demonstrates that a partnership between community based organizations and a Government health system is possible, is beneficial to both sides (the demand and provider side of the health system) and can be scaled up to a national level. Strong collaboration of VHCs with non-governmental structures/CBOs/CSOs (women's and youth committees) will maximize effectiveness of CAH model.

Strengthening organizational capacities and empowerment of VHCs contribute to sustainability. An important lesson to be learnt is the need to continue to build the organizational capacity of the key stakeholders including skills development and management ability and that this should be directed by a strategic plan for future implementation and further development of the CAH model. Empowerment of VHCs through provision of small grants to tackle health determinants and priorities defined by the community in close collaboration with LSGs, will further contribute to their sustainability.

Tackling the environment fostering improvement of health literacy at **institutional** (policymakers, local self-government, PHC facilities), **community, family,** and **individual** level, thus improving health literacy responsiveness at all levels and in different settings (family, schools, workplaces (i.e. salt retailers).

Ensure extended support to CAH: Long-term commitment (over 15 years) is crucial to induce structural changes, to change attitudes and behavior at individual level, and to support the development of new organizational values.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

This section of the report briefly summarizes findings of the evaluation as well as presents recommendations which possibly can ensure effectiveness and long term sustainability of the CAH model. As the CAH project is getting close to its end (March 2017), recommendations presented are developed for the consideration of the Government of Kyrgyzstan and development partners engaged in health sector.

5.1 CONCLUSIONS

CAH models have been widely recognized as having a vital role in complementing existing primary health care services and improving health outcomes of population in the Republic of Kyrgyzstan. Its role is most notable in resource poor settings where health and social services are inadequate, poverty is endemic[15]. The model proved its effectiveness by demonstrated improvements in health outcomes, knowledge and behavior change of population, and generated sufficient political support as well as sense of ownership among communities, health sector providers, and local governance structures. The CAH model is well accepted and valued by communities, but it was less effective in reaching out and empowerment of the most vulnerable and disadvantaged. Orientation on demand creation, without ensuring adequate supply of health services, reduced potential health gains the model could have achieved.

The model was successful in institutional building of VHC/RHC/AVHC as well as promoted the institutional development and capacity building of Health Promotion sector. It harnessed good governance practices by stimulation of VHC collaboration with local government structures and community-based organizations. The CAH empowered VHC and community members, created jobs and was instrumental to resolve community problems beyond health sector.

The CAH demonstrates good prospects of long term sustainability. VHCs are introduced country wide covering 87% of rural districts and more than 5 million population. It is organizationally developed and exhibits financial viability by mobilizing own resources through income-generation and membership fees. Nevertheless, to reach its full maturity, there is a need for further organizational development, capacity building and enhancement of revenue mobilization function.

Albeit the CAH model played a crucial role in the institutional development and capacity building of the Health Promotion sector in the country, safeguarding its effectiveness and long-term sustainability bears a risk if shortcomings are not addressed by the government in an immediate future. Delays in introduction and uncertainty of the public health sector reform may possibly have an impact on sustainability of the institutional set-up of the health promotion system. Irrespective of the reform design, long term sustainability of the health promotion sector requires: i) further capacity building with particular emphasis on the development of M&E and analytical capacity; ii) development of integrated M&E system enabling collection of quantitative and qualitative data, specifically measuring population's health literacy and behavior change; iii) considering high staff turnover at HPUs, human resource planning and development should be given a priority attention and finally, iv) allocation of adequate public funding for continuation of quality work on health promotion should be warranted.

[15] Irwin Friedman at al, Moving Towards Best Practice: Documenting and Learning from Existing Community Health/Care Worker Programmes, Durban: Health Systems Trust; 2007

5.2 RECOMMENDATIONS

POLICY LEVEL:

- MoH to establish enabling environment for introduction of shared responsibility of PHC health professionals, HPUs and VHCs on the final health outcomes. This would require well formulated operational procedures for collaborative effort of Family medicine teams, HPUs and VHCs;
- MoH to elaborate methodology/guidance for identification and targeting of most vulnerable and disadvantaged;
- RHPC/HPU/RHCs to build capacity of VHCs, Family doctors, nurses and HPU staff in utilization of methodology/guidance for identification and targeting of most vulnerable and disadvantaged;
- RHPC to develop effective M&E system that tracks population health literacy, behavior change and access to health services;
- MOH to ensure mobilization of adequate public funding for sustainability of Health Promotion activities and CAH model.

AVHC/RHCs/VHCs:

Further enhance organization capacity of AVHC/RHCs/VHCs through:

- Organization capacity assessment of AVHC/RHCs and provision of needs and competency based trainings;
- Refinement of self-assessment methodology and design of measurable results oriented indicators;
- Capacity building of AVHC/RHCs/VHCs/UHCs in proposal writing, project implementation, M&E and reporting;
- Development of PR and Fundraising strategy
- Elaboration of mechanisms for UHC sustainability and institutional integration into the AVHC;
- Develop/refine existing mechanism to ensure periodic renewal of VHC membership and attraction of younger members.

RHPC/HPUs:

- Development of integrated M&E system enabling collection of quantitative and qualitative data, specifically measuring population's health literacy and behavior change and staff analytical capacity building;
- Further strengthen RHPC's analytical capacity;
- Development of HP human resource planning and development plan;
- Mobilization of public and external resources for intensification of HPU interaction with VHCs and implementation of additional health promotion activities.

ANNEXES

ANNEX 1: CAH PROJECT EVOLUTION

The Program was implemented in seven phases since 2000. The Phase I of the KSHRSP (January 2000 - March 2001) focused on the rehabilitation of two rayon hospitals in Naryn oblast with the aim of increasing efficiency by downsizing them.

