The end of phase I evaluation report

"Health Facilities Autonomy" project in Kyrgyzstan

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Acronyms and abbreviations

ALOS	Average length of stay
CGC	Consulting Group Curatio Sarl
CHF	Swiss frank
CV	Curriculum vitae
DAC	Development Assistance Committee [of OECD]
FAP	Feldsher ambulator post
FDFA	Federal Department of the Foreign Affairs
FGP	Family group practice
FMC	Family medicine center
GDP	Gross domestic product
GFA	GFA Consulting Group GmbH
GOK	Government of Kyrgyzstan
HCO	Health care organization
HFA	Health Facilities Autonomy [project]
HH	Household
HMIF	Health Mandatory Insurance Fund
JD	Job description
LF	Logical framework (log-frame)
LTE	Long-term expert
M&E	Monitoring and evaluation
MoH	Ministry of Health
NCD	Non-communicable diseases
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-pocket [payment]
PBF	Performance-based financing
PBM	Performance-based management
PF	Performance framework
PHC	Primary health care
PPM	Provider payment mechanisms
PPP	Purchase power parity
QA	Quality assurance
QI	Quality improvement
RBF	Result-based financing
SDC	Swiss Development and Cooperation
SDO	[health care] Service delivery organization
SGBP	State guaranteed benefit package
STE	Short-term expert
STPH	Swiss Tropical and Public Health Institute
SWAp	Sector wide approach
TA	Technical assistance
TB	Tuberculosis
TH	Territorial hospital
TL	Team leader
ToR	Terms of Reference
TPH	[Swiss] Tropical and Public Health Institute
VEK	VEK Consulting Ltd
VHC	Village health committee
WB	World Bank

Foreword

On behalf of the Federal Department of the Foreign Affairs (FDFA) of the Swiss Confederation, the Embassy of Switzerland in the Kyrgyz Republic contracted Consulting Group Curatio Sarl (represented by David Gzirishvili) and national expert (Aida Abdraimova) to carry out an external evaluation of the “Health Facilities Autonomy” project in Kyrgyzstan in April - May 2018.

The evaluation team expresses its gratitude to the Swiss Embassy for guidance during preparation of the evaluation and in-country mission.

The evaluation team is grateful to the project management team for their invaluable support, professional attitude toward the evaluation, and understanding of the challenges the evaluation team faced, as well as for their openness and dedication.

Finally, the evaluation team highly appreciates contributions made by all key stakeholders the evaluation team succeeded to meet during the mission and would like to thank all of them for their time and inputs.

This report was prepared by David Gzirishvili (CGC) and Aida Abdraimova (national expert) in accordance with the Terms of Reference of the End of Phase Evaluation of the “Health Facility Autonomy” Project in Kyrgyzstan, based on the methodology developed for the evaluation and agreed upon with the Swiss Development and Cooperation (SDC) in Kyrgyzstan.

Executive Summary

The Health Facility Autonomy (HFA) Project, financed by the Swiss Development and Cooperation (SDC) and implemented by the GFA Consulting led consortium was designed to promote "greater efficiency and quality in health care delivery by developing, piloting, and rolling out a Model for Health Facilities' autonomy". In the first four-year phase (2015-2018), the consortium was expected to pilot the HFA model in three pilot districts demonstrating "more autonomy and better performance" of the network of HF with extended autonomy.

The SDC commissioned an external end-phase evaluation of the project to assess whether the project has met promised results or not using OECD-DAC criteria, and to determine whether the promised HFA model is ready to be rolled out nationwide in phase 2.

The evaluation could not find an HFA model being tested as a single whole. As a concept in the country context the HFA is much clearer than five years ago, but still remains on paper – there is no "showroom" to invite sceptics or supporters for them (a) to see the idea can work in Kyrgyzstan), can benefit more than give trouble, and (b) to learn what not to do and how to make it work in other districts.

The project team has accumulated good knowledge of supporting HF in availing themselves to expanded autonomy, has created instruments necessary for that, and even tested some of them, but has been mostly confined to theoretical reasoning instead of a full-scale piloting: the HFs selected for piloting had not received noticeable autonomy (compared to other HFs) – space to apply innovative approaches, and new knowledge and skills combined with financial and non-financial incentives.

It took the Government two years to endorse the project implementation and to start the development of a legal platform for piloting the HFA model in three districts in January 2017. The review and endorsement by the health authorities of the regulations that expand managerial or operational boundaries of primary health facilities or district level (territorial) hospitals in pilot administrative units (i.e. that creates a space to be filled with the technical content prepared by the project) were still pending. Therefore, despite the long awaited green light given by the Government, the project team was not able to change staffing or organizational structure of pilot HFs, to switch to true agreement-based human resource management, or to revise health facility budgeting and resource distribution, including remuneration of the staff.

Many lessons can be drawn from the project implementation:

- Changing the current legal status of health facilities to extend the autonomy is not at all necessary Lifting regulatory restrictions on staffing and financial management was sufficient.
- Tangible steps toward decentralization in the health sector is a precondition for any kind of meaningful improvement in service delivery efficiency and equity at the grass-roots level through better performance of HF enjoying expanded autonomy. Without local ownership of the matters related to health, without a clear responsibility of local constituents for ensuring access to essential health services including investment in physical infrastructure, and without effective governance (that entails contracting health facility managers on the ground, not in Bishkek), HFA remains an attractive concept on paper. Rayon Health Councils could be a creative solution for fostering local ownership in the absence of power at the local level, but it cannot replace a true top-down reallocation of power that comes in pair with obligations.

- Health facility autonomy is as needed as five years ago – the idea to support the country in this undertaking is valid and relevant, albeit needs a more cautious and systematic approach requiring the government to demonstrate its commitment in practice, not only by inspirational statements.

- The project lost momentum at the policy level after it launched and geared mostly toward field work with healthcare providers and local constituents with the assumption that a full political support was secured (expecting just some delays in the revision of regulations). It turned out to be innacurate – a 2-year lag in formal endorsement of the project and piloting in three districts speaks for itself. This was a predictable risk associated with a frequent (often unexpected) changes in health authorities while project relied mostly on the comment of people in power. A full-scale advocacy intervention at the policy level (targeting different power centers, not just the Ministry of Health or the Mandatory Health Insurance Fund) combined with public awareness and social mobilization efforts might have benefited the project at the onset, securing high level political commitment followed by the comprehensive revision of the regulatory framework.

The problem persists – health facilities are unlikely to upgrade performance and sustain it without profound changes in the mode of management and operation.

Is the project capable of helping the country to tackle this problem taking into consideration the lessons learned? Or has the project exhausted all possibilities, and it would be reasonable to put the implementation of the idea of HFA on hold until the government advances in decentralization in the health sector, and to think about sustaining and scaling up some valuable "assets" the project has accumulated?

	Impact	Sustainability	Adherence to policy on phases and timing	Risk minimization
A1: Limiting to proviing support to health care management education		1st choice	1st choice	2nd choice
A2.1: Scaling up of selected "assets" without completing HFA model		2nd choice		
A2.2: Building the center of excellence of HFA and rolling it out	1st choice			
B1: Not continuing to phase 2 moving some interventions to other projects				1st choice
B2: Not continuing to phase 2 and retendering	2nd choice		2nd choice	

If the desire to make an impact is a prevailing aspiration, then the country can still be given a chance to complete building of the HFA model and the roll out provided that: (a) the country demonstrates its commitment for structural changes in the healthcare by its actions (can be considered as conditions for further support), and (b) the project design and implementation arrangements are revisited making it more suitable for policy advise at the national level.

If minimization of the risks is more important than contributing to the impact, then transferring some valuable interventions and results to another SDC supported project (for rolling out nationwide) or limiting the project to investing into healthcare management education and accumulation of a critical mass of professionals could be the best solution. This approach is the most suitable for ensuring the sustainability. An alternative would be to continue the project focusing on scaling up some innovations tested in the pilot districts that would contribute more to the optimization of service delivery and its efficiency rather than to the expansion of health facility autonomy.

The evaluators believe that all possibilities for striving for the maximization of the impact should be exhausted before switching to alternative options. However, if the government fails to

demonstrate its readiness for starting decentralization in the health sector, other options guaranteeing the “value for money” should be considered.

1 Introduction

1.1 Purpose and objectives of the evaluation

The purpose of the evaluation was to assess the results of piloting a health facility autonomy model in three districts of Issyk-Kul oblast implemented by the consortium of GFA Consulting Group, STPH and VEK Consulting in 2015-2018.

The following specific objectives were defined for the external evaluation (as per the ToR):

1 To evaluate the activities of the HFA project pilot phase and to assess the outputs and outcomes of the interventions, if possible at this stage;

2 To evaluate the pilot model autonomy and to provide recommendations on further adjustments and adaptations;

3 To provide recommendations to scale up the autonomy and to design following phase of the project.

1.2 Scope of the evaluation

Progress in the project implementation (from January 2015 to March 2018), measured by achievement of outputs, was the primary focus of the evaluation. Technical merits of specific instruments (or methodologies) created or used by the project was beyond the scope of evaluation. Instead, the evaluation looked at the extent to which these technical elements advanced the key stakeholders toward the next level of changes as a whole (“broader networks of more autonomous HCO with the capacity and the ability to improve performance” as per the Project Document (Figure 1, page 19)).

1.3 Methods used

The review team developed an evaluation matrix by linking the evaluation questions to different types of data, data collection methods, and sources (as shown in Figure 9 on page 27).

The evaluation heavily relied on a desk-review of secondary data to extract (a) quantitative data for the project performance measurement, and (b) qualitative data to assess changes in the project context and/to interpret the performance measurements. A catalogue of project-specific documents as well as a list of complementary policy documents or technical reports reviewed can be found in the Annexes (see Figure 10 on page 31).

The evaluation team used the qualitative information obtained through key informant interviews primarily to validate preliminary findings of the desk-review, as well as to collect additional facts for causal analysis of the project performance. Relationships between evaluation phases and methods are shown schematically in Figure 6 (on page 26).

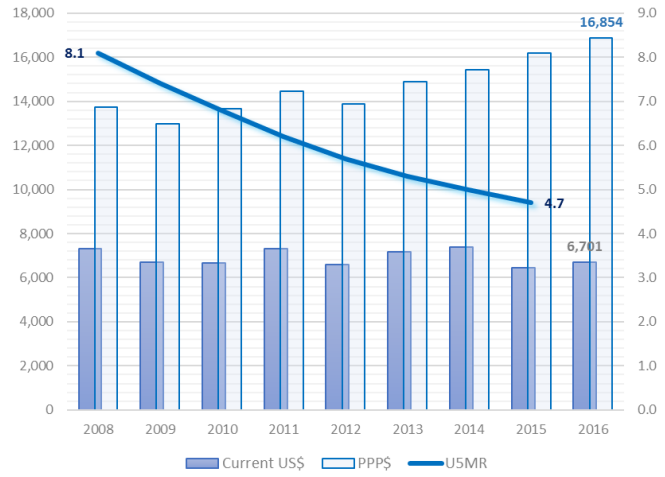
A shortage of time was the major limitation of the evaluation: it did not allow for exploring issues deeper during the key-informant interviews, or for conducting an extensive content analysis of hundreds of pages of technical information. The time was not sufficient for running the second round of consultations with the key stakeholders to validate findings and to discuss possible solutions.

The quality of the performance framework was another important limitation compelling the evaluation team to compensate it by qualitative assessment, to a possible extent.

2 Description of the intervention

2.1 Context

Figure 1: Macroeconomic trends and U5M in Kyrgyzstan



WB, World Development Indicators

The health status of the population has been improving in last decades: life expectancy at birth increased by 2.1 points from 68.6 years in 2000 to 70.4 in 2015 (up from the lowest 67.7 in 2006) (see Figure 7 on page 26). Healthy life expectancy increased even more in the same period – reducing the gap (years lost due to illness) from 8.9 in 2000 to 6.8 in 2015. Healthy life expectancy at birth among females was still higher in Kyrgyzstan compared to Europe averages (66.9 vs 65.6 respectively) (see Figure 8 on page 26), while among males, the expectancy is shorter by 9.5 years in Kyrgyzstan (World Health Organization 2016). According to the World Bank, under 5 mortality (U5M) reduced from 8.1 (per 1,000 live births) in 2008 to 4.7 in 2015 along with slow economic growth (2.8% average annual growth of GDP PPP$ per capita) as shown in Figure 1. Economic and social context and the latest trends are presented in detail in Annexes (see Figure 11 on page 34).

The country initiated health system reforms in 90s, and succeeded in splitting purchasing and provision of health services after establishing a Mandatory Health Insurance Fund (MHIF) in 1997 (Kutzin, et al. 2002). However, health care providers at all levels remained as public institutions administered by the Ministry of Health. Therefore, the 2nd sectoral reform program "Manas Taalimi" (2006 – 2010), inter alia, aimed at "Improving the management of health organizations working under *managerial and financial autonomy in order to increase the efficiency and quality of delivered health services.*" (Ibraimova, et al. 2011). As noted in 2011 health system review, "financial and administrative autonomy of health care providers was envisaged in the 2004 Law "On Health Care Organizations in the Kyrgyz Republic". However, this law has not come into full force yet. A needs assessment conducted by the Swiss Embassy (Lewis and Murzalieva 2013) confirmed that health facility did not demonstrate or enjoy administrative and financial autonomy despite improved legislation. Finally, the 3rd health sector program "Den Sooluk" (2012-2018) stated that "HFA is considered as one of the effective instrument to improve quality of the services".

2.2 Logic of the intervention

The intervention logic is defined in the Project Document as an "impact hypothesis to be tested by the Project: By granting expanded autonomy to HCO managers in combination with clear vision, adequate managerial capacity, appropriate accountability mechanisms and effective incentives, they will be able to provide health care services in a more efficient way and with better quality". The hypothesis "follows the logic of accumulative effects of improvements of health services delivery with an emphasis on expansion and full utilization of autonomy of health care organizations (HCOs), leading to improvements in health system performance and furthermore to better population health."

The diagram in Figure 17 (on page 64) represents an attempt to convey the intervention logic schematically by projecting "log frame" on the timeline of the "strategic framework". The diagram will be discussed in more details under section "Findings". However, the strategy was as follows: Phase 1: Legal framework is in place, so a "HFA model" is piloted in 3 selected rayons by upgrading internal management areas (4 outputs under outcome 1) and external enablers (3 outputs under outcome). Phase 2: the government rolls out the "HFA model" (presumably successful) with the project support through the country transforming HF network into more efficient and patient-centered care providers. Phase 3: While the expanded network of more autonomous healthcare providers benefits quality and efficiency of care, the project phases out gradually.

2.3 Implementation arrangements

The project was implemented by a consortium of partner organizations: GFA Consulting Group GmbH (GFA), Swiss Tropical and Public Health Institute (Swiss TPH), and VEK Consulting Ltd (VEK), with "GFA being the consortium leader and single point of contact for SDC".

The consortium led by GFA is accountable "towards SDC for the achievement of project results. If the Project is in danger of straying from the defined results corridor, **we will respond with flexibility and adjust the implementation strategy** in consultation with SDC and the PSC".

The roles between partners were divided originally as follows[1]:

Partner and its entities		Roles
GFA	Backstopping team:	• Provide international expertise in project management and act as point of contact for SDC and the project team in all contractual and management matters ○ An international long-term expert (strategic adviser) ○ Two international short-term experts (health facility management and contracting)
	Head office	• Monitor inputs of all experts (ensuring timely submission of high quality reports) to SDC • Manage financial and contractual matters
	Team leader	• Represent the consortium in the field • Responsible for day-to-day management • Single point contact for SDC and project partners in the field
Swiss TPH	Basel based institute	• Expertise in health system strengthening ("mandate … for SDC") via: ○ One international long-term technical expert ○ Two international short-term experts (health economics / financial management and clinical practice)
VEK	Local company / office	• Recruitment and management of all national experts and support staff, including a "strategic advisor for governance" • Administration of all project funds • Organization of logistics and infrastructure.

Originally, the Project Team (PT) was comprised of a "Team Leader" ("responsible for the overall **operational** project management"), one full-time (QA) and one part-time (M&E) project coordinators, a full-time office manager, and an accountant. The project team was expected to receive advice from two strategic advisers "upon request from the team leader concerning overall project implementation, strategic decisions, and technical questions. Should the project team need additional expertise, the consortium submits the ToR and a CV of respective experts to SDC for approval.

[1] The composition was modified later: GFA - national short-term expert instead of international long-term, three instead of two international short-term experts; STPH – no international long-term expert

The team composition and “internal organization” are schematically presented in Figure 18 (on page 64) and Figure 19 (on page 65).

3 Findings

3.1 Findings by core evaluation questions

3.1.1 Relevance

Q1:	*Was the project relevant at the time of conceptualization?*
Q2:	*Does the project remain relevant and suited for the current priorities and policies of the health sector and to the current population need?*

The project was relevant at the time of conceptualization and remains so:

Den Sooluk – the main health sector plan for 2012-2018 admits that (The Ministry of Health of the Kyrgyz Republic 2012):

- "Incomplete definition of roles and responsibilities and limited management autonomy of health care providers have generated a governance challenge." (Lesson 4, page 6)
- "Significant deviations of the care provided from evidence-based practice… is due to the … lack of autonomy of health care organization and weak mechanisms of their accountability…" (lesson 6, page 8)
- And states that the "accountability for performance and full autonomy" of healthcare providers is needed for the improvement of quality and efficiency of medical services.