The Phase II of the KSHRSP (April 2001 – March 2004), while continuing investments into infrastructure improvement (two more rayon hospitals were renovated), extended the project's objectives towards hospital infection control and strengthening of primary health care and health promotion. During Phase II health promotion became the main focus of the project through the development of the community centered health promotion strategy for rural areas, the CAH programme.

In Phase III of the KSHRSP (April 2004 – March 2008), the CAH programme was extended throughout Naryn and Talas oblasts and the MoH adopted CAH as part of the national health reform strategy for 2006-2010. The small grant component, begun in phase II, was continued; it provided communities an opportunity to improve priority infrastructure defined by them (e.g. primary health care units or other health related infrastructure). Besides the CAH, the project continued with inputs into improvement of hospital infrastructure (renovation of Naryn oblast merged hospital) and of infection control (IC) in Naryn hospitals. The latter included technical assistance to the MoH in developing a modern IC strategy for hospitals.

In 2006 the Swedish International Development Cooperation Agency (Sida) joined the support of the health sector in Kyrgyzstan in the framework of the Manas Taalimi reform and the new SWAp by, on the one hand, contributing to the sectoral budget support and, on the other hand, by financing bilaterally the extension of the CAH model in the remaining three oblasts of the country, namely Batken, Osh and Chui. Sida and SDC agreed on a “delegated implementation” for the extension, whereby Sida entrusted SDC with the implementation through the existing arrangements with SRC.

This development necessitated winding up of the Phase III of the KSHRSP in May 2006 and commencing a new contractual agreement between all stakeholders for Phase IV of the project - now referred to as “Kyrgyz-Swiss-Swedish Health Project” or KYSSHP - (June 2006 - March 2008). The collaboration with Sida continued in phase V (April 2008-March 2011). Both phases focused on extending the CAH programme to the three oblasts mentioned and strengthening the sustainability of VHCs and institutionalization of the CAH.

A Gender Analysis in 2010[16] concluded that many women see the VHCs as a chance to venture out of the house and as a platform to be active in society. It described positive effects for women in all four-gender roles (reproductive, productive, community management, and political participation). VHCs also play an increasing role in promoting good governance. Many VHCs have successfully advocated at their local self-governments and higher levels of authority for action and expenditures for health issues. Thus, the project is strengthening civil society through building the capacity of VHCs to act for health.

[16] Gender Study on the CAH programme, University College of London, 2010

Following the decision of the Swedish Government to withdraw from development aid in Central Asia, Sida ended their co-funding of the project by end of 2010. The Liechtenstein Development Cooperation has co-financed Phase VI (April 2011-March 2014) under a similar delegated implementation agreement with SDC. Since phase VI the project is referred to as "Community Action for Health Project" (CAH). The non-core component of IC/waste management was continued from phase VI on under a separate project (Health Care Waste Management project - HCWM). Hospital reconstruction was not part of phase VI anymore. Focus of CAHP phase VI was the continued institutionalization of CAH in the health system and further capacity building of VHCs and RHCs and the formation and capacity building of the national AVHC. Naryn and Talas oblasts, the regions where the CAH programme began, were exited. A description of the CAH programme is attached in Annex 2. The CAH programme finds increasing interest internationally and is proudly presented by MoH officials in international forums.

This Phase VII (exit phase, April 2014 – March 2017) was designed following an external review of July 2013 and a participatory planning process with a final workshop in November 2013. Starting from 2015 the project supported formation and operation of Social Health Committees (SHC) in regional centers and small towns to cover urban areas. 31 SHCs are operating in 35 new settlements of Bishkek, and 38 SHCs in new settlements and small towns around Osh city, covering all together approximately 315,000 urban populations. 54 SHCs are formed in smaller cities and rayon centers.

ANNEX 2: CAH PROJECT THEORY OF CHANGE

ANNEX 3: LIST OF DOCUMENTS REVIEWED

1. Project Document, KSHRSP, Phase III (April, 2004 – March, 2008);
2. Project Document, KYSS-HP, Phase IV (06.2006 – 03.2008);
3. Project Document, Community Action for Health Project, Phase VI (04.2011 – 03.2014);
4. Project Document, Community Action for Health Project, Phase VII (04.2014 – 03.2017);
5. Credit Proposal, KSHRSP, Phase III (04.2004 – 03.2008);
6. Credit Proposal, KYSS-HP, Phase IV (06.2006 – 03.2008);
7. Credit Proposal, KYSS HP, Phase V (04.2008– 03.2011);
8. Credit Proposal, Community Action for Health Project, Phase VI (04.2011 – 03.2014);
9. Credit Proposal, Community Action for Health Project, Phase VII (Exit Phase, 04.2014 – 03.2017);
10. End of Phase Report, KYSS-HP, Phase V;
11. End of Phase Report, Community Action for Health Project, Phase VI (04.2011 - 03.2014);
12. Community Action for Health Project, Phase VI, Annual Report (April - December, 2011);
13. Community Action for Health Project, Phase VI, Annual Report (2012);
14. Community Action for Health Project, Phase VI, Annual Report (January, 2013 – March, 2014);
15. Community Action for Health Project, Phase VII, Annual Operational Report (2015);
16. External Review of the KSHRSP, Phase II (July, 2003)
17. Gender Analysis of the KSSHP, Phase V (June, 2010)
18. External Review of the KYSS-HP, Phase V (July- August, 2010)
19. Sustainability of Village Health Committees and Rayon Health Committees, A Study for Swiss Red Cross – Community Action on Health (INTRAC Central Asia Programme, January-March 2011);
20. External Review: Community action for Health in the Kyrgyz Republic (CAH) Project, Phase VI (April, 2011 - March, 2014)
21. Community Action for Health in the Kyrgyz Republic. Overview and Results, Tobias Schueth and co-authors, Swiss Red Cross, April, 2014;
22. Impact Assessment of the CAH Project, 2016;
23. Assessment of knowledge and awareness among population of Osh, Batken and Jalalabad oblasts about the danger signs of pregnancy and childhood illnesses, UNICEF, 2014;
24. Follow-up survey of nutritional status in children 6-29 months of age, Kyrgyz Republic, UNICEF, 2013.

ANNEX 4: LIST OF PEOPLE MET

Organization	Name	Position
Swiss Embassy/Swiss Cooperation Office	Danielle Meuwly	Deputy Head of Mission/Deputy Head of Cooperation
	Elvira Muratalieva	Senior Program Officer
The CAH Project	Tolkun Jamangulova	Project Coordinator
	Rachat Aidaraliev	Coordinator of Health Promotion Component
	Ryspek Isaev	Coordinator of Health Promotion Component, South branch
MoH	Baktygul Ismailova	Head of Health Promotion Department
RHPC	Gulmira Aitmurzaeva	Director of RHPC
	Baktygul Toktorbaeva	Head of Department on work with communities
PEN team of MoH	Roza Djakypova	Project Coordinator
	Alina Altymysheva	Secretary of the Coordination Council on NCD of the MoH
Kyrgyz - Finnish Project on Tobacco prophylaxis	Anara Kalieva	Project Coordinator
Development Policy Institute	Nadezhda Dobretsova	Chairperson of the Board
USAID	Svetlana Asanhodjaeva	Quality Project, Deputy of the Project Manager
WHO	Jarno Habicht	The WHO Representative and Head of Country Office
	Oskon Moldokulov	National Professional Officer
UNICEF	Damira Abakirova	Health and Nutrition Officer
WB	Asel Sargaldakova	Health Specialist
Bishkek Centre of Health Promotion	Nazgul Akmatalieva	Head of the Center
Kochkor Rayon Family Medicine Center, Health Promotion Unit (HPU)	Gulkair Tentieva	Doctor of HPU
	Nurjan Baizakova	Nurse of HPU
Kochkor RHC	Dyikanbek Kadyrov	Head of Kochkor RHC
	Kaliman Artykbaeva	Member
	Tymar Bekkoshoeva	Member
	Jumakul Kurmanbaeva	Member
Kochkor FMC	Medet Jumaev	Ex-Director of Kochkor FMC
Buguchu VHC of Kochkor rayon	Mahabat Ybysheva	Head of Buguchu VHC
	Rapiya Kubatbekova	Member
	Nurjamal Imanalieva	Member
	Anar Isaeva	Member
	Almagul Isaeva	Member
	Zina Januzakova	Member

	Nurjamal Abylabekova	Member
	Aigul Asanbekova	Member
	Damira Beisheeva	Member
	Mira Bolotbekova	Member
LSG	Nurlan Akmatov	Head of local self-government (LSG)
Issyk-Kul Oblast FMC	Esenbek Satylkanov	Director of Oblast FMC
Issyk-Kul Oblast HPU	Maksat Kyrmanov	Head of Oblast HPU
	Erlan Mukashev	Member
	Nurjan Noryzbaeva	Member
LSG	Turar Asanaliev	Head of local self-government (LSG)
Rehabilitation Center for Children with Disabilities	Janyl Akmatova	Head of the Center
Saruu VHCs of Djeti-Oguz rayon	Klara Shekenbaeva	Head of Saruu VHC #1
	Zinagul Iskakova	Head of Saruu VHC #2
	Salamat Atabaev	Member
	Albina Eralieva	Member
	Cholpon Toktogonova	Member
	Elnura Kanibetova	Member
	Almagul Davuletova	Member
	Mahabat Kenenbaeva	Member
Ulahol VHC of Ton rayon	Aium Abdrazokova	Head of Ulahol VHC
	Umut Shailoobekova	
	Asya Abaskanova	
	Ruslan Kadyrov	
	Nurkul Erkinbaeva	
	10 people	Ulahol Village Residents
LSG	Ishenbai Sabitakunov	Head of local self-government (LSG)
Association of Village Health Committees	Aigul Il'yasova	Executive Director
	Gulnara Rahmatova	Accountant
	Halima Usmanova	Program Coordinator
	Venera Toktogonova	Program Coordinator
	Rakhat Mamytkanov	Program Coordinator
	Bakyt Kushnazarov	Program Coordinator
RHPC, Osh	Elnura Mamatova	Staff of RHPC, South branch
HPU	Gulzada Anarkulova	Head of HPU of Osh city
Bek-Djar VHC of Kara-Suu rayon	Tallahan Shaipova and 15 members	Head of Bek-Djar VHC
LSG	Abibilla Ermenov	Head of local self-government (LSG)
HPU, FMC of Osh city	Alima Urbaeva	Doctor of HPU
	Ulukbu Ergeshova	Nurse of HPU
Public Health Committee of Osh city	7 people	Public Health Committee members