The political commitments and "structural (framework) conditions" constituting the basis for the implementation of Den Sooluk includes, inter alia, the following: "autonomy of health care providers will be expanded, which will give an opportunity to introduce the best practices of quality management, the responsibility for the quality of services provided will be intensified, efficiency in resource use will be increased". The Ministry of Health listed the revision of "regulations to enhance the autonomy of health organizations and optimization of laboratory services" among key activities of Den Sooluk for 2017-2018 (Ismailov 2016, 8).

A new health sector plan is under development (to become effective from 2019), and the aspirations of the project most likely will be aligned with health sector priorities, considering understanding of the importance of HFA by majority of the stakeholders interviewed, and confirmed by the public statements of the health officials (during the roundtable conducted at the end of the mission).

Q3:	*How good was the quality of the design? Namely:*
Q3.1:	*Were objective and results consistent with and supportive of Government policies?*
Q3.2:	*Were the intervention **logic** (log frame) and related **indicators** technically sound?*

The project design was quite good when measured by the alignment of its objectives and expected results with the government policies as defined in Den Sooluk. The project approaches or main directions (corresponding to seven outputs) were consistent with the national health priorities supported by the development partners.

The log-frame reflected properly "the impact hypothesis", but not the strategic framework of the project (Figure 1 on page 19 of the Project Document):

- The obvious and critical (for Phase 1) result - "a 'HFA Model' piloted and ready to be rolled out" got lost behind seven output level results (each of them being an important element of a HFA model) as illustrated in Figure 17 (on page 64).
- It is difficult to project the logic on a timeline, especially when neither the statements in the hierarchy of results, nor the indicators are time bound. One might expect that the project intended to deliver output level results (and to certain extent, achieve outcomes 1 and 2) in an area limited to 3 pilot districts in first 4 years, gradually rolling out the same changes throughout the country, striving to attain long term outcome and impact afterwards. However, the indicator proposed for "Impact (Overall Goal)" – "Point of increase of a composite quality score *of pilot HFs* (requires development of methodology)" assumes that the project promised to demonstrate a result at impact level in the first 4 years in 3 districts.

The evaluators found assumptions and risks being inconsistent across the project document and some of them being confusing or questionable:

- Assumptions used in the last column of the Log-Frame (matrix) were not analyzed thoroughly as risks (for the likelihood of occurrence and severity of the damage it can cause) and were not followed by respective risk management strategies.
- Risks listed under "Risk assessment and Mitigations strategies" (annex 11 of the Project Document) were not consistent with assumptions defined in the Log-Frame matrix.
- A few examples below illustrate weaknesses of risks-related aspects of the logic:
    - The logic of starting the list of risks (in Annex 11) with: "No detailed plan and description of the HFA model have yet been defined and agreed between the key stakeholders at the national level" was unclear:
        - What was claimed as "risk" was already the reality, and therefore, could not be characterizes as an undesirable event that might or might not occur;
        - Absence of agreement on HFA model at the national level was a gap at the policy level (one might argue the project had to address from the day first), but definitely not a risk.
    - "Slow or delayed adoption of legislative and regulatory initiatives can jeopardize implementation progress" - articulated as risk, this statement was placed in the top row between long-term outcome and impact, implying that it might jeopardize achieving the highest-level results. However, the risk, if materialized, was capable of paralyzing the delivery of most of outputs, and its placement in the log frame remains unclear.

Many indicators proposed in the original log-frame were either not specific enough to attribute the change it measured to the project, or not instrumental to understand the measurement (especially in case of composite indexes). Geographic scope was specified only for some indicators (assuming that others are capturing changes nationwide), and time dimensions was missing, making it difficult to project the logic on paper (presented nicely in tables and result-chain diagrams) into the strategies directing changes in real life.

The evaluation team tried hard to capture all (or most) of the changes that the indicators have experienced in the log-frame since 2015: some indicators moved up or down (the hierarchy of results),

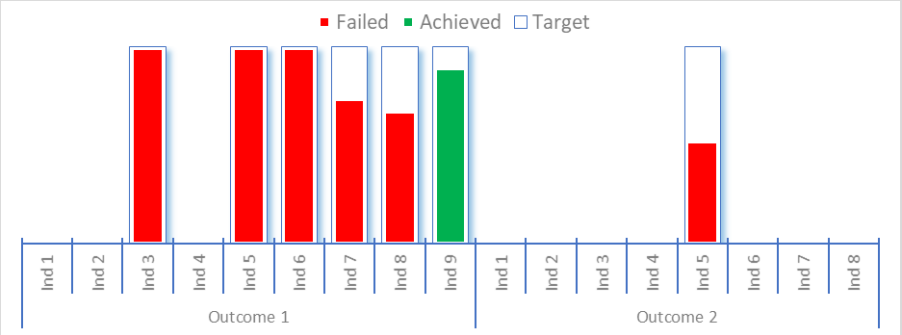
some disappeared or were abandoned (remained in the framework but were not used), and a dozen of new ones appeared (most of them even harder to attribute or interpret, some even looking irrelevant to the subject to be measured).

3.1.2 Effectiveness and efficiency

Q2	*(Efficiency): What results have been achieved by the project (as of Jan 1, 2018)?*
Q3	*(Efficiency): How the actual results stand against expected results as stated in the project documents?*
Q2	*(Effectiveness): Did the project attain strategic objectives for the pilot phase as defined in the log frame?*

The project did not attain "strategic objectives"[2], nor did it make sufficient progress (as measured at the level of outputs) to its attainment as of 31 December 2017.

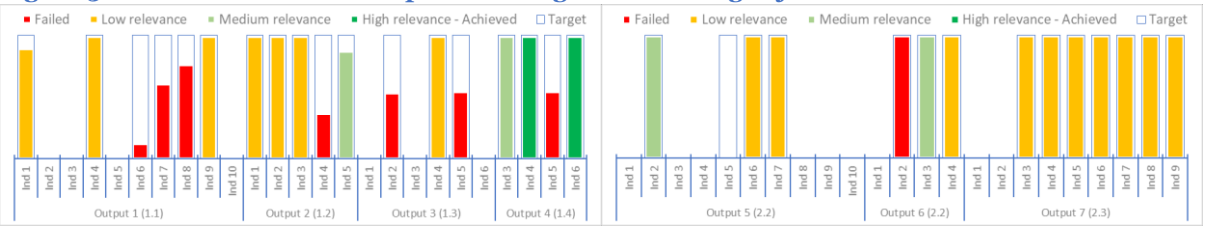
Figure 2: Achievement of outcomes by indicators (as of 31 December 2017)



The quality of performance framework does not allow for measuring achievement of the outcomes (see summary of the evaluability assessment findings in Figure 22 on page 66). Irrespective of the quality of the performance framework, all targets were either not met (except one), or the achievement cannot be assessed (because of the lack of respective targets) as illustrated schematically in Figure 2 above.

Although many output level targets were achieved (as shown in Figure 25 on page 68), particularly for output 2 (i.e. introduction of modern auxiliary services), output 4 (i.e. infrastructure and equipment improvement), and output 7 (i.e. improvement in contracting and payment mechanisms), the evaluability assessment revealed that the most of these indicators had either low relevance or low specificity (see Figure 23 for Outcome 1 specific outputs on page 67 and Figure 24 for Outcome 2 specific outputs on page 68), and many of them were hard to interpret. Therefore, the actual achievement of the outputs when adjusted for the quality (i.e. relevance and specificity) of indicators used looks as follows – except output 4 outputs were not achieved or results cannot be meausred:

Figure 3: Achievement of output level targets after being adjusted for relevance



[2] Long-term outcome "HCOs transformed into efficient and service- and patient-oriented care providers" or mid-term outcomes "1. Health Facilities are modernized to be effectively managed and capable to utilize expanded autonomy" and "2 Autonomous Health Facilities' supervision and performance improvement enabling systems are in place"

Q1	*(Effectiveness): How well the piloted autonomy model has served its primary purpose: "to improve efficiency and quality of health care services by expanding the autonomy of health facilities"?*

As of the 31st of March 2018, a health facility autonomy model (as a whole) has not been piloted, i.e.: (a) it has not been designed fully (although many components exist on paper), therefore,(b) it has not been introduced in selected health facilities in 3 pilot rayons by changing management or operational mode of these facilities as required by the model; thus,(c) – it has not been assessed for its feasibility, effectiveness, sustainability or any other criteria defined in advance). Therefore, the project could not serve its purpose (expected from the piloting of an autonomy model) at all.

The evaluators noted that the Government Decree #10-p on the implementation of "the pilot project 'Health Facility Autonomy' till 31 December 2018" in selected health facilities of Issyk-Kul Oblast was issued only on January 17, 2017, almost a year before the end phase evaluation.

Q3	*(Effectiveness): Are there any unintended results of the project ("good or less good")?*

Together with the project management team (PMT), the evaluation team tried to systematize technical products produced during the implementation or other deliverables that have a "market value": which implies that it can be used by partners and the government benefiting the health system performance eventually. The benefits of each product ("selling points"), requirements for using these products (or scaling up), and the readiness of being "sold from the shelf" were described[3] and are presented in Annexes (see Figure 13 on page 52) as "project assets" accumulated irrespective of meeting output or outcome level targets.

Q1	*(Efficiency): How efficiently the project was administered in terms of converting inputs and activities into results (outputs)?*

When results cannot be measured with the existing performance framework or are not delivered adequately (at the output level at least), an efficiency question cannot be answered.

From a perspective of "Value for Money" concept, so called "assets" generated by the project (listed in Figure 13 on page 52) are not worth of the millions of CHF or time spent taking into account either their relevance to the idea of health facility autonomy, or their "liquidity" (i.e. maturity for being "marketed" or scaled up nationwide).

3.1.3 Sustainability

Q1:	*How sustainable is the autonomy model?*
Q3:	*How far the piloted model has been integrated into the country's health system to sustain after the project ends?*

Similar to the efficiency question, there was no autonomy model piloted yet (except for some elements, at the best) to discuss its sustainability and to answer the two questions listed above.

Some deliverables of the project (irrespective of their relation to "autonomy" or the original logic) are very likely to be sustained. For instance, "basic package of services at the PHC level (FMC / GFP)" with accompanying 20 job descriptions were formalized (by MoH Order #1208 of 30.12.2017 and MoH Order #65 of 21.01.2018) and will be used (hopefully, they will also get integrated in the pending health service optimization masterplan). The same can be true regarding two software applications on patient flow management system and laboratory information management that will be handed over to the MoH and integrated into the upcoming e-Health architecture. Sustainability of other deliverables,

[3] But not validated due to the scope of the evaluation and the limitations.

such as "Rayon Health Councils", is hard to assess – one may expect them to disappear soon after the project withdraws from the pilot districts, but there is no evidence to test this hypothesis.

Q2: Can the Ministry of Health replicate the autonomy model in other regions?

The evaluation team could not find any plan that describes mechanisms for replicating the autonomy model in other regions, or a clear vision of the process among key actors. It means that the question "*how*" to replicate has not been answered yet, which is a necessary step to answer the next question: "*can*" the Ministry of Health replicate the model. There is one place in the Project Document strategic framework that mentions "excellence center". As confirmed by one of key informants, the original idea was to transform the piloted autonomy model into a showroom, which any skeptic or opponent could visit, and where those willing to replicate the model could learn how it works. This vision has not been translated into actionable plan (albeit waiting the completion of phase 1).

3.2 Additional evaluation questions

Q1: Was the project initiated timely against current context of the health sector reforms in Kyrgyzstan?

Yes, timely: the project can be said to be initiated in a timely manner (as clearly articulated in the several background documents and confirmed by many respondents), **if** one considers only the need for substantial and sustainable improvement in healthcare provider performance (through extended autonomy).

No, it was early: the project can be said to be initiated early **if** one considers the pace and scale of structural changes toward decentralization in the health sector (going beyond declaration of intentions) or governance decentralization in the country in general.

Q2: How the autonomy model was designed for pilot areas and how it is concluded?

According to the initial vision, the first 4 months should have been spent on the HFA model design through a participatory process (see Figure 20 on page 65). However, this approach cannot be traced in the later preparatory and planning documents. There is no single component in the Phase 1 work plan (see Gantt Chart in Figure 26 on page 69) that implies the design of an HFA model in an integrated manner. Presumably, the design of most (if not all) essential components of the HFA model are spread across more than 140 lines of the Gantt Chart, but it is impossible to comprehend. As confirmed by the PMT, nobody knew how autonomy (and its model) should look like (even on paper) when the project started. The understanding seems to come later, when the PMT laid down on a paper a description of three options (or levels) of extending autonomy and shared the understanding of the autonomy among the key stakeholders in the beginning of 2018. Therefore, the evaluation team cannot answer additional questions from #3 to #6 on the merits of the autonomy model piloted, about the gains from improved autonomy in the pilot area, or expected gains from scaling up the piloted autonomy model.

Q7: What is the role of the result-based financing model (joint initiative with WB) in promoting autonomy of the facilities and its sustainability?

The project management team has made significant progress in the design, and piloting RBF model at the PHC level in the pilot districts under activity 7.2. The evaluation team had neither a mandate, nor the resources to dive into the technical content of the model. However, several observations the evaluation team made from aside might help to answer the question on the role of RBF in promoting autonomy of facilities:

- ***Conceptual aspects***: No clear distinction could be found between result- or performance-based financing (actually reimbursement) of HFs and performance-based management PBM of HCSs across project documents. For the sake of this evaluation we can draw the following line between these two:
  - External (to HFs) vs internal: The first is more abouthealthcare financing approaches and practices to pursue health policy goals by linking some amount of money channeled to HF to the policy priority (such as improved maternal health, reduction in the complications of NCDs, or early detection and better treatment outcome of TB cases). The second refers to mechanisms and practices of allocating funds *within* an organization promoting efficiency.
  - The former (RBF) does not necessarily imply the latter (PBM), and the latter can exist without the former: "disposable revenues" for the management is sufficient to exercise various performance-based management options irrespective of the origin of extra revenues– be them incentive rewards under RBF schemes, or efficiency gains under core financing, or funds collected through selling.
  - Dependence on or relation to HF autonomy:
    - RBF does not require extended health facility autonomy, but can be more effective (i.e. motivating) if a health facility can use extra funds ("rewards") at its own discretion.
    - Performance-based management can only exist properly in extended HFA.
  - The World Bank has been developing a true RBF (alas, for hospitals only) focusing on how to reward an organization for meeting performance targets, without going further (defining how the additional fund generated are used within the organization).
  - Presumably, the HFA project was supposed to focus on performance-based management within the HFs in the pilot districts and on introducing RBF (as a source of additional revenue) at the PHC level solely for the purpose of demonstrating how the extended autonomy (interventions in governance and service delivery areas) augments benefits of RBF (interventions in health care financing).
  - The PMT perceived the RBF as the mechanism to somehow equalize FGPs, which were a part of the network administered by FMCs, with stand-alone FGPs (legally independent entities) at least in earning and distributing the rewards paid for the reported results. The evaluators found this argument reasonable (but still debatable) and wished it had been explained and documented properly (e.g. in a technical report or in the project annual progress reports).
  - It seems that the PMT got carried away by developing healthcare financing instrument (RBF) for PHC instead of focusing on governance and service delivery (and internal, performance-based management arrangements including remuneration-this probably was the key issue to introduce RBF at PHC level of the personnel) , as a health facility autonomy initiative. The Project Document does appear instrumental to guide the PMT strategically.
- ***Missed alternatives***: The Project Document refers to effective "provider payment methods to support better performance of HFs and their networks" under Activity 7.2 (that includes but is not limited to RBF/PBF). The level of core funding – its adequacy to resource requirements was one of the fundamental questions for any level of extended autonomy to sustain. Can a facility with

extended autonomy demonstrate significant improvement in results/performance for each extra dollar paid (per capita)? Or can internal optimization (within the organization and across the network) demonstrate the same level improvement without extra financing? Presumably, these healthcare financing policy questions determining >90% of the funds inflow to HFs would have been the primary focus of the HFA project rather than RBF/PBF, which is favorable but not essential for health facility autonomy.

- ***Repercussions on partner and government relations***: the policy-makers have to choose now between two competing versions of PHC RBF: one piloted by the WB and another – by the HFA Project. There is nothing wrong with this process; on the contrary, it is an opportunity for the country to get the best model of PHP RBF. However, why is it that the initial intention to collaborate with the World Bank on RBF methodology development (as described in page 41 of the Project Document) ended up in two parallel and competing work streams? Could it be avoided? And, what was the initial intention of the move: collaboration with the World Bank or competition? All stakeholders agree that an independent expertise is needed to assess pros and cons of competing models, and to provide a conclusive recommendation to the MHIF. Unfortunately, the evaluation team could not find anyone who understands how this expertise can be carried out under the time pressure – the money for RBF is already earmarked in 2018 budget and the MHIF has to spend it nationwide.