ANNEX 5: HEALTH AWARENESS AND BEHAVIOUR CHANGE INDICATORS BEFORE AND AFTER HEALTH ACTIONS

Health Action	Indicators	Before*	After*	The latest data**
Brucellosis	Presence of four indicators of **brucellosis** prophylaxis (holes for placentas, lambing place, gloves, disinfection) in homes with sheep/goats/cows in villages			
	Naryn oblast	12-32% (2007)	42-81% (2011)	
	Batken oblast	2-12% (2007)	44-62% (2011)	
Hypertension	No. of people newly detected with high blood pressure (all oblasts)	0 (2010)	57 044 (2013)	
Danger signs in pregnancy and early childhood	Percentage of mothers able to identify at least three danger signs in pregnancy			
	Naryn, Talas, Chui, Issyk-Kul oblasts	41% (June 2012)	86% (Sept 2012)	
	Batken oblast	26% (July, 2011)	56% (Oct, 2011)	
	Osh, Batken, Jalalabad oblasts	25-40%**** (July,2013)	44-67%**** (Oct, 2013)	
	Percentage of mothers able to identify at least three danger signs in early childhood			
	Naryn, Talas, Chui, Issyk-Kul oblasts	39% (June,2012)	77% (Sept,2012)	
	Batken oblast	33% (July, 2011)	75% (Oct, 2011)	
	Osh, Batken, Jalalabad oblasts	5-24%**** (July, 2013)	4-47%**** (Oct, 2013)	
Nutrition	Percentage of pregnant women who ate meat the day before the survey	69% (2009)	86% (2013)	
	Percentage of pregnant women with anemia who took iron/folate acid	43% (2009)	66% (2013)	84,7% (2016)
	Exclusive breastfeeding of children < 6months	53% (2009)	70% (2012)	54,3% (2016)
	Gave tea to child < 6 months	24% (2009)	15% (2012)	6,7% (2016)
	Percentage of mothers who reported breastfeeding beyond the age of 6 months	68% (2009)	73% (2012)	87% (2016)
	Percentage of mothers who reported giving black tea to children 6-11 months of age	65% (2009)	44% (2012)	40% (2016)
	Percentage of mothers with children 6-24 months of age who reported giving Gulazyk	85% (2009)	71.2% (2012)	
	Percentage of Gulazyk consumption among children 6-29 months of age (every day for one month)	27.2%***** (2011)	37.2%***** (2013)	
Sexual and reproductive health	Knows about infection through needles	79% (Oct, 2011)	90% (Feb, 2012)	
	Knows about fidelity as a means of avoiding infection	10% (Oct, 2011)	31% (Feb, 2012)	
	Knows about condom use as a means of protection	22% (Oct, 2011)	44% (Feb, 2012)	
	Awareness of STD symptoms (F/M)			72%/59% (2016)
Tuberculosis	Awareness of TB symptoms (3 and more)		73% (2013)	

	Awareness of TB symptoms (persistent cough more than 2 weeks)			79% (2016)
Alcohol	Traditions around alcohol consumption, Naryn oblast (7 indicators)	29-51% (2006)	14-39% (2009)	
	Consumption among men (1 time per month)			
	aged 20-34		12.2%-18.7%*** (2012)	7,8-16,2% (2016)
	aged 35-49		12.2-18.3%*** (2012)	21,3-22,8% (2016)
Tobacco	Knows smoking is bad for health	74% (2011)	99% (2013)	
	Knows passive smoking is unhealthy	71% (2011)	96% (2013)	
	Knows tobacco creates dependency	25% (2011)	66% (2013)	
	Has a friend who smokes	29% (2011)	17% (2013)	
	Has a family member who smokes	65% (2011)	60% (2013)	
	Has a family member who smokes inside the house	35% (2011)	25% (2013)	
	Has tried smoking (school students)	31% (2011)	23% (2013)	
Iodine deficiency disorders	Household coverage with iodized salt			
	Naryn	80% (2004)	98% (2005)	
	Talas	91% (2005)	97% (2006)	
	Issyk-Kul	62% (2006)	90% (2007)	
	Batken	85% (2007)	94% (2008)	
	Chui West	85% (2007)	97% (2008)	
	Percentage of people who indicated the importance of the presence of iodine in salt			86,2% (2016)
	Percentage of people who are aware of the importance of proper storage of iodized salt			95,3% (2016)
Empowerment of VHCs	Number of own initiatives by 699 VHCs in 4 oblasts (Naryn, Talas, Chui, Batken)	300 (2007)	1450 (2013)	

ANNEX 6: AVHC IMPLEMENTED PROJECTS

№	Donors	Implemented Projects	Years
1	ICCO&Kerk in Actie	Strengthening the institutional capacity of the Association	2010
2	UNICEF	Promotion of the Program “Gulazyk”	2010г
3	GFATM/UNDP	Ensuring favorable conditions for interruption of local transmission of malaria and transition to elimination in KR	2011-2012
4	Agricultural Project Implementation Department, Ministry of Agriculture of KR	Prevention of echinococcosis and rabies	2012
5	Swiss Red Cross	The needs of Mothers	2013
6	ICCO, DCA	Promotion migrants’ rights to access to health care services on social diseases	2012-2013
7	The World Food Program, UN	Providing food assistance to vulnerable population	2012
8	CAH Project	Incentive Grant Programs for RVHCs	2014-2015
9	Health Policy Analysis Center	The study “Determining the causes of low uptake of men with high blood pressure of health care at PHC level”	2015
10	Development Policy Institute (WB Project)	“The Voice of VHCs and social accountability of LSGs on the Determinants of Health of rural communities in KR”	2014-2017
11	CAH Project	Transparency of local budgets	2014-2017
12	CAH Project	Small Grant Program in Issyk-Kul and Jalalabad oblasts	2014-2017
13	SPRING/USAID	Mobilization of communities’ efforts on issues of nutrition	2015-2017
14	«Agro Horizon» Project (USAID	Promotion of the company “AGRO WESH“ on prevention of using pesticides by small farms	2016
15	DPI, ADI и IsDB (GIZ)	The Project “Social – economic development of aiyl aimaks based on needs of local communities”	2016
16	CAH Project	The Program for elections to the local councils	2016

ANNEX 7: EVALUATION METHODOLOGY AND FRAMEWORK

METHODS OF DATA COLLECTION

The methodology will comprise a mix of site visits and observations, face-to-face in-depth interviews, focus group discussions, desk-based research and review of existing reports, documents and available secondary data. All data collected during the evaluation will be analyzed using NVivo 10™ software[17]. Summary of Methods and data collection framework are outlined below (Figure 8):

Figure 8: Data Collection Framework

Desk Review (DR): Review of documents was a major part of the assignment. The ET consulted with and obtained from SDC Country Unit all necessary documents. The list of documents reviewed is provided (ANNEX 2: LIST OF DOCUMENTS REVIEWED). The desk review will also study qualitative and quantitative secondary data available around the themes of the evaluation and informed preparation of data collection tools.

Site Visits (SV): The programme coverage extends to all regions of Republic of Kyrgyzstan. For the evaluation purpose, 20% of supported regions (2 regions out of 7 regions) were sampled using the multistage sampling methodology. Parameters used for sampling comprises number of years VHC model operates in geographical location, # of VHCs established and Share of population targeted out of total number of population (Table 2). Ranking of each indicator was performed on the scale 0-3 (meaning of the scores will be discussed separately for each indicator below).

Table 2: Site Sampling

Region	Years of operation	Ranking score	# VHC	Share of VHCs out of total number of VHC	Ranking score	# of targeted population	% of population covered	Ranking score	Total Scores
Naryn	2002	3	119	7%	1	160,000	5%	1	5
Talas	2004	3	94	6%	1	114,000	4%	1	5
Issyk-Kul	2005	2	171	11%	2	255,000	8%	1	5
Jalalabad	2006	2	431	27%	3	871,332	27%	3	8
Chui	2007	2	234	15%	2	542,000	17%	2	6
Osh	2008	1	350	22%	3	973,747	30%	3	7
Batken	2008	1	201	13%	2	321,000	10%	2	5
KR			**1600**			**323,7079**			

[17] NVivo is a qualitative data analysis (QDA) computer software package produced by QSR International. It has been designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required. The software allows users to classify, sort and arrange information; examine relationships in the data; and combine analysis with linking, shaping, searching and modeling.

In the first stage all regions were listed by their geographical location representing different parts of the country and clustered by years of VHC model operation (Table 2). The highest-ranking score ("3") was attributed to the regions where the model worked longer. On the next stage regions from each geographical cluster were mapped against number of VHCs established and share of population covered. Regions with the highest number of VHCs and population covered were ranked as high (score "3"). At the end the total ranking scores were calculated and regions with the highest and lowest scores selected for the site visits (see shaded rows in Table 2). Considering that Social Health Committees have been introduced in Bishkek and small towns of Osh regional centers covering urban population, starting from 2015, the ET decided to select Osh region (7 scores) from the cluster which commutated highest scores instead of Jalalabad (8 scores) to make sure that evaluation examines operations of health committees in both, urban and rural areas. From the lower ranked cluster of regions Issyk-Kul was sampled, as there are the highest number of VHCs.

In sampled project sites, the ET will carry out In-depth Interviews with local key stakeholders, SHCs/VHCs as well as visit service provider facilities (PHC facility) and FGDs with direct beneficiaries (see bellow).

In-depth Interviews (IDI): IDIs with various key stakeholders and individuals will be an important source of evidence for many of the evaluation questions. The objectives of IDI's are twofold: i) solicit stakeholder's views on the key evaluation questions and ii) gather data and other evidence that supports analysis.
Prior to visiting key informants IDI interview topic guides will be developed based on the Evaluation Framework to help ensure systematic coverage of questions and issues (ANNEX 2: PRELIMINARY STAKEHOLDER LIST). The interview topics are selected around the evaluation questions, but grouped and targeted according to the organization and/or individual to be interviewed (ANNEX 5: IDI GUIDE).
Focus Group Discussions (FGD): The ET selected FDGs as another method for data collection as this method is particularly suited for obtaining several perspectives from VHCs and beneficiaries about the improvements in health service quality. Based on the discussions and mutual agreement with SDC, the formal ethical clearance will be obtained.
In the context of this evaluation, the FGDs serve to capture the perspectives of service providers, as well as of direct beneficiaries. Focus group discussions will be organized in sampled project sites for beneficiaries. FGDs with beneficiaries will bring together a balanced mix of men and women. The purpose of FGDs with beneficiaries is to gauge the extent to which project support, as well as VHCs, might have contributed to improved demand of high quality services and behaviors, as well as utilization of services, measured by satisfaction. Furthermore, FGDs will also attempt to identify key bottlenecks/challenges and unmet needs of the target population. The principal topics to pursue as part of these FGDs are: i) degree of accesses to services; ii) their perception on the VHC service quality; iii) bottlenecks, challenges; iv) unmet needs.
FGDs participants will be recruited per each VHC to be visited by the ET. Each FGD will target eight to ten participants and will last about 60 minutes. For each FDG the FGD guides are designed (ANNEX 6: FGD GUIDES). The ET will conduct one FGD per each selected site, in total 2 FGDs in selected project sites. FGD for service beneficiaries are subject to SDC clarification on National Ethical Board clearance.
These methods were selected because:

- They are appropriate ones for strategy and intervention-level enquiry
- On the basis of data review during the Inception Phase, they are both feasible and

sensible
- Combined, they form a relatively effective means of triangulation
- An emphasis on interview and group/cluster discussions, particularly at field study level, maximizes the breadth of perspectives and data that can be secured.

METHODS OF DATA ANALYSIS

Triangulation of Findings: Both quantitative and qualitative data will be analyzed to assess evaluation domains and criteria. Findings based on qualitative data will be triangulated across key informants, compared with available documentary evidence and validated in the focus groups before drawing conclusions and formulating recommendations.