- ***Consistency with autonomy***: The RBF model piloted by the project entails that RBF funds the organization receives is composed of individual rewards linked to and calculated by each family practitioner (thanks to the software installed in each family practitioner's notebook), who also decides the percentage of RBF to be split with the management. As a result, the RBF funds are actually channeled to staff while the facility management has a little discretion (if any) over the distribution of these funds. This approach can be the most efficient (with the lowest transaction costs) and the most transparent solution, as well as the most "democratic" (resembling various loose managed healthcare arrangements established by traditionally independent, and self-sufficient medical professionals for the sake of efficiency gains and competition – a common practice in the USA). However, the evaluation team wonders if this approach conflicts with the essence of health autonomy (when rewards given to the organization "bypasses" the management[4] and are distributed as calculated by the software), and thus, undermines the idea that the project is supposed to champion.

The evaluators noted that project efforts dedicated to the introduction of RBF at PHC, including the financing of RBF rewards from the project budget in the pilot districts for two quarters, encouraged the health authorities to introduce the RBF nationwide and earmark funding in the budget. Although the government has still to decide on the final configuration of the RBF, it is a rare case where the project, together with other development partners, contributed to policy changes (i.e. RBF mechanisms to be rolled out nationwide, and funding for PHC RBF earmarked) even if the instruments to implement it have yet to be finalized.

[4] Technically, the money is handled by an accountant, and the manager signs off wage bills, but the management has no say regarding fairness or appropriateness of the funds

Q8:	*How the study tours to other countries contributed to the results of the project and capacity improvement of the facilities management?*

The evaluation team was not able to trace the contributions of the study tours to the capacity improvement of the facility management, which is more indicative of the limitations on the evaluation part rather than of the lack of such contributions.

Q9:	*What are the main political and technical bottlenecks to scale up the autonomy model?*
Q9.1:	*How the project has maintained the policy dialogue?*
Q9.2:	*What kind of resistances were in these areas and how they were overcome?*

There is no documented evidence that the project either intended to (on its own) or has engaged in the policy dialogue in a systematic way such as establishing bridges and building trust with different power centers within the Parliament, President's office, the Government (Prime Minister's Office), as well as in other line ministries (such as the Ministry of Finance), using a mix of channels and approaches (social mobilization/PR campaigns, open advocacy or lobbying). The evaluation team could not find sufficient evidence that the importance of large-scale interventions at the policy level was understood from the onset of the project, or that adequate capacity was mobilized.

Q10:	*What is the role of the Rayon Health Councils to address health issues with multisectoral approach?*
Q10.1:	*What is the added value of the collaboration with the local municipalities?*
Q10.2:	*What are the de jure competences of local municipalities in health?*

The Rayon Health Councils (RHC) have been praised highly by the PMT. The evaluation team could not find the same attitude among most of the key informants interviewed (however, that does not necessarily mean that the RHC does not deserve it). Most likely, the PMT did not disseminate the information properly (that is also a valid observation of some other "assets" generated by the project). The evaluation team was not able to meet with the RHCs during the mission, or to review any technical report assessing the added value of RHCs. However, the evaluation team is not certain about the boundaries (and potential benefits) of the collaboration with the local governments in the current setup of decentralization when most of the health facilities are owned by the Ministry of Health and administered directly. This does not imply questioning the importance of collaboration with the local authorities, but mostly setting realistic expectations. As reported by one of the key informants, the RHCs presumably were the best solution for fostering local ownership while compensating for the gaps in top-down power redistribution (i.e. "the lack of decentralization"). Finally, the evaluation team has no evidence to believe that RHCs will sustain its operation after the project withdraws from the region.

Q11:	*What is the position of the Kyrgyz Government in terms of granting autonomy to the health facilities? Is the MoH ready:*
Q11.1:	*To decentralize the management of the health facilities?*
Q11.2:	*To prepare actors mapping of the government representatives involved in this process and analyze interests and resistances.*
Q11.3:	*Which of them are the connectors and dividers of the autonomy process?*

The evaluation team received reassurance from a health official regarding (a) the recognition of the importance of extending autonomy to health facility, and (b) the readiness to take actions. However, the evaluation team noticed that the autonomy of health facility (as a term and concept) is interpreted differently by the officials. The review of high level policy documents for the last decade, including health sector plans, are rich of promises to unfold decentralization in health care in general and extend autonomy of health facilities. However, comparing the promises to the actions undertaken

in this regard leaves no ground to feel optimistic about changes in the mindset of political elites on the redistribution of power along the administrative vertical. Nevertheless, the evaluators did not find any reason to think that the momentum cannot be created at the political level that opens a window of opportunity wide enough for the middle level management to overcome fears and to endorse regulations expanding space for managerial and financial decision-making at the health facility level.

Q12: How the model should be scaled up?

Q12.1: What kind of interventions should be covered by the Kyrgyz Government?

Q12.2: What should be the role of the health facilities?

Q12.3: Which elements of the model should be carried by the project in the phase II?

Q12.4: How long the project should be engaged in the scaling up of the autonomy model?

The evaluation team could not find a clear understanding of an approach to scale up a health facility autonomy model (other than a reference to "excellence center" established in the pilot rayons, and an additional reference by one of the key respondents). Therefore, the subjective opinion of the evaluation team on this matter will be presented in the next section on "Lessons learned".

Q13: What is the specific role and added value of the Consortium members (GFA, STPH, VEK) in the project implementation?

The specific roles of the consortium members as defined in the Project Documents were described briefly in the previous section (see 2.3 "Implementation arrangements"). However, the evaluation found that there is no division of roles in terms of areas of responsibility for delivering results within the consortium or the project management team members. The formula looks like this: everybody contributes to the delivery of expected results within the competences (agreed from the beginning) while the GFA assumes an overall responsibility for the project in front of the SDC (overall meaning technical / programmatic, administrative, and financial). Project coordinators or long-term consultants are not assigned to specific outputs and there are no clear accountability lines for deliverables (outputs). Short-term consultants deployed periodically are assigned to specific activities or sub-activities in accordance with the annual work plan, and do not share responsibility for the delivery of tangible results. The only clear division of roles the evaluation team found was purchasing of TA: VEK purchases short or long-term consultancy service from Kyrgyz residents while GFA and STPH – from non-residents.

The ToR for each consultancy is developed by the PMT in Bishkek. Nothing precludes VEK to purchase these services directly from non-residents, from in-house consultants of STPH or GFA, or from others (except for the agreement within the consortium and with the SDC). Therefore, the evaluation team found a little added value in consortium members behaving as brokers of technical support from non-Kyrgyz residents without clear accountability mechanisms within the consortium or responsibilities for project outputs (or sub-results).

~~The evaluation team noticed that the initial balance between thematic areas (i.e. governance and financing) has not been restored in the implementation arrangements after the strategic advisor on governance dropped from the project despite governance being the primary profile of the project.~~

~~Based on the project document and as confirmed by respondents, the evaluation team found that the owner of one consortium member is employed by other member as a team leader, which further blurs the accountability lines and understanding of the roles.~~

~~The added value of GFA having the leading role in the consortium, and presumably, being responsible for all levels of management for overall project success will be discussed in the next section which makes an attempt to understand what happened with the strategic management of the project.~~

Q14:	*Are there any courses concerning health sector management?*
Q14:1	*What are strengths and weaknesses of these courses?*
Q14:.2	*How the project should be involved in this issue within phase II?*

The evaluation team was not able to detect any interaction of the project with teaching institutions on upgrading and institutionalizing healthcare management programs (bachelor, master, or post-graduate short and mid-term training courses). According to the Project Document, the project was supposed to "support the institutionalization of management capacity building for medical and other HCOs… in cooperation with the established teaching institutions such as" KSMA and KSMIRCME in the second phase (on page 48), or presumably in phase one as well (page 61). According to the Phase work plan, the project was expected to develop leadership and management training curricula and to test them (see activity 5.5.3 in Figure 26 on page 69). However, the evaluation team could not find any evidence of the activities being carried out.

As reported by some key respondents, the capacity of existing training courses in health sector management is weak, and they are not ready to supply the pool of healthcare managers necessary to manage existing facilities (as well as to establish a reserve of such professionals considering the high turnover).

Q15:	*In terms of cross-cutting issues, what kind of gender specific issues were addressed within the project and how were they implemented?*
Q15.1:	*What kind of measures were taken to ensure equity and inclusion (how it was planned and implemented)?*
Q15.2:	*What kind of recommendations to address cross-cutting issues can be provided for Phase II?*

The evaluation team was not able to explore cross-cutting issues including gender adequately as one should However, it was noticeable that some indicators in the performance matrix (such as ones related to health care service utilization) lacked disaggregation by gender. s

3.3 Summary of findings

The project failed to deliver the main result of phase 1 as defined in the strategic framework: a health facility model piloted in three districts and ready to be scaled up in phase two.

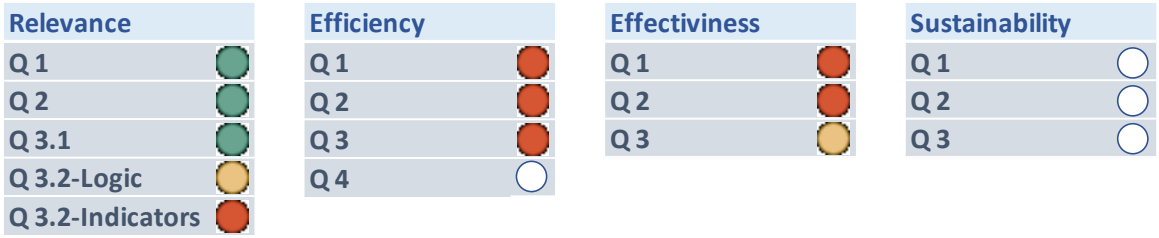
The project failed to deliver five out of seven outputs as defined in the project logical framework, demonstrating relatively better achievements in two areas: optimizing auxiliary services (output 2) and improvement of the HCO infrastructure and equipment (output 4).

None of the two mid-term outcomes have been achieved eventually considering the progress observed in reaching output level targets.

The logical framework, namely, indicators and its targets has been modified constantly, ultimately, making the performance framework useless for (a) assessing progress toward targets set originally, or (b) capturing valuable changes made by the project irrespective of the original log frame design.

The overall assessment of the project progress and performance against OECD DAC evaluation criteria can be summarized as follows (see Figure 4 below).

Figure 4: Summary of the findings by the DAC criteria (by core questions[5])



- **Relevance**: The evaluation team found the project relevance to be satisfactory when considering the alignment to national priorities (policies on paper), but unsatisfactory when measured for the technical soundness of the logical frame and proposed performance matrix (see "yellow" light" for Q 3.2-Logic-related and "red light" for Q.3.2-Indicators-related questions).

- **Effectiveness and efficiency**: the evaluation team found that the project failed when measured for efficiency and effectiveness – answers to 3 out of 4 core efficiency questions were not satisfactory ("red lights"), and the 4th could not be assessed (white circle); the project only met the 3rd effectiveness-related question partially ("yellow light"), while answers to two other questions were not satisfactory).

- **Sustainability**: The evaluation team could not assess the project for sustainability, because the main result to be sustained (by scaling up and transferring gradually to national ownership) has not been delivered as expected.

The evaluation team found difficult to understand the rationale behind the design of the project implementation arrangements including mapping of the responsibilities within the consortium for results or thematic areas, or lines of accountability between operation and different levels of management.

The evaluation team found that the notion of or attitude to autonomy of health facilities is still controversial among health authorities, and there is still a gap between the willingness to decentralize and the readiness to take actions.

The evaluation team recognizes that the project team has made massive efforts in the last two years to rectify the situation and deliver the promises. However, these efforts, mostly technical by their nature (such as developing tools, guidelines, draft regulations, service packages and descriptions), and suitable to generate some valuable assets, still could not tackle health sector or broader governance issues that required structural changes.

[5] Numbering of questions in the summary under reach criteria (Q1 to Q3 or Q4) corresponds to the numbering of questions in the main text in the previous subsections for easy reference.

4 Lessons learned

4.1 Major lessons

Importance of structural reforms in the health sector

The project was inspired by and was built upon the premise that the country embarks on structural reforms in the health sector that entails, inter alia, decentralization of the governance (presumably followed by financial decentralization of health financing as implied by the Law on local self-governance). These intentions were clearly defined in the policy (i.e. the health sector plan Den Sooluk 2012-2018), and have been re-confirmed by the health officials at high level meetings with the development partners. The national health policy did not consider[6] autonomy of healthcare providers as a stand-alone solution for increasing the coverage of population with a patient-centered, quality and efficient medical services, or as a silo intervention to advance the health system by transforming success of healthcare financing into tangible benefits. "The decentralization of the administrative functions" was recognized as a prerequisite for the implementation of Den Sooluk, and "the decentralized management" of healthcare providers as a requirement for "enhancing autonomy" (Section 13§2, page 38).

The evaluation team could not find any indication of the steps made by the government toward decentralization in the health sector (see summary of findings in Figure 14 on page 55). Even if subtle efforts had been applied, the signature in Bishkek is still required (and sufficient) to appoint or dismiss a small ambulatory clinic manager somewhere in a remote mountainous village, and no manager dares to dismiss a redundant staff against staffing rules based on doctor/nurse to population ratios. The most of grass-root level healthcare providers are owned (i.e. "founded") by the Ministry of Health, and allegedly the owner of the assets (buildings) used by health facilities is not always clear.

Furthermore, the evaluation team neither found documented evidence, nor gained an impression that the development partners put adequate pressure on or have provided support to the authorities encouraging them to take decisive actions for structural changes in the health sector. The evaluators recognize that addressing structural obstacles to the country's development (such as the concentration of power in the center limiting space for local ownership and initiatives) is far beyond the mandate of development partners in health care (not to mention the mandate of the HFA project). However, convincing the political elites to delegate more power in one sector (health care) to three remote districts that would have allowed demonstrating the benefits of decentralization was in the sphere of influence of the project and development partners in the health.

Unfortunately, the authorities turned out to be unready to experiment decentralization even in three pilot districts. It took the Government two years to officially endorse the project implementation and to set a regulatory platform for piloting extended managerial and financial autonomy.

Why two years? What has been missing since May 2014 (when the project started)?

The evaluators noted that the project team concentrated on "internal" deliberations in the field of operations (assessing different aspects of pilot health facilities and developing methodologies (to be applied in HF with extended autonomy) from the project onset. Presumably, the project team neither used the momentum gained by the project negotiation and development through consultations with the

[6] At least, the evaluation team was not able find any evidence of the opposite

health authorities and partners, nor unfolded a set of organized activities which would influence policy-makers at different levels and power centers (including the President's office, the Parliament, sectoral ministries, political parties and/or other interested). There was no plan to raise public awareness on decentralization, or on potential benefits to medical service users from the extended autonomy through mass media campaigns or other social mobilization activities creating a conducive environment for engaging into a policy dialogue with the key stakeholders. The project did not try (or the evaluators could not find the evidence that the project team had tried but did not succeed) (a) to mobilize partners to "put up a united front" to advocate for extending the autonomy to pilot health facilities (along with the decentralization) using existing formal channels for policy dialogue (e.g. related to SWAp in health sector), and/or (b) to establish so called "support groups" within the parliament, the president's office and the cabinet of the ministers through informal networking to secure understanding of the importance of extended HFA (at least) and to use it as a political lever (i.e. instrument for "soft pressure") against the Ministry of Health or other sectoral authorities.

Can health facility autonomy be extended in Kyrgyzstan without decentralization in the health sector? Only cosmetically (if at all), i.e. without changing external accountability lines, or without giving discretion to define staffing and remuneration. Is that the type of health facility autonomy the project has been designed to support?

Two lessons can be drawn in this regard:

- The government first must set a time bound plan for decentralization with milestones, and subsequently, demonstrate movement toward decentralization, while putting safeguards in place to ensure its irreversibility. Only after reaching a point of "no return" will it make sense to support expanding health facility autonomy in the long run. Any other option is associated with a high risk of stalling in limbo, with a little change for the project management team to mitigate the risk and/or to find a way out of it.
- Declarations at the policy level (even existence of provisions in the legislation obliging the government to do A or B), and candid expressions of interest and readiness of health authorities to increase health facility autonomy does not guarantee structural changes that are critical for creating (a) a sense of ownership at each level of health care delivery, and (b) a space for exercising managerial and/or financial autonomy. This leads us to the next major lesson that can be learned.

Erroneous assumption distorting the strategy

The evaluation team believes that one of the assumptions underpinning the project strategy was erroneous: it was assumed that there was sufficient space (policy/ legal) for health facilities to upgrade operation and management by acquiring skills, introducing new instruments, and applying incentive mechanisms.

The situational analysis preceding the project design found that "legal and regulatory framework for the development of HFA has already been developed… and according to the key informant currently there are no obstacle from the legislation side that could have limited the HFA" (Edward Lewis and Guglu Murzalieva, Autonomy of Health Facilities in the Kyrgyz Republic, Assessment of Needs for providing autonomy for health facilities in the Kyrgyz Republic. 2013. Paragraph 2.2, page 9). It was concluded that outdated format or content of relationship among the key

stakeholders was the only constraint (external) to "strengthening autonomy of Health facilities" (point 2.5 on page 10).

The evaluation team was unable to explore factors explaining such misinterpretation of the policy landscape (due to the evaluation limitations), namely, the underestimation of the policy challenges the project would face at any attempt to revisit the power distribution architecture in the health sector. As a result, policy-related risks (formulated as "slow or delayed adoption of legislative and regulatory initiatives can jeopardize implementation progress.") was only recognized at the top level of logical hierarchy results (threatening translation of long-term outcome to impact in the project log frame). From a point of view of a logical framework, as a risk, it was capable of damaging the project at the grass-roots level (in delivering outputs). However, this was not even a risk, i.e. phenomena that might happen (and damage the project if materialized), but an existing factor. Therefore, it had to be recognized as a challenge and merited a separate component or group of interventions to be address right from the beginning. Instead of tackling policy level gaps at the national level (going far beyond a dialogue with the Ministry of Health and MHIF), the project strategy was focused on the production of technical products/solutions (necessary for the health facilities to avail themselves of expanded autonomy) tailored to the country context that has been facing barriers every time they required the revision of existing rules.