Qualitative data analysis will entail documentation, conceptualization, coding, and categorizing, as well as examining relationships. More specifically, it is expected that the qualitative data will allow obtaining in depth perspective on context, actors and processes related to the programs' design and implementation and testing/identification of the factors shaping the pattern of UNICEF contribution. A framework analysis approach will be mainly used for the analysis of the qualitative data obtained through the variety of the data collection methods described above. This approach is sought to allow capturing the complex environment and wide range of new issues and propositions that may emerge during the evaluation process, rather than focusing analysis on solely on predetermined propositions and prior understandings, as required in a purely deductive approach.

Quantitative data analysis will be made based on available secondary data (national Statistics, Global databases, Research, surveys and studies) and in comparison with original project objectives.

Data Verification – The ET will review data from various sources to answer main questions of the evaluation. Responses from each data source will be compared in order to identify discrepancies in country data. For treating response variations the team will establish a protocol for "treating discrepancies in the data".

Information derived from each of the sources of qualitative and quantitative used at every stage of the study will be triangulated within and between data sets with the aim of identifying common understandings of the experiences of issues at focus, as well as differences of opinion between various stakeholders. Following triangulation, the data sets will then be used to develop specific analyses, such as timelines summarizing the chronology of program implementation, descriptions of particular processes used in the design or implementation of the programs and stakeholder analyses of actor positions on specific features of the design and implementation at specific time.

DATA QUALITY ASSURACE

The following techniques will be used during the evaluation to assure the quality:
- Elements of multiple coding, with regular cross checks of coding strategies interpretation of data between local and international experts participating in the study and this will represent one of core activities of the regular meetings and/or online conferences during the evaluation when the data is collected through in depth interviews and focus group discussions;
- Respondent validation, which will involve cross checking interim and final evaluation findings with key informant respondents, along with proposed mode of

work with key stakeholders on relatively continuous basis are expected to enhance the rigor of the proposed evaluation and the evaluation results

- Triangulation of data collected from different sources during the evaluations, may help to addresses the issue of internal validity by using more than one method of data collection to answer proposed evaluation questions;

Table 3: Robustness Ranking for Evaluation Findings

RANKING	DESCRIPTION
A	The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (i.e., there is very good triangulation); and/ or the evidence source(s) is/are of relatively high quality and reliable to draw a conclusion (e.g., there are no major data quality or reliability issues).
B	There is a good degree of triangulation across evidence, but there is less or 'less good' quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence are present.
C	Limited triangulation, and/ or only one evidence source that is not regarded as being of a good quality.
D	There is no triangulation and/ or evidence is limited to a single source and is relatively weak; or the quality of supporting data/ information for that evidence source is incomplete or unreliable.

However, it is expected that the quality of the data will vary. As such, to account for the data quality and assess the strength of our conclusions we intend to use the "robustness scoring" approach for each finding. Consequently, four scores (A to D) will be used in this process. Assignment of the score will depend on an assessment of the combination of the following two criteria: a) the extent to which qualitative and/or quantitative evidence generated from different sources point to the same conclusion and b) what is the quality of the individual data and/or source of evidence (e.g., as determined by sample size, reliability/ completeness of data, etc.). Table 3 shows detailed description for "robustness score" assignment.

EVALUATION FRAMEWORK

	QUESTIONS	JUDGMENT AND INDICATORS	DATA COLLECTION METHODS				TYPE OF ANALYSIS	
			DR	IDI	FDG	SV	QUALITATIVE	QUANTITATIVE
RELEVANCE								
Q1	Was the defined model of the CAH at the design stage relevant to Government policies?	• Strategies explicitly reference analytical basis / relevant data; • Efforts made to commission analysis where gaps exist, or to identify relevant available analyses; • Objectives / activities respond to relevant national needs analyses; • Identified priority groups reflect those of national or independent analyses / policy priorities	✪	✪	✪		✪	
Q2	Is the CAH model appropriately designed, taking into account the rural context and cultural peculiarities of the population?							

Q3	Are the applied strategies the most relevant to achieve the expected results in the concerned CAH programme area?	• Extent to which strategy-level theories of change were valid and robust in the light of change	✪	✪	✪	✪	✪	✪
Q4	To what extent the needs and interests of target group and subgroups are addressed?	• Extent to which interventions as planned target the key barriers/bottlenecks faced by target group and subgroups	✪	✪	✪	✪	✪	✪
Q5	Is the CAH model as a rural health promotion model still relevant (after 15 years of implementation) to the needs of the population?	• Number and type of follow-up assessments conducted examining bottlenecks and barriers affecting target population • Findings confirm a need and validity of CAH model to minimise remaining bottlenecks and barriers	✪	✪	✪	✪	✪	✪
Q6	Is the CAH model as a rural health promotion model still relevant (after 15 years of implementation) with Government priorities?	• Government policy (ies)/strategies highlight the importance of the CAH, as a rural health promotion model	✪	✪			✪	
EFFICIENCY								
Q7	Were the available resources adequate to meet project objectives?	Resources were adequate/non-adequate (yes, no) • All planned activities implemented within available budget • All planned activities implemented were adequately financed	✪	✪				✪
Q8	Were the inputs and outputs designed correctly and to what extent have they contributed to the outcomes?	Adequate resources and timeliness of inputs (yes, no) • Extent to which instruments/modalities/delivery mechanisms and M&E processes delivered against their stated intentions • Timeliness of delivery of concerned programme area compared to anticipated timelines	✪	✪				✪
Q9	Were objectives achieved on time?							
Q10	To what extent were beneficiaries involved?	• Extent to which beneficiaries were involved at design, implementation and M&E phases (yes, no)	✪	✪	✪		✪	
Q11	Has the project been implemented in the most efficient way compared to potential alternatives?	If the plausible possibility is established, the improved results would have been achieved by: • Better responsiveness and flexibility of the Project management • Improved monitoring of risks and external factors • Shifting balance of responsibilities between the various stakeholders • Accompanying measures taken or to be taken by the government	✪	✪	✪		✪	
Q12	Does the project have enough management capacities to effectively run the project?	• Extent to which management systems support or hinder the realization of results, including M&E systems	✪	✪			✪	✪
EFFECTIVENESS								
Q13	What is the effectiveness of the grants component of the project?	• Grant component effectiveness against stated objectives (yes, no)	✪	✪	✪	✪	✪	

Q14	What are the most effective elements of the CAH model?	• Grant elements that proved attainment of results	✪	✪	✪	✪	✪	
Q15	What were the most effective results of the CAH model at institutional and beneficiary level?	• Evidence of changes (positive/negative) at institutional and beneficiary level	✪	✪	✪	✪	✪	✪
Q16	Was a risk analysis conducted?	• Evidence of risk	✪	✪	✪	✪	✪	
Q17	Was CAH implemented according to the set timelines?	• Timeliness of delivery of concerned programme interventions compared to anticipated timelines	✪	✪	✪	✪	✪	
Q18	Extent to which the CAH monitoring and evaluation results and recommendations were accounted?	• Evidence of monitoring and evaluation results used for the implementation correction	✪	✪			✪	
IMPACT								
Q20	To what extent the project has had an impact on the target group? • What is the level of behavioural change of the population towards healthier lifestyles? • To what extent has the health literacy of the population improved? • Are there any types of diseases, which have been considerably reduced or eliminated thanks to the project's activities?	• Evidence of changes in the lives of beneficiaries • Volume of any beneficiaries affected (disaggregated by gender, region etc.) • Explanations for results achieved to arise from analysis	✪	✪	✪		✪	✪
Q21	To what extent did the project address all determinants of health?	• Evidence of addressing health determinants	✪	✪	✪		✪	✪
Q22	To what extent can observed changes (in reaching objectives) be attributed to the intervention?	• Explanatory factors, to arise from analysis (yes, no)	✪	✪	✪		✪	
Q23	To what extent the new model had an impact on the strengthening of the Kyrgyz health system ad PHC level (structural and institutional changes)?	• Explanatory factors, to arise from analysis (yes, no)	✪	✪	✪		✪	
Q24	To what extent the project addressed good governance (participation of population, social accountability, and organizational governance of VHCs) and inclusion issues (targeting the most vulnerable, ensuring equity in assessing preventive and promotional services)?	• Explanatory factors, to arise from analysis (yes, no)	✪	✪	✪	✪	✪	✪
Q25	What mechanisms delivered the impact? What are key contextual features for these	• Explanatory factors, to arise from analysis (yes, no)	✪	✪	✪		✪	

	mechanisms?							
Q26	Where there any unintended positive and/or negative results and whether the negative results could have been foreseen and managed?	• Evidence of unintended positive and negative results to arise from analysis	✪	✪	✪	✪	✪	
SUSTAINABILITY								
Q27	Does the Government accept the CAH model as an effective and efficient model of health promotion?	• Extent to which CAH model is integrated into the Kyrgyz Health System (yes, no)	✪	✪			✪	
Q28	What is the degree of ownership of the model by health authorities?	• Extent to which any aspects of programming have been adopted into national programming/ strategies/ budgets • Extent to which programme supported interventions have been scaled up or replicated by others • Extent to which any benefits of investment have continued / are likely to continue should funding cease or be reduced. In other words, the extent to which the system level changes are likely to be permanent	✪	✪	✪		✪	
Q29	Are the capacities of the Republican Health Promotion Center built enough to run the CAH model without external support?	• Extent to which the Republican Health Promotion Center has adequate capabilities and resources to run CAH model independently. Specifically looking at Human resources and the organization of work in RHCs, mobilization of financial resources and external relations (yes, no)	✪	✪			✪	
Q30	What is the level of sustainability of the VHCs/RHCs and AVHC? What is the degree of ownership of the model by the community and VHCs?	• Explanatory factors, to arise from analysis, Specifically looking at organizational structure and capabilities, work systems, mobilization of financial resources and external relations (yes, no)	✪	✪	✪	✪	✪	
Q31	what extent the facilities constructed within the Small Grants are sustainable and maintained?	• Explanatory factors, to arise from analysis, specifically examining availability of adequate staffing and availability of resources for regular maintenance	✪	✪	✪	✪	✪	

IDI GUIDE

Speak to the respondent:

Good morning/afternoon/evening. My name is _____. I am a researcher carrying out a study on the evaluation of CAH project. The Main objective of the evaluation is to examine: ----------.

The interview should take about an hour. I am kindly asking for your permission if I could go ahead with this interview. All responses will be kept confidential. This means that your

interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent.

Remember, you do not have to talk about anything you do not want to and you may end the interview at any time. Therefore, I sincerely request your cooperation in responding to the following questions. However, at any time during the course of the interview, you are free to terminate the interview.

Are there any questions about what I have just explained? Are you willing to participate in this interview?

Yes: Proceed with questions
No: Thank you. Terminate the interview.

Start asking questions.

Questions for IDIs for each stakeholder to be interviewed will be selected from the Evaluation Framework prior to the interview. Schematically information to be collected through IDIs is presented in Table 4 below.