One of the possible reason of such omission could be the quality of situational analysis and risk assessment methods used while designing the project document. The assessments preceding the project design generated sufficient evidence for more advanced (structured) analysis (e.g. root cause analysis using problem tree diagrams) that are more instrumental for building a technically sound logical framework compared to a simpler SWAT approach.

Therefore, another lesson learned is that the application of more advanced techniques for problem analysis and risk assessment could have been prevented from strategic mistake. However, this defect in the strategy would not have damaged the project if a proper strategic management and more efficient implementation arrangements ~~was~~ were in place~~ – the next major lesson to be learned as discussed below~~.

~~Absence of strategic management~~

~~A management, different from one in charge of day-to-day implementation, capable of keeping the project pursuing its original course and/or adjusting its course to significant changes in the project landscape, predicting and then preventing a possible failure of the project (irrespective of the causes) has been missing. At least the evaluation team could not find any proof if its existence, but found many examples demonstrating its absence. For the sake of simplicity, it is often called "strategic" to distinguish from day-to-day "operational" management.~~

~~The PMT admitted that they did not know where to start from piloting HFA autonomy. The Project Document work plan in the Project Document contained a long list of activities, but nothing explained clearly how to develop a model (or what a model should look like), how to design a pilot (including criteria for assessing its success or failure) and how to implement it. The PMT was looking for the overall guidance but could not receive it. So they started implementing work plan activities as prescribing hoping that it would lead to building and piloting a model of health facility autonomy.~~

~~Gradually, the project began losing traction, and it was not difficult to notice in the beginning of 2016 that the project was heading toward optimization of service delivery at the grass-roots level (at~~

~~the best), but not to the outputs and outcomes (as promised) related to extended HF autonomy. The project team in the field responded presumably by accelerating technical work in all directions – but generating richer technical content (methodologies, instruments, new service delivery arrangements, rules and professional standards, etc.) could not compensate for the lack of strategic steering critical for the achievement of the outcome level targets. The project team has been revising indicators, downgrading many of them (from the measurement of immediate results to the measurement of processes) or replacing the most relevant or specific indicators with less adequate ones presumably after realizing that the project cannot deliver on its promises. Adding the clinical performance indicators from RBF methodology to the project performance framework illustrates in the best way how the understanding of difference between the HFA Project and health facility (i.e. self-identity) has been lost.~~

~~Gradually the project implementation became opportunistic – another sign of losing the strategic focus – it got engaged in building up oblast level laboratory network, or decided to contribute to e-Health development by designing and testing software modules (quite valuable per se, but not directly related to expanded autonomy). A lot of energy and efforts were devoted to RBF methodology development and implementation at the PHC level – valuable on its own but neither essential nor specific feature of expanded HFA autonomy.~~

~~The resistance of a different level of health authorities to accept the proposal on revising the regulations (e.g. on service delivery organization standards or on the remuneration of medical staff) has been left to technical professionals to resolve, but has never been recognized as a symptom of deeper structural problems (that cannot resolved by "shelling" technical arguments).~~

~~The Steering Committee has a mandate to "provide overall strategic guidance to the project management team". This entity (expected to meet biannually and composed of high level representatives of health authorities and partners) could have played a valuable role as a complementary mechanism, but not the only backbone of the strategic management. An external body might be instrumental to mobilize support from and cultivate ownership among key national actors, but cannot be held responsible for continuous, comprehensive strategic oversight and remedial interventions (that can be requited sometimes as often as every month).~~

~~The most important lesson learned is that the absence of management (capable of (a) detecting and fixing flaws in original approaches, (b) seeing the larger picture from above and ensuring that different fragment of work done fit nicely into awaited HFA model, (c) tracking the progress and revising the original logic and milestones (instead of playing constantly with indicators and targets in the logical framework)) reduces the chances of project success close to zero unless the project has very effective and efficient implementation arrangements (that leads to the discussion of the next and last lesson learned).~~

Inadequate implementation arrangements

For the sake of clarity, "implementation arrangements" in this report has a broader sense encompassing not only the organizational structure with the distribution of competences (along managerial vertical or across thematic areas), and accountability lines (for end results and/or for operational reporting), but also technological processes that define technical inputs (via long and short term consultancy services), get them, process and translate them into products and services necessary to deliver the outputs and outcomes.

To be successful, the existing implementation arrangements (productive and efficient) required a team leader to combine three distinct competences: (a) strategic management (including familiarity with root-cause analysis techniques, logical frameworks, risk assessment, and management), (b) healthcare policy and management (including experience in advocacy, policy advise, service delivery organization), and (c) day-to-day management (including planning, performance assessment, communication). Even if the consortium succeeded in finding such a unique professional, the implementation arrangement would have been extremely unstable due to being fully dependent on a single person.

Instead of concentrating so much technical expertise in Bishkek through permanent or regular presence of "heavy-weight" consultants (who fully share the responsibility for outcome/outputs with the operational staff, not just for the content of a technical or mission report), the project opted for fly-in approach relying mostly on short-term consultancy services. Nominally, the team leader, guided by the advice of long-term consultants, was responsible for translating the inputs of short-term consultants in specific thematic areas into project outputs.

The implementation arrangements missed safeguards and check and balances (that could minimize human errors or bias). After one of two "heavy-weight" long-term consultants ("strategic advisors") left the project, there was no mechanism to counter-balance initiatives, proposals, and advises of the remaining consultant through peer review or professional discussions. This is not about how good or bad the "strategic advisor" or her/his advice is – it is about whether a system is in place that can restore a balance irrespective of individual merits or deeds.

The matrix type organizational or managerial arrangements the current practices resemble have its own benefits and disadvantages, and the evaluation team could not detect whether the choice of the approach was deliberate, or the observed practice was a residual effect of the failure of more traditional managerial pyramid (or an expression of the lack of such).

The evaluation team believes that factors behind the observed inadequacy of the existing implementation arrangements (apart from the failure at the strategic management level) are much more complex than the lack of capacity, or poor performance of any single individual in the project management team.

4.2 Other lessons learned

Lack of horizontal cooperation

The evaluation team noticed that some stakeholders with very positive attitude toward the project complained about the lack of knowledge of technical developments or products prepared by the project management team.

The evaluation team is far from the notion that the project has been hiding its technical deliberations from others, but there was no platform that allowed interested parties to familiarize themselves with some technical content ("passive engagement"), or to get engaged in a professional discourse. In addition to the collection of some valuable inputs (alternative opinions), this platform would have benefited building confidence in the project deliverable.

Lack of "marketing "

The entire project phase 1 served one purpose: to market HFA autonomy model to the key constituencies after building it, running it in pilot districts, and subsequently, demonstrating the difference it makes, and how it can work.

Even if the strategic product "the piloted HFA model" has not been produced to be marketed, the project succeeded in production of some valuable technical products, but has done almost nothing to market them (except for software modules). Marketing in this context means not only acceptance of innovations or proposals (such as PHC service package with job descriptions) by health authorities, but also acknowledgement of these products by a wide range of stakeholders.

The lack of marketing approach became most obvious after the project product has been competing with similar initiatives of another development partner. The evaluation team could not find that the PMT has made efforts to mobilize external/independent expertise to prove the advantage of the method/product making it more attractive to the ultimate user.

Lack of performance framework

The evaluation team found it very difficult to use some indicators for assessing progress the project made because there was no single document with clear definition (e.g. nominators and denominators) of the indicators proposed originally or added afterwards. The indicators were listed in logical frameworks. However, the evaluation team could not find a performance framework that defines baseline values, milestones and targets for each indicator, type of indicator, technical definition and disaggregation requirements, notes for interpretation, and reported results with optional monitoring and evaluation plan that describes data flow (i.e. collection, processing, reporting, calculation of indicators), responsible actors, and data varication mechanisms.

The project used more and more composite indicators either by borrowing from other methodologies or by using proprietary ones developed for the project specifically. Although composite indicators could be useful to a trend over time, they cannot be interpreted without understanding its logic / methodology that was not provided to the evaluation team.

Finally, the evaluation team would have found it useful if any modification to the performance framework have been explained and documented, ideally, formalized as long as the performance framework defines what to expect from the project implementation and how to access its success.

5 Recommendations

There is sufficient ground for not moving the project to the next phase, as well as for opportunities and factors speaking in favor of at least trying to move the project forward. The evaluation team is not in a position to recommend one way over another based on technical arguments. There are many other factors the decision-maker needs to consider in addition to the findings of this evaluation. Therefore, the evaluation team presents possible options for moving forward with all cons and pros to help the donor to take a decision.

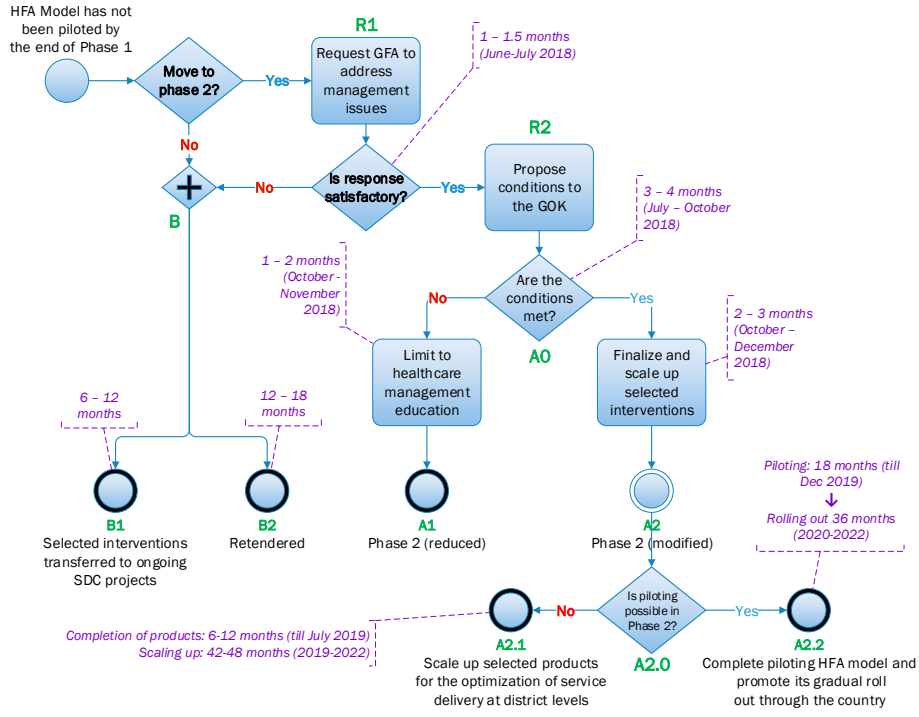
Theoretically, the HFA project can end up in any of the four scenarios shown below:

- A: The project continues to phase 2:
  - A1: Limited to supporting the institutionalization of the education of healthcare managers
  - A2: With modified design (interventions either only at the national level to scale up "assets", or finishing the HFA model, and subsequently, promoting its proliferation throughout the country)
- B: The project does not continue to phase 2:
  - B1: Some selected valuable achievements are transferred to other ongoing SDC funded projects
  - B2: A new RFP is issued to support expanded autonomy of health facilities in Kyrgyzstan

B1 and B2 are rather complementary than mutually exclusive.

If SDC decides to give another chance to the consortium and the country to cooperate and enhance health facility autonomy (direction "A"), the offer is made (action "R1") to the GFA to address management issues based on the lessons learned that entails changes in the implementation arrangements, as well as introduction of effective strategic management. If the SDC finds that the GFA response is not satisfactory, the project does not move to phase 2 (redirecting flow to point "B" in the diagram). If the GFA led consortium addresses all major concerns adequately, the next critical step is to find out whether the government is serious or

Figure 5: Possible developments after the end-phase evaluation



not about the structural changes necessary for unfolding any initiative in support of health facility autonomy (action "R2" in the diagram). If the Government is not ready, the investment in healthcare management education capacity seems to be the only feasible option ("A1" in the diagram). Finally, if the Government meets the conditions, i.e. starts taking real steps toward decentralization simply by (a) changing power distribution landscape in the pilot districts by lifting all restrictions on staffing and remuneration, (b) reflecting decentralization specific interventions in the plan of action of the health sector plan for 2020-30, that (c) serves as one of the conditions for the donor support through SWAp, GFA is invited to re-design the project for phase 2 (circle shape "A2" in the diagram).

The intervention strategy for phase 2 is informed by SDC's decision (diamond shape "A2.0" in the diagram) regarding building the HFA model: if the policy does not restrict completion of piloting of the HFA model in the 1 year of phase 2 (that entails some of the current efforts in pilot districts to continue in 2019), and if SDC finds that delaying nationwide roll-out by 1 year is worth of having working HFA model for demonstration purposes, then option "A2.2" is the final destination. Otherwise, SDC can opt for re-directing the project toward optimization of service delivery by selecting some of the provisional directions/interventions as outlined in Figure 27 (on page 72). Irrespective of the prioritization of interventions, none of them is expected to be implemented in pilot districts or to be considered being a pilot under option "A2.1".

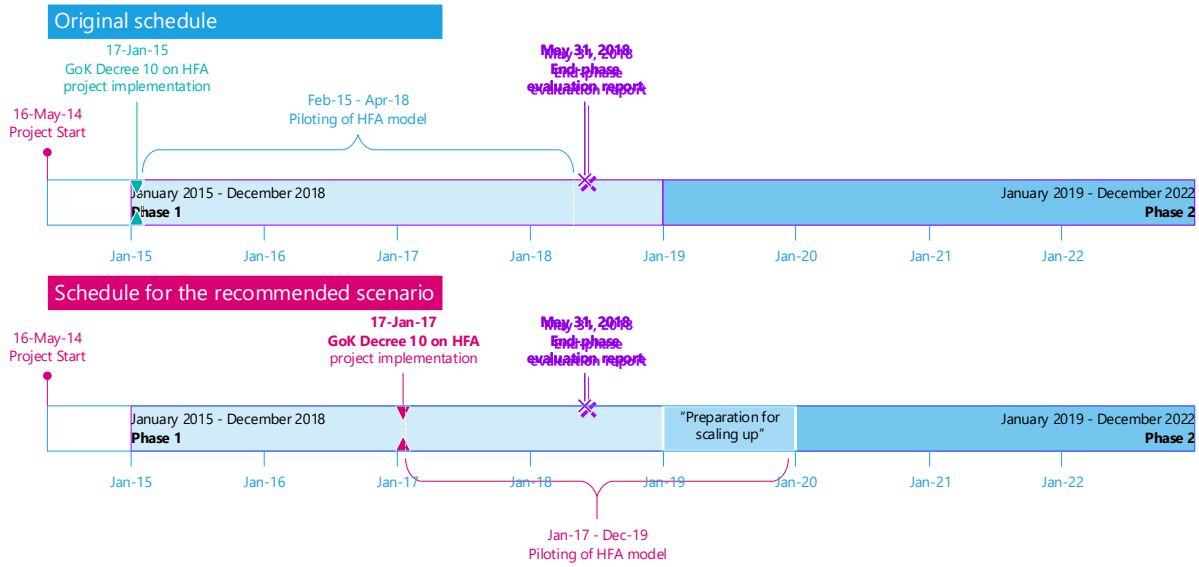
	Advantages / benefits	**Disadvantages / risks**
A1: the project is continued, but is confined to the investment in healthcare management education capacity	• Minimum benefit, but the most certain (and sustainable) option compared to other options – can be the best value for money investment in the long run	• Transaction costs can be high if the implementation arrangements are not trimmed accordingly
A2: the project is continued - GFA is invited to re-design the project focusing support on:	• More chances for breaking through at the policy level, promoting decentralization	• High risk for investment compared to other options (that can be minimized if conditions are used as safeguards)
A2.1: Optimization of service delivery by selecting directions /interventions that are feasible for nationwide implementation ("Service Optimization" vs. "HFA extension)	• Some continuity with the phase 1 in terms of promoting and rolling out certain technical solutions / know-how produced in phase 1 • Stronger alignment with and support of implementation of the pending Masterplan for the Optimization of Medical Services	• "Assets" accumulated by the project may not be as demanded and valuable as expected, reducing the value for money of the entire Phase 2
A2.2: The improvement of quality and efficiency of services through availing HF of the extended autonomy and stronger local ownership and governance (as planned originally)	• The project abides by the original idea of supporting better quality and efficient medical care through the extension of HFA • Little, but still a chance to build an excellence center in the pilot districts in the 1st year of the phase and to promote HFA autonomy	• Project continues implementation (although temporarily) at the grass-roots level • Without strict conditions (or a chain of sequential conditions), the project may occur hand up in air again.
B1: the project does not continue to phase 2, but selected assets (as described in Figure 13 on page 52)	• Minimal losses – most valuable products / "assets" are preserved and presumably, scaled up	• Relatively rigid project implementation and contracting procedures

	Advantages / benefits	Disadvantages / risks
are transferred to ongoing SDC projects for implementation)	• Relatively low transaction costs (compared to re-tendering)	• May cause (hopefully temporary) disruptions in the operation of "hosting project"
B2: the project is re-tendered – situation is reassessed, priorities re-visited and a new RFA is issued to select and award a grant	• Can increase chances for more productive collaboration if the decision is communicated to in-country stakeholders and strict conditions even before moving to re-tendering are discussed and agreed upon (requiring the government to start decentralization in the health sector) • Better chances for success with more calibrated and realistic expectations considering the lessons learned	• Wrong message to the in-country stakeholders – as if the project has to be blamed for the failure, not the government and partners for disregarding structural reforms • No guarantee that stronger and more committed implementing agencies respond – could be waste of time and cause false expectations

The evaluators believe that the scenario through step R1 → step R2 → Decision "A2" – Option "A2.2" is the most desirable not because it pursues the original course, but because it strives for addressing the most critical health system bottleneck on the supply side such as governance and service delivery (that impedes the success of healthcare reforms despite the progress in healthcare financing). At the same time, it is the most challenging scenario both in terms of risks and timing:

Timing

The scenario implies "prolonging phase 1" by one year by letting the project to complete the HFA model in 2019, or the first year of Phase 1 while reducing the duration of scaling up from four to three years.



Ideally, the Government had to endorse the project by providing a regulatory framework for piloting HFA models in January 2015, so piloting FHA models was expected to last 3 years with end-phase evaluation in April-May 2018. In reality the Government gave a green light to unfold managerial or service delivery innovations in January 2017 (as shown above). Therefore, the project can spend 3 years on building HFA model in practice (i.e. establish the "centers of excellence" in the pilot districts demonstrating feasibility and benefits of extended HFA) if SDC policy allows so.

Risks:

The scenario entails 2 safeguards to minimize the associated risks:

- The first one is related to strategic management and implementation arrangements – the scenario stops there (at box "R1" in the diagram) if the GFA response is unsatisfactory
- The second safeguard is securing the commitment from the top political layers (the President's office, the Parliament and the Government) to decentralize governance of the health sector and support expansion of health facility autonomy; 3- 4 months (July -October) should be sufficient for the Government to sign off another decree addressing outstanding gaps in the regulatory framework.

	Impact	**Sustainability**	**Adherence to policy on phases and timing**	**Risk minimization**
A1: Limiting to proviing support to health care management education		**1st choice**	**1st choice**	**2nd choice**
A2.1: Scaling up of selected "assets" without completing HFA model		**2nd choice**		
A2.2: Building the center of excellence of HFA and rolling it out	**1st choice**			
B1: Not continuing to phase 2 moving some interventions to other projects				**1st choice**
B2: Not continuing to phase 2 and retendering	**2nd choice**		**2nd choice**	

A choice of possible five options can be made other way around – based on a single or a combination of guiding criteria or core values (such as "impact", "sustainability", "polices on phases and timing, or "risk minimization"). Finally, the evaluators believe that it is at the discretion of the SDC to select criteria/principles guiding a choice of proposed option. Once selected, the matrix above with the 1st and 2nd choice of options for each criteria can help SDC to validate whether the recommended algorithm lead to the decision that best suits its interests and core values.

✧

6 Annexes

Figure 6: Relationships between evaluation components and methods

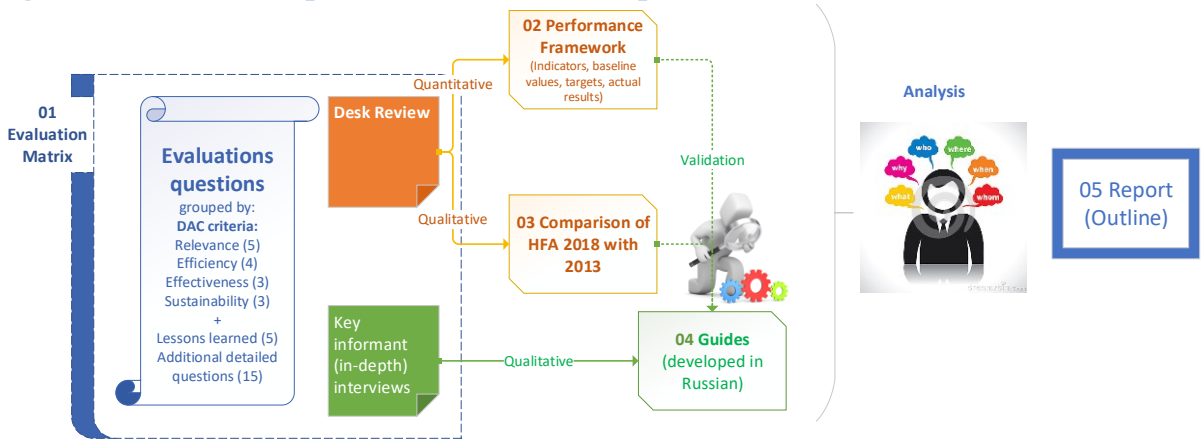
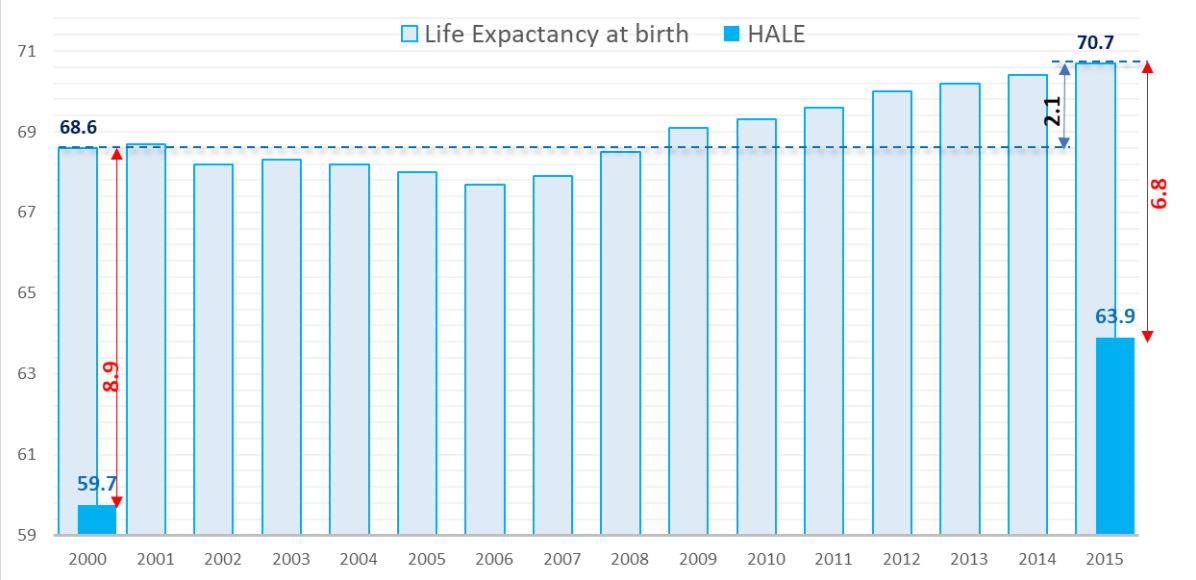
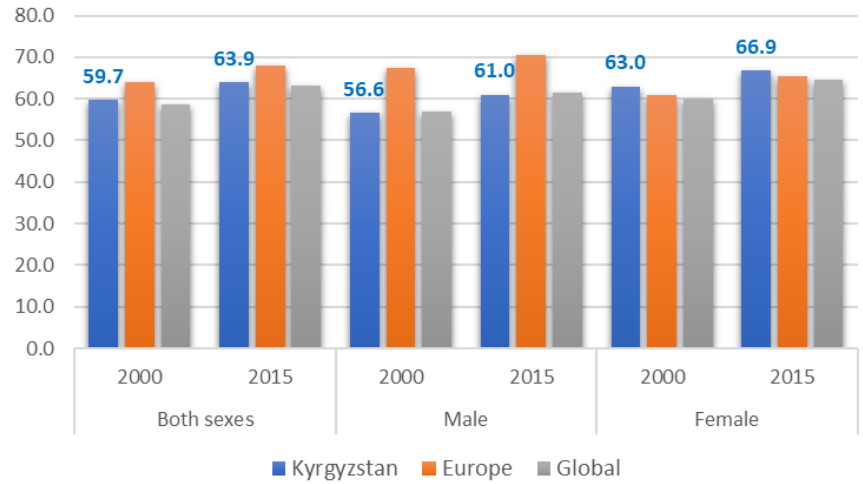


Figure 7: Life expectancy and health life expectancy (at birth) trends in Kyrgyzstan by years



Source: World Health Organization, Global Disease Burden Database. World Bank, WDI

Figure 8: Healthy life expectancy (HALE) at birth by years and gender

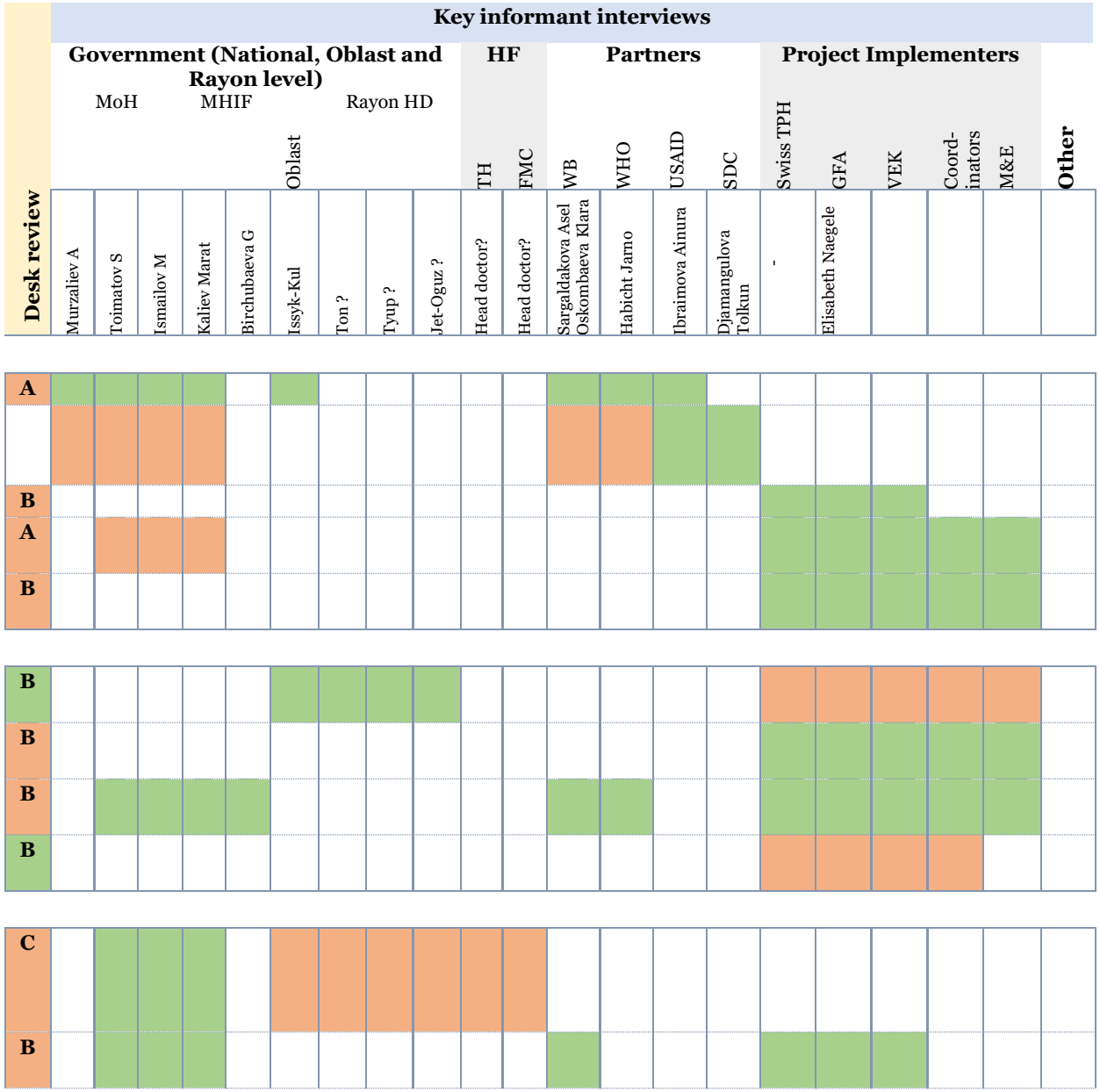


Source: World Health Organization, Global Disease Burden Database

Figure 9: Evaluation Matrix

Legend

- **A** National policy documents, including legislation
- **B** Project specific documents
- **C** Project assessment / technical reports
- Primary source of information
- Secondary source or source for validation



Legend

- **A** National policy documents, including legislation
- **B** Project specific documents
- **C** Project assessment / technical reports
- Primary source of information
- Secondary source or source for validation

		Key informant interviews																					
		Government (National, Oblast and Rayon level)									HF		Partners				Project Implementers					
		MoH		MHIF			Oblast			Rayon HD													
	Desk review	Murzaliev A	Toimatov S	Ismailov M	Kaliev Marat	Birchubaeva G	Issyk-Kul	Ton ?	Tyup ?	Jet-Oguz ?	TH	FMC	WB	WHO	USAID	SDC	Swiss TPH	GFA	VEK	Coord-inators	M&E	**Other**
		Head doctor?	Head doctor?	Sargaldakova Asel Oskombaeva Klara	Habicht Jarno	Ibraimova Ainura	Djamangulova Tolkun	-	Elisabeth Naegele														
3 Are there any un-intended results of the project ("good or less good")?	**B C**																						
Sustainability (3):																							
1 How sustainable is the autonomy model?	**C**																						
2 Can the Ministry of Health replicate the autonomy model to other regions?																							
3 How far the piloted model has been integrated into the country's health system to sustain after the project ends?	**B C**																						
Lessons learned (5):																							
1 What lessons have been learned by the project and the partners?	**B C**																						
2 To what extend have these lessons already been taken into account during the project implementation in phase I?	**B**																						
3 What kind of experience have been made in cooperation with other similar projects in this area?	**B**																						
4 What kind of resistances were identified?	**B**																						
5 Who are the drivers of change/connectors or refrainers?	**B**																						
Additional detailed questions to be answered (15):																							
1 Was the project initiated timely against current context of the health sector reforms in Kyrgyzstan?																							
2 How the autonomy model was designed for pilot areas and how it is concluded?	**B C**																						
3 As a result of the pilot, how the autonomy model is looked like?	**C**																						

Legend

- **A** National policy documents, including legislation
- **B** Project specific documents
- **C** Project assessment / technical reports
- Primary source of information
- Secondary source or source for validation

		Desk review	Key informant interviews: Government (National, Oblast and Rayon level) – MoH: Murzaliev A	MoH: Toimatov S	MHIF: Ismailov M	MHIF: Kaliev Marat	MHIF: Birchubaeva G	Oblast: Issyk-Kul	Rayon HD: Ton ?	Rayon HD: Tyup ?	Rayon HD: Jet-Oguz ?	HF: TH: Head doctor?	HF: FMC: Head doctor?	Partners: WB: Sargaldakova Asel Oskombaeva Klara	Partners: WHO: Habicht Jarno	Partners: USAID: Ibraimova Ainura	Partners: SDC: Djamangulova Tolkun	Project Implementers: Swiss TPH: -	Project Implementers: GFA: Elisabeth Naegele	Project Implementers: VEK	Project Implementers: Coord-inators	Project Implementers: M&E	Other
3.1	What kind of elements of the model are most efficient?																						
3.2	What kind of elements are useless?																						
3.3	Is it ready to be implemented in other regions?																						
4	What are strengths and weaknesses of the autonomy model?	C																					
5	What are the gains from improved autonomy in the pilot area?	B																					
6	What kind of gains are expected from the scaling up of the autonomy model to other regions?																						
7	What is the role of the result-based financing model (joint initiative with WB) in promoting autonomy of the facilities and its sustainability?	C																					
8	How the study tours to other countries contributed to the results of the project and capacity improvement of the facilities management?	B																					
9	What are the main political and technical bottlenecks to scale up the autonomy model?	B																					
9.1	How the project has maintained the policy dialogue?	B																					
9.2	What kind of resistances were in these areas and how they were overcome?	B																					
10	What is the role of the Rayon Health Councils to address health issues with multisectoral approach?																						
10.1	What is the added value of the collaboration with the local municipalities?																						
10.2	What are the de jure competences of local municipalities in health?																						