Table 4: IDI questions per type of stakeholder

Key Informant	Questions
SDC	Q7; Q8; Q9; Q10; Q11; Q14; Q15; Q18; Q21
MOH	Q1; Q2; Q3; Q4; Q5; Q6; Q7; Q8; Q10; Q11; Q12; Q13; Q15; Q18; Q20; Q21; Q23; Q24; Q25; Q27; Q29
AVHC	Q5; Q6; Q11; Q20; Q21; Q24; Q25; Q28; Q29; Q30
Development Partners	Q1; Q2; Q3; Q4; Q5; Q6; Q10; Q11; Q12; Q15; Q20; Q21; Q22; Q23; Q28; Q29;
LSGA	Q5; Q6; Q11; Q13; Q14; Q15; Q20; Q21; Q23; Q24; Q28; Q29; Q31
PHC/HPU	Q5; Q6; Q15; Q20; Q21; Q23; Q24; Q25; Q28; Q31
VHC	Q5; Q6; Q11; Q15; Q20; Q24; Q25; Q28; Q29; Q30

FGD GUIDES

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
    - Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
    - Every statement is right;
    - Please do not hesitate to disagree with someone else;
    - But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review - We are here to evaluate the training supported by the UNICEF's "Ensuring access to affordable health services in the affected areas of the country for women of reproductive age and newborns" Project
- Ask questions

Questions:

1. How will you describe the work of VHCs in your community?
2. What type of services they deliver and what is the frequency?
3. In your opinion, why the VHC is a "good" or "bad" model?
4. What are the benefits of VHC work?
5. Do you think VHC model is acceptable to the community members? Please explain why.
6. Can you please describe relation/working modality with PHC facility?
7. In your best understanding please explain which categories of population/households receive more attention from VHCs and why?
8. Please explain why are you satisfied or not satisfied with CAH model.

9. In your opinion, would VHCs continue work after the project ends? Please provide arguments for your responses. What can be done to sustain CAH model?
10. In your opinion, what other services can VHCs provide to the population?

ANNEX 8: RESULTS FRAMEWORK[18]

Expected Outcomes	Indicators	Baseline	Status as of December 31, 2015	Rate
Overall Goal: Health in rural and urban areas of Kyrgyzstan is improved	Infant mortality rate (IMR)	22.8 (2010)	20.1	↓
	Child mortality rate (CMR)	26.5 (2010)	22.8	↓
	Maternal mortality ratio (MMR)	50.6 (2010)	51.7	↑
	Cardiovascular diseases mortality rate (CVDMR)	51.5 (2010)	50.4	↓
Outcome 1: CAH Program is sustainable	Number of health promoting actions in the annual plan of Den Sooluk and number of health promoting actions, which were actually funded by MoH/SWAp	100%	In 2016, 7 mln KGS from SWAp/MoH for the first time were given for the development and printing informational materials for conducting trainings and workshops with HPU and VHCs	Partially met
	Percent of HPUs received funding from the MoH for HPU quarterly visits to VHC	100%	FMC directors are committed to the CAH program, quarterly visits are financed by FMC	Fully met
Output 1: The AVHC is a viable organization, providing effective services to its members and closely collaborating with MoH (RCHP) in steering the CAH program	Percent of administrative costs of AVHC covered by collaborating projects	100%	85% of administrative costs of the AVHC is covered by collaborating projects	Partially met
	MoU between AVHC and RCHP developed and signed	Yes	Memorandum is signed	Fully met
	Percent VHCs satisfied with the service of AVHC	50%	85% of VHCs gave to AVHC score 5 out of 10	Fully met
Output 2: VHCs / RHCs function as independent organizations, capable of planning their activities and financing essential expenditures	Percent RHCs who finance at least 2 meetings/year by themselves	75%	67% of RHCs financed at least 2 own meetings	Partially met
	Average number of own initiatives per VHC/year	>2 per VHC/year	In the “mature” regions VHCs organized 2 own initiatives per 1 VHC, in the “new” regions – 1.2 (overall average 1.4)	Partially met
	Percent VHCs involved with budget planning and monitoring of local self-government	75%	13 out of 19 plans of joint actions based on JSPN were approved by the LSGBs	Not met
	Percent RHCs involved in development of rayon public health plans	100%	43% of RHC has successfully implemented a joint plan with partner organizations at the rayon level, 23% of RHCs have implemented more than 1 joint plan with partner	Partially met

[18] During the Field Visit Results framework will be updated based on 2016 results

			organizations	
Output 3: MoH is committed to sustain the CAH program and other projects contribute to its sustainability	Existence of an incentive scheme for VHCs' members from the health system	Yes	There is no official incentive scheme	Not met
	Percent of projects cooperating with VHC that contributed to CAH Program sustainability (100%)	100%	SPRING, Agro Horizont and QHCP/USAID, UNICEF, Finish Lung Health Project, HRBF project/WB	Fully met
Outcome 2: Raised awareness and improved behavior in men's and women's health care issues among rural and urban population	Number of newly detected people with hypertension (>20'000 per year)		In 2016, 19'037 new people were detected with elevated blood pressure	Partially Met
	Percent of people, who know that cough, that lasts more than 2 weeks can be a TB symptom (>75%)		88% of people know the symptoms (survey September 2015)	Fully met
Output 4: Health promoting actions correspond to population's priorities concerning men's and women's health and are implemented in accordance with Den-Sooluk priorities	No. Health actions implemented and documented with their results by sex (9)		All the actions are documented and 2 of them with the results by sex (2015) 10'760 people took part in SHCs' PRA sessions: 4'359 males (40%) and 6'401 females (60%)	Partially Met
Output 5: A model for involvement of female and male population in health promotion in urban areas has been introduced in rayon centers and towns	Percent rayon and oblast centers and towns where SHCs have been established and are involved in health promotion (100%)		92% of all rayon and oblast centers	Partially Met