Legend

- **A** National policy documents, including legislation
- **B** Project specific documents
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- Primary source of information
- Secondary source or source for validation

		Desk review	Key informant interviews																				
			Government (National, Oblast and Rayon level)									HF		Partners				Project Implementers					
			MoH		MHIF		Oblast	Rayon HD				TH	FMC	WB	WHO	USAID	SDC	Swiss TPH	GFA	VEK	Coord-inators	M&E	Other
			Murzaliev A	Toimatov S	Ismailov M	Kaliev Marat	Birchubaeva G	Issyk-Kul	Ton ?	Tyup ?	Jet-Oguz ?	Head doctor?	Head doctor?	Sargaldakova Asel Oskombaeva Klara	Habicht Jarno	Ibraimova Ainura	Djamangulova Tolkun	-	Elisabeth Naegele				
11	What is the position of the Kyrgyz Government in terms of granting autonomy to the health facilities? Is the MoH is ready:																						
11.1	To decentralize the management of the health facilities?																						
11.2	To prepare actors mapping of the government representatives involved in this process and analyse interests and resistances.	B																					
11.3	Who of them are the connectors and dividers of the autonomy process?																						
12	How the model should be scaled up?	B																					
12.1	What kind of interventions should be covered by the Kyrgyz Government?	B C																					
12.2	What should be the role of the health facilities?	B																					
12.3	Which elements of the model should be carried by the project in the phase II?	B																					
12.4	How long the project should be engaged in the scaling up of the autonomy model?	B																					
13	What is the specific role and added value of the Consortium members (GFA, STPH, VEK) in the project implementation?	B																					
14	Is there any courses concerning health sector management?	C																					
14.1	What are strength and weaknesses of these courses?																						
14.2	How the project should be involved in this issue within phase II?																						

Legend

- **A** National policy documents, including legislation
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	Desk review	Key informant interviews: Government (National, Oblast and Rayon level) – MoH: Murzaliev A	MoH: Toimatov S	MHIF: Ismailov M	MHIF: Kaliev Marat	MHIF: Birchubaeva G	Oblast: Issyk-Kul	Oblast: Ton ?	Oblast: Tyup ?	Rayon HD: Jet-Oguz ?	HF: TH: Head doctor?	HF: FMC: Head doctor?	Partners: WB: Sargaldakova Asel Oskombaeva Klara	Partners: WHO: Habicht Jarno	Partners: USAID: Ibraimova Ainura	Partners: SDC: Djamangulova Tolkun	Project Implementers: Swiss TPH: -	Project Implementers: GFA: Elisabeth Naegele	Project Implementers: VEK	Project Implementers: Coord-inators	Project Implementers: M&E	Other
15 In terms of cross-cutting issues, what kind of gender specific issues were addressed within the project and how they were implemented?	B																					
15.1 What kind of measures were taken to ensure equity and inclusion (how it was planned and implemented)?	B																					
15.2 What kind of recommendations to address cross-cutting issues can be provided for Phase II?																						

Figure 10: A catalogue of project specific documents reviewed

Group and #	Folder or File Name	Vol	Lang	Year	Document Title	Comment
Key Project documents (0x)	00 HFA ProDoc.pdf	90 p	En	2014 ?	Project Document – Final Draft. "Health Facilities' Autonomy in Kyrgyzstan". Implementation Phase I	Main document explaining the context, concepts, objectives, implementation strategy, project implementation arrangements, risk assessment, and M&E
	01 Prodoc ANNEXES.docx	154 p	En	2014 ?	Annexes. "Health Facilities' Autonomy in Kyrgyzstan". Implementation Phase I	Presents 13 annexes, including stakeholder analysis, SWAT analysis, risk assessment and mitigation strategies, action plan and project deliverables.
	02 Annex 2 Logframe.docx	7 p	En	2014 ?	Annex 2. The Logframe of the "Health Facilities Autonomy" Project	A comprehensive and detailed log frame (includes activates)
	09 Selection of HF	6 + 1p	En	2014	ProcessAnnex 2: Selection criteria for pilot and description of the selection process of the HFA project pilot rayons	Described the rationale behind and process of selection HF for piloting a model of autonomy
Project Implementation	10 HFA Annual report 2015.docx	31 p	En	2016	ANNUAL REPORT 01 January 2015 – 31 December 2015	Presents the progress (results against the targets) in producing outcomes and outputs, challenges and risks (confirmed or revealed), budget execution and

Group and #	Folder or File Name	Vol	Lang	Year	Document Title	Comment
progress reports (1x)						revisions (with justification), list of 16 annexes available on demand, "THE HFA PROJECT LOGICAL FRAME FOR IMPLEMENTATION PHASE 1: INDICATOR BASELINE" that looks as a set of baseline measurements for the performance framework desegregated by target rayons.
	11 Revised HFA Semi-annual report 2016.pdf	51 p	En	2016	SEMI-ANNUAL REPORT 01 January 2016 – 30 June 2016	Presents deliverables under each outcome and output, financial performance, plus 3 annexes: a detailed Plan of Action 2016, THE HFA PROJECT LOGICAL FRAME FOR IMPLEMENTATION PHASE 1: INDICATOR BASELINE" and other 7 annexes on Demand
	12 GFA HFA annual report_2016_final.pdf	41 p	En	2017	ANNUAL REPORT. 01 January 2016 – 31 December 2016	Presents SDC Transversal Theme "Gender and CSPM", "Outlook on Project Impact", description of the progress toward outcomes and outputs, and the list of 10 Annexes "available upon request". Annexes 1 to 6, and 13 might be needed for the review.
	13 HFA Semi-annual report June 2017_approved.dox	60 p	En	2017	SEMI-ANNUAL REPORT 01 January 2017 – 30 June 2017	Presents three "SDC Transversal Themes" in introduction section, and "Progress toward outcomes in January – June 2017". Two annexes are presented in standalone documents (12.1 and 12.2 see below)
	13.1 Annex 1 Logframe_HFA status update June 2017.docx	14 p	En	2017	The Logframe of the "Health Facilities Autonomy" Project – status update June 2017	Looks as Log frame repeating the hierarchy of 2014 Logframe, but presents a set of indicators with baseline values and targets, and results. The set of indicators is not the same as was in doc 02.
	13.2 Annex 2 Risk assessment_update 2017.docx	4 p	En	2017	Annex 2: Risk Assessment and Mitigating Strategies, June 2017	Lists the major risks and compares the level of risk at the beginning and during the implementation for each of the risk, followed by mitigation actions and updates.
	14 RU_HFA_Package of Indicators_2018_01_01.docx	26 p	Ru	2018	Индикаторы мониторинга и оценки	Performance framework with 44 indicators by the hierarchy of results, baseline values, 2018 targets and actual results
Project deliverables and/or applied research reports (2x)	20 Final_отчет АОЗ барьеры_02042018_IE.docxs	60 p	Ru	2018	Отчет исследования по выявлению барьеров к улучшению результатов деятельности организаций здравоохранения	Presents 4 categories of barriers to the introduction of health facility autonomy (related to internal management of health facilities, incentives and capacity of health managers, staffing with appropriate health professionals, and accreditation). A table on pages 38-41 presents the list of barriers, the status of addressing them, and solutions.

Group and #	Folder or File Name	Vol	Lang	Year	Document Title	Comment
						Annexes contain useful references to legal norms related to health facility autonomy.
	21 Пакеты_Продукты АОЗ 2015-2018.docx	1 p	Ru	2018	Перечень пакетов мероприятий и результатов Проекта АОЗ за 2015-2018	Presents a list of deliverables next to project interventions in different areas of administration, MIS, legislation, capacity building and inter-sectoral coordination.
	22 Характеристики автономной ОЗ_final_29032018	5 p	Ru	2018	МОДЕЛЬ АВТОНОМИИ ОЗ	Presents key characteristics of three versions (levels) of health facility autonomy to inform policy makers. One of the most critical technical products.
	23 Last_14032018_Матрица направлений работы проекта АОЗ	16	Ru	2018	Направления работы Проекта АОЗ 2015-2018 и видение на будущее 2019-2028. Версия 03.2018 vs.1.0	Presents the list of problems, expected results and corresponding interventions for 2015-2018 (original or revised?), followed by the intervention projections for 2019-2028 and the prospects of sustainability/transition
	29.01 Автономия Здравоохранения_М-Вектор.docx	35	En	2015 ?	Brief report on the research findings . Assessment of innovations' impact in the sphere of public healthcare: determination of baseline indicators for the project's impact	The Russian Version provides methodological details for the measurement of 4 impact level indicators and results of the actual measurement (to be used as a baseline). The study is accompanied by 6 attachments in Russian.
	223 Last_14032018_Матрица направлений работы проекта АОЗ.	68	Ru	2015?	АНАЛИТИЧЕСКИЙ ОТЧЕТ ПО РЕЗУЛЬТАТАМ ИССЛЕДОВАНИЯ. Оценка влияния инноваций в области государственного здравоохранения: определение исходных уровней индикаторов влияния проекта	
Other documents (9x)	90 KYR Hawkins Health Provider Autonomy report Aug 2013_v4_FINAL	28 p	En	2013	Using Health Facility Autonomy, Management and Governance Reform to Improve Quality and Efficiency in the Kyrgyz Health System Consultancy report in support of the Den Sooluk National Health Sector Reform Program	Presents the situation in health sector or reform as of 2013 and lays out a conceptual framework for health facility autonomy, as well as solutions (e.g. in section "VIII. What Kind of Reform is Needed: Priorities for System Reform and Local Pilots")
	91 Needs assessment_Final Report 2013-04-28_eng.docx	53 p	En	2013	Autonomy of Health Facilities in the Kyrgyz Republic Assessment of Needs for providing autonomy for health facilities in the Kyrgyz Republic	Defines the context, and justification of possible interventions to address the gaps in health facility autonomy

Group and #	Folder or File Name	Vol	Lang	Year	Document Title	Comment
	92 Report_Bernard_C._HFA Project Design_final.docs	45 p	En	2013	PROJECT DESIGN FOR HEALTH FACILITY AUTONOMY IN KYRGIZSTAN	The project proposal (the value of the document for the external evaluation yet to be defined)
	93 Логическая матрица проекта АОЗ по итогам за 2017	8 p	En-Ru	2018	Project performance framework	Working documents / needs to be discussed with the M&E and project team

Figure 11: Economic and social context in numbers (selected World Development Indicators)

№	Indicator Name	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
	Macroeconomic indicators																	
1	GDP growth (annual %)	5.30		7.00	7.00	-0.20	3.10	8.50	8.40	2.90	-0.50	6.00	-0.10	10.90	4.00	3.90	3.80	
2	GDP per capita (current US$)	308	322	381	433	477	543	722	966	871	880	1124	1178	1282	1280	1121	1078	
3	GDP per capita growth (annual %)	4.33	-0.93	5.91	5.74	-1.30	2.00	7.51	7.38	1.65	-1.65	4.67	-1.74	8.74	1.96	1.76	1.73	
4	GDP per capita, PPP (current international $)	1,755	1,765	1,907	2,071	2,110	2,219	2,449	2,681	2,746	2,734	2,921	2,923	3,229	3,352	3,448	3,552	
5	GNI per capita, Atlas method (current US$)	280	290	340	400	450	500	610	760	860	850	880	1,040	1,190	1,250	1,180	1,100	
6	Inflation, consumer prices (annual %)	6.92	2.13	2.97	4.11	4.35	5.56	10.18	24.52	6.90	7.97	16.50	2.69	6.61	7.53	6.50	0.42	
7	Tax revenue (% of GDP)														17.5	16.8	17.6	
8	Labor tax and contributions (% of commercial profits)					28.2	27.1	2.3	2.3	2.3	21.5	19.5	19.5	19.5	19.5	19.5	19.5	19.5
9	Tax payments (number)					76	76	76	76	76	48	52	52	52	51	51	51	51
10	Profit tax (% of commercial profits)					5.1	5.4	3.0	3.0	3.0	8.6	5.9	5.9	6.4	6.4	6.4	6.4	6.4
11	Total tax rate (% of commercial profits)					68.3	67.4	40.3	40.3	40.2	30.6	33.4	33.4	29.0	29.0	29.0	29.0	29.0
12	External debt stocks (% of GNI)	124.4	126.5	115.7	121.4	95.1	93.2	76.8	73.5	91.4	91.7	99.0	93.6	98.4	101.4	117.0	125.3	
13	Central government debt, total (% of GDP)														54.0	72.0	63.0	
14	Foreign direct investment, net inflows (BoP, current US$, in million)	5	5	46	175	43	182	208	377	189	473	686	261	612	343	1,144	619	
15	Foreign direct investment, net inflows (% of GDP)	0.3	0.3	2.4	7.9	1.7	6.4	5.5	7.3	4.0	9.9	11.1	4.0	8.3	4.6	17.1	9.5	
16	Personal remittances, received (current US$, in million)	5	30	70	179	313	473	704	1223	982	1266	1709	2031	2278	2243	1688	1995	
17	Personal remittances, received (% of GDP)	0.3	1.9	3.7	8.1	12.7	16.7	18.5	23.8	20.9	26.4	27.6	30.8	31.1	30.0	25.3	30.4	
18	Net official development assistance and official aid received (current US$, in million)	188.0	186.0	200.0	261.0	267.0	311.0	281.0	357.0	313.0	384.0	523.0	470.0	539.0	627.0	770.0	515.0	
19	Official exchange rate (LCU per US$, period average)	48.0	47.0	44.0	43.0	41.0	40.0	37.0	37.0	43.0	46.0	46.0	47.0	48.0	54.0	64.0	70.0	69.0
	Social (Demographic, Social Protection, Labor market, Poverty)																	
20	Population ages 0-14 (% of total)	34.30	33.50	32.60	31.70	31.00	30.50	30.20	30.00	29.90	29.90	30.00	30.20	30.40	30.80	31.10	31.50	
21	Population growth (annual %)	0.90	0.90	1.00	1.20	1.10	1.10	1.00	1.00	1.20	1.20	1.20	1.70	2.00	2.00	2.10	2.00	
22	Population, total (in million)	4.95	4.99	5.04	5.10	5.16	5.22	5.27	5.32	5.38	5.45	5.51	5.61	5.72	5.84	5.96	6.08	
23	Urban population (% of total)	35.30	35.30	35.29	35.29	35.29	35.29	35.29	35.29	35.28	35.30	35.34	35.40	35.48	35.59	35.71	35.85	
24	Birth Rate (crude, per 1,000 people)	19.80	20.20	20.90	21.50	21.30	23.10	23.40	23.90	25.20	26.80	27.10	27.60	27.20	27.70	27.40	26.00	
25	Adequacy of social protection and labor programs (% of total welfare of beneficiary households)						27.80					32.90	42.00	42.20				
26	Benefits incidence in poorest quintile (%) -All Social Protection and Labor						11.60					13.30	14.20	15.50				
27	Coverage (%) -All Social Protection and Labor						36.60					60.00	58.30	57.90				

№	Indicator Name	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
28	Adequacy of unemployment benefits and ALMP (% of total welfare of beneficiary households)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
29	Adequacy of social safety net programs (% of total welfare of beneficiary households)						9.20					8.40	10.00	11.20				
30	Coverage (%) – All Social Assistance						8.10					8.50	7.30	7.20				
31	Adequacy of social insurance programs (% of total welfare of beneficiary households)						30.00					34.70	44.00	44.40				
32	Benefits incidence in poorest quintile (%) – All Social Insurance						10.20					12.50	13.80	14.90				
33	Coverage (%) – All Social Insurance						30.50					40.20	41.60	39.30				
34	Unemployment, youth total (% of total labor force ages 15-24) (national estimate)		20.1		15.2	14.4	14.6			16.8	16.7	16.6	17.6	13.4	14.0	15.0	15.5	
35	Unemployment, youth total (% of total labor force ages 15-24) (modeled ILO estimate)	14.2	20.1	16.6	15.2	14.5	14.6	14.8	15.4	16.8	16.5	16.4	17.5	13.4	14.0	15.0	15.6	15.7
36	Share of youth not in education, employment, or training, total (% of youth population)									17.8	18.5	60.5	62.5	21.2	20.7	21.4	20.4	
37	Unemployment, total (% of total labor force) (national estimate)	7.8	12.6	9.9	8.5	8.1	8.3	8.1	8.2	8.4	8.6	8.5	8.4	8.3	8.1	7.6	7.2	
38	Unemployment, total (% of total labor force)	7.8	12.6	9.9	8.5	8.1	8.3	8.1	8.2	8.4	8.6	8.5	8.4	8.3	8.1	7.6	7.2	7.3
39	Poverty headcount ratio at $3.10 a day (2011 PPP) (% of population)	72.8	71.9	69.3	46.7	51.8	39.1	36.0	25.0	21.1	23.3	21.4	21.5	26.3	19.7	23.2	19.1	
40	Poverty headcount ratio at $1.90 a day (2011 PPP) (% of population)	36.4	34.2	28.1	13.6	15.4	9.9	9.9	4.0	2.1	4.1	1.8	2.9	3.3	1.3	2.5	1.4	
41	Poverty gap at $3.20 a day (2011 PPP) (% of population)	28.9	27.8	24.7	14.0	15.7	10.9	10.3	5.9	4.1	5.7	4.0	4.7	5.6	3.5	4.7	3.4	
42	Poverty gap at $1.90 a day (2011 PPP) (%)	9.3	8.7	6.2	2.8	3.1	1.8	2.0	0.7	0.3	1.1	0.2	0.7	0.5	0.2	0.5	0.2	
43	GINI index (World Bank estimate)	30.2	30.3	28.7	34.8	32.6	37.4	33.9	31.5	29.9	30.1	27.8	27.4	28.8	26.8	29.0	26.8	
44	Poverty headcount ratio at national poverty lines (% of population)						39.9	35.0	31.7	31.7	33.7	36.8	38.0	37.0	30.6	32.1	25.4	
	Education																	
45	Pupil-teacher ratio in pre-primary education (headcount basis)	19.0	19.8	21.0	21.8	22.7	23.9	25.4	26.8	27.2	26.2	26.9						
46	Pupil-teacher ratio in primary education (headcount basis)	24.4	24.0	24.5	24.2	24.5	23.8	24.2	24.2	24.0	24.3	24.9	23.9	24.5	25.3	26.2	25.0	
47	Pupil-teacher ratio, secondary	13.7	13.4	14.0	13.7	13.4	13.5	13.6		14.7	14.3	14.3	12.6	12.2	12.4	10.8	11.0	
48	Effective transition rate from primary to lower secondary general education, both sexes (%)	99.7	98.4	99.0	99.1	100.0	99.0	99.9	99.6	99.3	98.2	98.9	99.7	99.7	99.2	99.7		
49	Expenditure on primary education (% of government expenditure on education)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
50	Expenditure on secondary education (% of government expenditure on education)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
51	Expenditure on tertiary as % of government expenditure on education (%)	17.2	19.6	19.9	19.8	19.2	18.0	15.9	16.4	15.6	15.5		12.0	12.8	4.6			
52	Expenditure on education as % of total government expenditure (%)	13.7	15.1	15.9	16.2	16.5	18.4	20.3	20.2	18.1	15.7	18.2	18.2	17.8	16.1	16.3		
53	Government expenditure on education, total (% of GDP)	3.9	4.4	4.5	4.6	4.9	5.5	6.5	5.9	6.2	5.8	6.8	7.4	6.8	5.5	6.0		
54	Literacy rate, adult total (% of people ages 15 and above)									99.2								
55	Literacy rate, youth total (% of people ages 15-24)									99.8								
	Health																	
56	Life expectancy at birth, total (years)	68.7	68.2	68.3	68.2	68.0	67.7	67.9	68.5	69.1	69.3	69.6	70.0	70.2	70.4	70.7	71.0	
57	Prevalence of HIV, total (% of population ages 15-49)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
58	Mortality rate, under-5 (per 1,000 live births)	47.2	45.1	43.1	41.2	39.4	37.7	35.8	33.8	31.6	29.6	27.8	26.2	24.8	23.5	22.3	21.1	
59	Mortality rate, neonatal (per 1,000 live births)	21.1	20.7	20.2	19.8	19.4	19.0	18.4	17.6	16.8	15.9	15.0	14.2	13.5	12.9	12.2	11.6	
60	Children (0-14) living with HIV	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	200.0	200.0	200.0	200.0	200.0	
61	Prevalence of HIV, female (% ages 15-24)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	

№	Indicator Name	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
62	Prevalence of HIV, male (% ages 15-24)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	
63	Antiretroviral therapy coverage (% of people living with HIV)						1.0	2.0	3.0	4.0	5.0	7.0	8.0	13.0	19.0	28.0	28.0	
64	Maternal mortality ratio (modeled estimate, per 100,000 live births)	72.0	81.0	82.0	81.0	85.0	90.0	89.0	89.0	89.0	84.0	87.0	81.0	79.0	77.0	76.0		
65	Maternal mortality ratio (national estimate, per 100,000 live births)			49.0			104.0		55.0	63.5			49.1					
66	Completeness of infant death reporting (% of reported infant deaths to estimated infant deaths)						80.7		77.2	75.6								
67	Mortality rate, infant (per 1,000 live births)	40.4	38.8	37.2	35.7	34.2	32.8	31.3	29.6	27.8	26.1	24.6	23.2	22.0	20.9	19.9	18.8	
68	Births attended by skilled health staff (% of total)	98.7	98.8	98.9	98.2	97.9	97.6	98.4	98.5	98.5	98.3	98.6	99.1	99.0	98.4			
69	ARI treatment (% of children under 5 taken to a health provider)						62.0						33.2		59.7			
70	Physicians (per 1,000 people)	2.7	2.6	2.6	2.5		2.4	2.3	2.5	2.4	1.9	1.9	1.9	1.9	1.9			
71	Nurses and midwives (per 1,000 people)						5.8	5.7	5.5	5.4	6.0	6.2	6.3	6.4				
	Healthcare Financing																	
72	External health expenditure (% of current health expenditure)			10.0	15.7	6.4	10.1	12.6	7.9	12.0	9.5	5.2	7.4	5.4	5.7	6.9		
73	Out-of-pocket expenditure (% of current health expenditure)	53.2	51.7	51.1	46.6	42.6	39.2	42.9	48.2	38.1	42.3	43.2	43.1	46.4	50.0	48.2		
74	Proportion of population spending > 25% of HH consumption or income on OOP healthcare expenditure (%)					0.5	0.8	0.6	0.3	0.4	0.3	0.8						
75	Current health expenditure per capita (current US$)	13.2	14.8	22.3	27.2	36.1	45.9	50.8	64.4	61.3	62.6	80.6	100.8	105.7	107.5	92.1		
76	Current health expenditure per capita, PPP (current international $)	75	81	112	130	160	188	172	179	193	194	209	250	266	282	287		
77	Domestic private health expenditure (% of current health expenditure)	53.1	51.7	51.1	46.6	42.6	39.2	42.9	48.2	38.1	42.3	43.2	43.1	46.4	50.0	48.2		
78	Domestic general government health expenditure (% of current health expenditure)	46.9	48.3	38.9	37.7	51.0	50.7	44.5	43.9	49.9	48.2	51.6	49.5	48.2	44.4	44.9		
79	Domestic general government health expenditure (% of general government expenditure)	7.1	7.6	8.1	8.2	12.8	14.0	9.7	9.9	10.1	9.2	9.9	10.4	10.3	10.7	9.9		
80	Domestic general government health expenditure (% of GDP)	2.0	2.2	2.3	2.3	3.8	4.2	3.1	2.9	3.5	3.4	3.7	4.2	3.9	3.7	3.7		
81	Current health expenditure (% of GDP)	4.3	4.6	5.8	6.2	7.5	8.3	6.9	6.6	7.0	7.1	7.2	8.5	8.2	8.3	8.2		

Source: *World Bank, World Development Indicators for Kyrgyzstan*

Figure 12: Results of the project evaluability and performance assessments

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
0. Impact: 0.1 Efficiency and quality of health care services	1. % population satisfied with rayon health care delivery system	82.4% (score 344)	2014	100? (x / 435)	2017	Pending	2017	Cannot be measured.	Irrelevant to measure result in 2017 (in pilot rayons presumably) even if the pilot had been tested;

[7] Indicators in *italic* means that they were added recently to the log-frame (LG) or performance framework (PF)

[8] The criteria used for the evaluability assessment are defined as follow:
Relevance (in this context): does the change/phenomena measured by indicator is related somehow to the stated result? Does the feature measured by indicator capture changes we are interested in?
Attribution (in case of outcome and impact), **specificity** (in case of outputs): are their factors/interventions that determine the feature/phenomena measured by indicator other than this project (or other than proposed activities)? How likely the same results can be achieved by other interventions (or projects)? How likely other factors can offset the changes made by this project as measured by the proposed indicator?

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
to population improved by expanding Health Facilities autonomy	2. Point of increase of a composite quality score of pilot HFs (requires development of methodology)	78.9% (score 181.5)		90 or 100% (x / 230)	2017	Pending	2017	Will be available in 2018 (?)	Hard to interpret if used only subjective dimensions of quality and efficiency.
	3. Points of increase of a composite efficiency score (allocative and technical efficiency) at rayon level (requires development of methodology)	128.8		"steady decline"	2018			Not found in the latest LF or PF	Should be balanced with objective standard indicators of quality of health care services. More clear definition of efficiency is needed accompanied by relevant objective (quantifiable) indicators
	4. Score improvement measured by Social Accountability Monitoring and Evaluation (SAME) indicators	44.%[9] | 55.5%[10]		60% | 70% or 100%	2017	Pending	2017	Will be available in 2018	The same as above about inappropriate timing.
0.2 HCOs transformed into efficient and service- and patient-oriented care providers	1. % of reduction of emergency admissions to rayon hospitals with ambulatory manageable conditions/diseases					10.4% (as per 2017 H1) 11.57 (as per PMT)	2017	**Achievement is unclear**	Moved to outcome #1, modified… presumably into indicator #13 in the latest PF. As explained by the PMT, it was replaced by Outcome 1 Indicator 5 (#1-5) below *"Number of emergency hospitalizations of patients with hypertension to pilot hospitals"*. As per PMT, the indicator was modified / replaced because of the MoH Order 651 (24.08.2016) Definition changed from % reduction to % and absolute number of visits.
	2. % of reduction of ambulance calls for ambulatory manageable conditions/diseases							No data	Cannot be found in any recent M&E document. Replaced by indicator 1-5 below because of the MoH Order 651 (24.08.2016)

[9] Among population
[10] Among health workers

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	3. % of increase of direct actual expenditures on patient care (drugs, medical supplies) at rayon level per capita							No data	Moved down to outcome #1, as indicator #5 in Logfame 2017 (doc #13.1). Removed in the latest PF (doc #14) as confirmed by the PMT.
	4. % of increase of direct actual expenditures on patient care (drugs, medical supplies and food) at rayon level per hospital admission	13.4% (13 | 13.5 | 13.7)		Increase by 10%?	?	9.6 (8.14 | 10.3 | 10.3)	2017	**Not Achieved**	#5 in the latest PF (doc #14) and moved to Outcome #1 below. Hard to interpret, and does not seem relevant unless compounding factors are measured (for instance, if HFA increases earnings of medical staff, it may reduce the share of drugs / consumables in current expenditures; or rationale, evidence-based treatment protocols may contribute to this reduction itself). As explained by the PMT, the share of wages in hospital expenditures should decrease after staff optimization eventually. If the result the project should attain is the optimization of hospital staff and associated expenditures, then this indicator is **absolutely irrelevant**.
	5. Average quality score achieved by FGPs, measured by quality assessment of FGPs within PHC RBF model	0	2014	850	2018	514 in H1 621 (as per PMT)	2017	**Not Achieved (60% of the target in H1, 73% in 2017)**	#6 in the latest LF (moved to outcome 1) and PF Hard to interpret; 100% of the maximum composite score does not seem realistic anyway. Unclear how relevant it is to the HFA project as long as it is induced by PBF (quality stimulated by payment modality conceptually can be distinguished from a "genuine quality" of more mature, autonomous SDO…)
	6. Average quality score achieved by Family Medicine/General Practitioner Center	0	2014	850	2018	487 in H1 576 (as per PMT)	2017	**Not Achieved (57% of the**	#7 in the latest LF and PF The same as above

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	measured by quality assessment of management and support to PHC (within RBF)							**target in H1, 67% in 2017)**	
	7. Average quality score achieved by THs/GPC, measured by quality assessment of THs/GPC (within hospital RBF)	0	2014	850	2018	723 in H1 764 (as per PMT)	2017	**Partly achieved (85% of the target in H1, 89% in 2017)**	#8 in the latest LF and PF The same as above
	8. Доля средств ФОР ПМСП пилотных ОЗ, полученных за результаты деятельности (ФОР ПМСП)	0	2014	Annual increase		2.1% → 4.4% | 2.6% → 1.8% | 1.5% → 1.6%		**Mixed achievements**	Definition in English could not be found. #9 in the latest PF, absent in the latest LF Hard to interpret, and target is vague (just "annual increase")
1. Health Facilities are modernized to be effectively managed and capable to utilize expanded autonomy	1. Average number of hospital discharges per hospital – based physician ("practicing physicians")							Data missing	Removed as confirmed by the MPT (because of its **irrelevance**)
	2. % day cases in total of hospital discharges							Data missing	Removed as confirmed by the MPT (because of its **irrelevance**)
	3. Average number of patient visits per physician at HFs of PHC level	2.3 | 1.5 | 1.6	2014	2.7	2017	1.8 | 0.9 | 1.5	2017 H1	**Not Achieved**	#10 in the latest PF Reduction is explained by changes in registration of visits (due to improved internal controls). If so, the indicator cannot be used to measure any progress unless new baseline values are defined. The project contribution to the improvement as explained by the MPT (IT hardware, training of medical staff in registration/data management) makes this indicator look even more **inappropriate**. Relevance – Zero Attribution – Low

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	4. Number of adverse events in pilot HFs, including cases of nosocomial infections	?		?				No data	Is in the latest LF, but cannot be found in the latest PF. Removed as confirmed by the PMT (because of poor attribution); the explanation is debatable: the indicator seems **RELEVANT** to the original project, but may **not capture the changes** the project made concerning quality of care. Relevance – Hight Attribution – Medium
	5. (PF Ind 11) Number of emergency hospitalizations of patients with hypertension to pilot hospitals	67	2014	Annual decrease by 10% (as per the attest LF) 0 (as per the last 2017 annual report)		20	2017	**Not Achieved** (if 2017 annual report target is considered)	Indicator #11 in the latest LF and PF Target is unclear; the result was 72 in 2015, 89 in 2016 and then 20 in 2017. **Relevance to the HFA (at least in its phase) is very low, and attribution of** HFA project interventions – almost ZERO. As explained by the PMT, the indicator was added because of the establishment of emergency departments in territorial hospitals. Still, the indicator **seems useless** unless refined properly. Interpretation is difficult without understanding the context (e.g. respective morbidity trends)
	6. Работа койки в ОЗ пилотного района (turnover rate of hospital bed)			Annual increase or national average of 291 days		69% | 77% | 81% 234 | 262 | 276	2017	**Not Achieved**	#12 in the latest PF, presumably "Hospital bed occupancy rate" in the LF as shown below. In the latest 2017 annual report it was moved down to Output 1.4 **NOT Relevant** to HFA. Presumably indicates the efficiency of hospitals, but hard to attribute to the HFA (because it increases only after hospital optimization, that can be a consequence of HFA with a very

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
									high degree of discretion, or can happen due to a reform process on hospital optimization that is not related to HFA at all). As per PMT explanation, the optimization affects this indicator. The evaluation team agrees with that, but does not understand what piloting of HFA has to do with this intervention (when hospitals autonomy has not expanded yet).
	7. (PF Ind 6) Average quality score achieved by FGPs, measured by quality assessment of FGPs within PHC RBF model	0	2014	850	2018	514 (H1) 621 (as per PMT)	2017	**Not Achieved**	Formulated as "Average quality score achieved by FGPs" in the latest LF in 2017 Relevance – Low Attribution – Low
	8. (PF Ind 7) Average quality score achieved by Family Medicine/General Practitioner Center measured by quality assessment of management and support to PHC (within RBF)	0	2014	850	2018	487 in H1 576 (as per PMT)	2017	**Not Achieved (57% of the target in H1, 67% in 2017)**	Relevance – Low Attribution – Medium
	9. (PF Ind 8) Average quality score achieved by THs/GPC, measured by quality assessment of THs/GPC (within hospital RBF)	0	2014	850	2018	723 in H1 764 (as per PMT)	2017	**Partly achieved (85% of the target in H1, 89% in 2017)**	Relevance – Low Attribution – Medium
1.1 Managerial and operational knowhow in clinical and para-clinical fields applied at HFs	1. Bed occupancy rate (%)	66.6 70 | 58 | 72	2014	85	2017	70.33 67 | 70 | 74	2017 H1	**Not achieved** Increased only by 2 points from 72 to 74, not passed even the midpoint between baseline and target	See comments above. Not relevant to output 1 Specificity – very low

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	2. Annual bed turnover	28.1 | 36.9 | 29.6	2014			39.1 | 47.9 | 39.8	2017	Cannot be assessed	Removed as confirmed by PMT. However, the data is still collected for reporting. Relevance – Zero Specificity – very low
	3. % decrease waiting time of starting therapy and/or surgery for planned/elective hospital admissions							No data	Not found in the LF or PF. Removed as explained by the PMT because of absence of waiting lists (for hospitalization). As it seems to the evaluation team, the indicator was intended to measure a lag between hospitalization and the first curative intervention (medical treatment or surgery). Therefore, the PMT explanation is debatable. Relevance – high Specificity – medium
	4. % of nurses at PHC settings (FMC and their branches) with expanded job descriptions (JDs)	0		4	2017	4	2017	Achieved ???	Cannot be found in the latest PF. As explained by the PMT, it was excluded because of new job descriptions for PHC with extending scope (but values still were reported by mistake). Definition is unclear, so cannot be unpretreated. Relevance – Low Specificity – Low
	5. % medical personnel of pilot HFs participating in peer chart reviews, incident reporting, quality audits to monitor implementation of clinical guidelines	?		?		?		No Data	Cannot be found in the latest PF. Excluded because is not monitored either by SDOs or the project (as explained by the PMT). The evaluation team found the explanation insufficient considering the relevance and specificity of the indicator. Relevance – high Specificity – high

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	6. *Indicator 13: Percentage and number of inappropriate hospital admissions/stay*	9.4%				11.57 %(H1) 10.5%	2017	**Not Achieved.** ("off – track") Was 11% in 2015, went down to 5.4% in 2016.	Not found in the PF, but as explained by the PMT, it was replaced by 1-5 indicator. However, results against the indicator were reported in 2017 Semi-annual and 2017 annual reports. Hard to interpret. Relevance – medium Specificity – low
	7. *Average quality score (QS) received by FGPs for the introduction of separated patient flow*	0		10		3.3 (H1) 6.0 (as per PMT)	2017	**Not Achieved (60% in 2017)**	#15 in the latest PF Hard to interpret Relevance – High Specificity – High
	8. *Average score of FGPs assessed on the basis of quality of data entered into e-DB (patient Encounter)*	0		10		5.4 (H1) 7.6 (as per MPT)	2017	**Not Achieved (76% in 2017)**	#16 in the latest PF Hard to interpret Relevance – Medium Specificity – High
	9. *Number and % of day cases in TH/GPC*	0		20%	2017	19.3% 1282 / 6643 (H1) 31.4% 4074/12970	2017	**Achieved**	Indicator #17 in the LF and PF Hard to interpret without indicator definition (of the denominator in particular) Relevance – Low Specificity – Zero
	10. *Number of laboratory tests conducted in the newly centralized laboratories*	0						No data	#18 in the latest PF. The measurement will be made later this year as explained by the PMT. Relevance – Low Specificity – High
	11. *Количество вновь разработанных и (или) пересмотренных НПА как результат деятельности рабочих групп,*					10	2017	Cannot be accessed	#14 in the PF, not found in the LF Definition in English cannot be found Hard to interpret without clear definition Relevance – Low

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	поддерживаемых Проектом								Specificity – High
1.2 Modernized auxiliary services introduced at HFs	1. % in-patients supplied with linens	0	2014	100	2017	100	2017	**Achieved**	Indicator not numbered in the PF, missing in the latest 2017 annual progress report Relevance – Low (availability of linen hardly falls under the category of "modernized" – this is something basic as "window pane"..) Specificity – Low
	2. Number of daily menu courses for patients with different diagnoses	0	2014	5	2017	5	2017	**Achieved**	Indicator not numbered in the PF, missing in the latest 2017 annual progress report Relevance – Low Specificity – Low
	3. (Indicator 19) Number of specialists of pilot HFs trained in new infection control requirements	*0*	*2014*	*96*	*2017*	*96 (62 as per PMT)*	*2017 H1*	***Achieved + 20 retrained***	Target is not explained ("as needed" stated in the GF – unclear how this needed is defined) Relevance – Low (it measures the process, not the result of training!!!) Specificity – High
	4. (Indicator 20) Average Quality Score received by FGPs for the execution of A Medical Equipment Preventive Maintenance Plan	*0*	*2014*	*10*	*2017*	*3.6*	*2017 H1*	***NOT** achieved*	*Target is 12 in the PF.* *Underperformance is explained by the lack of specialists to provide maintenance services* Relevance – Medium Specificity – High
	5. (Indicator 21) Average Quality Score received by TH/GPC for the execution of A Medical Equipment Preventive Maintenance Plan	*0*	*2014*	*10*	*2017*	*5 or 8.7 as per PMT*	*2017*	***Partly Achieved (50% in H1, 87.5% in 2017)***	*Under-performance explained in the PF by the absence of a specific equipment* Relevance – Medium Specificity – High
1.3 Modernized and optimized methods and processes of HR management, financial management,	1. % of employees of pilot HFs received any professional development benefit during annual cycle of work (% of women)	?		?				No data	Removed and replaced by indicator 1.3-4 below (or indicator 22 in the latest PF) as explained by the PMT Relevance – High

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
									Specificity – medium
commodity management and information system introduced at HF level	2. % of accounting/financial management and inventory management staff trained to use Upgraded financial management and commodity management (# of trained women)	0		36	2017	19	2017 H1	***Not** Achieved*	Not found in the latest PF. **Removed** as confirmed by the PMT, but still reported. Relevance – Low (would have been "high" if the application of acquired skills had been measured) Specificity – high
	3. Number of HMIS modules at HF level automated on the basis of modern IT (e.g. pharmaceutical management)							No data	Missing in the latest LF and PF. Removed as confirmed by the PMT. **Why? (no explanation provided).** Relevance to the project – high Specificity to the output – high
	4. (Indicator 22) Number of (trainings of) specialists of pilot HFs trained by using distant methods.	*0*		*100%*	*2017*	*100%*	*2017*	*Cannot be assessed.*	*Target missing. 100% in the LF is IRRELEVANT.* *Joint intervention with MER.* Specificity – medium
	5. (Indicator 23) Average QS received by FGPs for adhering to the schedule of physicians' visits to the FAPs	*0*		*10*	*2017*	*2.6 (Q1-Q2)* *6.8 (Q4)* *5.4*	*2017*	***Not Achieved (54% for 2017)***	*Relevance– Very low (close to Zero)* *Specificity – Medium* The PMT explained that indicator shows the results related to the introduction of micro-planning (and has nothing to do with vehicles purchased for SDOs). Relevance – medium Specificity – medium
	6. (Indicator 24) Number of physicians – young professionals employed in pilot HFs in the current year:	*0*		*?*		*3*	*2017*	*Cannot be assessed*	*Target not defined.* Relevance to the project – Very Low Specificity to the output – ZERO The PMT explained that Rayon Health Councils (established by the project) influence the inflow of young professionals. Still depletable. And

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
									has nothing to do with the piloting an autonomy model.
1.4 HCOs infrastructure is improved and required equipment has been installed. Maintenance of this equipment is ensured	1. Number of HCO who have improved infrastructure based on their needs	?		?		?		No data	Missing in the latest PF. **Removed** as confirmed by the PMT. Hard to interpret unless "needs" are clearly defined (or rules are known how they are measured) **Relevance – High** **Specificity – High**
	2. Number of HCO that have received medical equipment based on their needs.							No data	Missing in the latest LF and PF. Replaced by next two indicators (1.4-2 and -3) as explained by the PMT. Relevance – High Specificity – High
	3. (Indicator 25) Share of FGP/FAP equipped in accordance to National Standards / requirements	*0*		*26/71*	*2017*	*26/71*	*2017*	**Achieved**	As explained by the PMT, 26 stands for the number of GFPs in 3 pilot districts, and 71 for – FAPs. "National Standards" were defined in the basic package of services of PHC facilities in accordance with the MoH Order 1203 (30.12.2017) Relevance – medium (would have been "High" if the use of equipment had been measured) Specificity – High
	4. (Indicator 26) Share of hospitals (DoEMC) equipped in accordance to national standards (requirements)					*100%*	*2017*	**Achieved**	"National Standards" were defined in the MoH Order 551 (year 2012) about the establishment of emergency departments in territorial hospitals Relevance – High Specificity – medium
	5. (Indicator (27) Average QS for introducing new	*0*		*12*	*2018*	*3.3 (in H1), 5.4*	*2017*	**Not Achieved (45% of the target)**	Relevance – High Specificity – High

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	methods/forms of recording medical equipment utilization at FGP/GPC level								
	6. (Indicator 28) Average Quality Score for introducing new methods/forms of recording of medical equipment utilization at TH/GPC level	*0*		*10*	*2017*	*10*	*2017*	**Achieved**	Relevance – High Specificity – High
2. Autonomous Health Facilities' supervision and performance improvement enabling systems are in place	1. Number of barriers removed to allow for achieving better performance of pilot HFs	?		?				No data	**Missing** in the latest PF. Removed as confirmed by the PMT. Hard to interpret (numbers are not applicable to barriers…). Replaced by the measurements via a qualitative study (report for 2018 was available to the evaluation team.. Relevance – High Attribution – Medium/High
	2. % of employees of pilot HFs covered by updated and upgraded accountability mechanisms	?		?				No data	**Missing** in the latest PF **Removed** because of the inability to measure (as confirmed by the PMT). Relevance – High Attribution – medium
	3. % of performance-based earnings by employees of pilot HFs	?		?				No data	**Missing** in the latest PF. **Removed**. No explanation provided Relevance – Low Attribution – Low
	4. Expenditure on PHC in total health expenditures at rayon level	?		?		50,979,613 KGS		**Cannot be assessed**	**Missing** in the latest PF (but #31 in the latest LF) 35% as specified by the PMT. Relevance – ZERO (the project does claimed to change the flow of funds from the MHIF that is defined by the SGBP). Attribution –low

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	5. PF Ind 9: Share of RBF PHC funding received based on achieved results (RBF PHC)	*0*		*5%*		*2.6%*		***Not Achieved***	*Relevance – ZERO* *Attribution – Low*
	6. PF Ind 14: Number of the newly developed and/or revised Normative Acts and Regulations as a result of WG Activities supported by Project	*0*		*?*		*24*		***Cannot be assessed***	Unclear whether the indicator is cumulative or annual. Target not set. Use of "Quantity of regulations acts" does not make sense. Relevance – low Attribution – high
	7. PF Ind 29: Number of decisions made by Rayon Health Councils	*0*		*?*		*11*		***Cannot be assessed***	*Number of decisions?* Relevance – low Attribution – high
	8. PF Ind 30: Number of Normative Acts and Regulations approved by GOK, MOH and MHIF	*0*		*?*		*14*		***Cannot be assessed***	*Relevance – low* *Attribution – low*
2.1 Improved decentralized health governance (rayon and oblast level) with consolidated monitoring, accountability mechanism and effective communication strategy in place	1. Number of functioning Health Boards at Rayon level/RHB (or number of RHB members with regular attendance)							No data	**Missing** in the latest PF As explained by the PMT, it replaced by indicator 2.1-5 (PF ind. 32). Relevance – low (existence of a board is a prerequisite for but not a sign of "decentralized governance). Specificity – high
	2. Number of rayons where developed M&E program for rayon health care is in use	0		3		3	2017	**Achieved**	**Missing** in the latest PF Needs to be validated. Definition of "is in use" is unclear Relevance – medium Specificity – high
	3. % of HF managers and LSG representatives covered by leadership and management trainings (over all HF managers and LSG representatives)								Replaced by Indicator 2.1-5 (or PF Ind. 32) in the latest LF and PF (see below) as confirmed by the PMT

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	4. % of oblast coordination committee meetings on pilot rayon's performance conducted as scheduled (timely, regularly and in accordance to agenda and expected scope of decision)								**Missing** in the latest LF and PF Relevance – medium Specificity – high
	5. (Indicator 32) Number of representatives of Rayon Health Councils (RHCs) in pilot rayons trained on leadership and management:	*0*		*100%*		*36*	*2017*	*Cannot be assessed*	Target not defined: "100% or RHC representatives" in the LF, and "In accordance with the request / needs of RHC" in the latest PF. Denominator – unclear. As explained by the PMT, target cannot be set because of changes in the compositions of the councils. Relevance – Low (just training is the process indicator) Specificity – High
	6. (Indicator 33): Number of RHC meetings held at rayon levels	*0*		*Quarterly*	*2017*	*Quarterly (12)*	*2017*	***Achieved***	Number of meetings has nothing to do with improved governance… Relevance – low Specificity – high
	7. (Indicator 33) Number of RHC meetings held on Oblast level	*0*		*Semi-annual*	*2017*	*2*	*2017*	***Achieved***	*Useless as described above*
	8. (Indicator 34) Number of inquiries, proposals and recommendations on health issues submitted to RHCs by pilot HFs	*0*		*?*		*17*	*2017*	*Cannot be assessed*	Target not defined in the LG and PF. Result in the latest LF – 17, in the PF – 12. Relevance – medium Specificity – high
	9. (Indicator 35) Number of inquiries, proposals and recommendations on health issues submitted by RHCs to Oblast and Republican	*0*		*?*		*13*	*2017*	*Cannot be assessed*	Target not defined in the LG and PF. Result in the latest LF – 13, in the PF – 10. Relevance – medium Specificity – high

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	agencies and institutions								
	10. (Indicator 36) Number of thematic meetings and formal consultations with representatives of MoH, MHIF and Development Partners	*?*		*?*		*?*		*"On-track" ???*	Target not defined in the LG, not results presented, but still considered "on-track" According to the latest PF: target >5, result – 3. Indicator needs to specify – meetings of who? Oblast/Rayon level stakeholders or HFA team? Relevance – Low Specificity – medium
2.2 Improved health care delivery established at rayon level through introduction of better integrated HF networks and services	1. Number patient visits at the PHC level per capita							No data	**Missing** in the latest LF and PF. Repeats the Outcome level indicator (1(3)) Relevance – Low Specificity – ZERO
	2. % of patients at territorial (rayon) hospital with referrals from PHC level	90%	2015	100%	2018	73%	2017	Not Achieved.	**Missing** in the latest PF. Removed as confirmed by the PMT, but numbers are collected for GFA. Relevance – low Specificity – low
	3. (Indicator 37) Revision of Normative Acts and Regulations on continuity of care and patient referral system in accordance with introduced structural changes in pilot rayons	*?*		*Legal bases revised*		*+*	*2017*	*Cannot be assessed*	"Revision" – e.g. key requirements/ terms to be reflected in the revised legislation should be articulated to conclude, whether the expected revisions take place, or just a revision (with no impact on HFA) Relevance – medium (would have been "high" if its application had been measured) Specificity – medium / low
	4. (Indicator 38) Number of visits/consultations at TH/GPC with involvement / presence of Oblast level	*30*	*2015*	*>0*	*2017*	*65*	*2017*	**Achieved**	Formally, even 1 visit in 2017 is achievement when target is set as ">0".

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	specialists, including consultations by telemedicine means								Relevance – low Specificity – low
2.3 Improved contracting and provider payment mechanisms introduced to support better performance at HF and their networks	1. % of contractual funding from MHIF related to performance of pilot HFs.							No data	**Missing** in the latest LF and PF. Removed as confirmed by the PMT because the project cannot influence financing. Relevance – Medium Specificity – Low
	2. % employees of pilot HFs whose performance is measured/assessed regularly	0							**Missing** in the latest LF and PF. Relevance – medium Specificity – low
	3. % of employees of HFs of PHC level covered by ERBF rewards/receive RBF earnings.	0		100	2017	100	2017	**Achieved**	**Missing** in the latest PF. Relevance – Low Specificity – Low
	4. (Indicator 39) Actual RBF rewards of FGPs.	*0*		*Increase*		*1,465,919 KGS (in H1)* *4,167,233 KGS*	*2017*	**Achieved**	Target is "increase", so formally any expenditure higher than last year means "achieved". Relevance – Low Specificity – Low
	5. (Indicator 40) Число детей в возрасте до 5 лет, обслуженных ГСВ в соответствии с требованиями ФОР по результатам верификации			*Increase*		*10,694 (as per PMT)*	*2017*	**Achieved**	**Missing** in the latest LF. Target -questionable as above Relevance – ZERO Specificity – ZERO
	6. (Indicator 41) Число беременных, обслуженных ГСВ в соответствии с требованиями ФОР по результатам верификации	*0*		*Increase*		*625 (as per PMT)*	*2017*	**Achieved**	**Missing** in the latest LF. Target -questionable as above Relevance – ZERO Specificity – ZERO
	7. (indicator 42) Verified number of new patients with	*0*		*Increase*		*198 (as per PMT)*	*2017*	**Achieved**	**Missing** in the latest LF. Target -questionable as above

Hierarchy of objectives (impact | Outcomes | Outputs)	Key indicators[7]	Baseline		Target		Actual result		Comment	Evaluability[8]
		Value	Year	Value	Year	Value	Year		
	hypertension registered by FGP								Relevance – ZERO Specificity – ZERO
	8. (Indicator 43) Verified number of bacteriologically confirmed TB cases	*0*		*Increase*		*10 (as per PMT)*	*2017*	**Achieved**	**Missing** in the latest LF. Target -questionable as above Relevance – ZERO Specificity – ZERO
	9. (Indicator 44) Verified number of TB patients who completed treatment at PHC level	*0*		*Increase*		*4 (as per PMT)*	*2017*	**Achieved**	**Missing** in the latest LF. Target -questionable as above Relevance – ZERO Specificity – ZERO

Figure 13: An inventory of technical products produced by the project (so called "assets" and their "liquidity")

Products		Benefit	Composition | Requirements			Level of maturity | "liquidity"	Importance for scaling up or transfering to other project[11]	Relevance to HFA
			Norms	Instruments	Knowledge			
1	New scheme of patients flow in PHC HF	Improves compliance with infection control requirements	Pending approval of the MoH	Methodology SoP (Endorsed by WHO)	Not needed	Prototype	• Medium for scaling up • Medium for transfering	Medium
2	Medical checkup of army recruits	Attract more revenues providing services usually done by specialists	Order of the GoK (draft)	Clinical Guidelines	Training on clinical peculiarities of this service Organization of this services – Head doctors, military services	Not even prototype – training plan (capacity) costs	Low	Low
3	Basic package of services of PHC (FMC/GFP)	Standardize services to be delivered by PHC and balance with knowledge, and tools	MoH Order 1208 30.12.2017 + for SoW MoH order #65 21.01.17	Methodology + Skills set + 20 SoW	No training is needed	Ready for mass production	• High (linked to intervention #5.3 in Figure 27) • Medium for transferring	High

[11] If only one criteria is listed it means the "asset" is not deem important for transferring to other projects

Products		Benefit	Composition | Requirements			Level of maturity | "liquidity"	Importance for scaling up or transfering to other project[11]	Relevance to HFA
			Norms	Instruments	Knowledge			
4	Package for installing Emergency Department	Optimize hospitalization still responding to populations needs, additional benefit for patients < 24 h	MoH Order 551 27.10.2010 + 661 31.12.2010	Clinical and functional guidelines Norms about space (functional planning) Staffing	There is a need in professional training conducted	Prototype	Low	Medium
5	Package for installing day care units for children	Install day care units	As above	As above	No training	Ready for mass production mass	Medium	Low
6	Basic package of services of TH	Standardize services to be delivered by TH and balance	Regulation drafted, pending MoH approval	20 attachments of + 54 SoW	No need	Not even prototype	• Low for scaling up • Low for transferring	Medium
7	Consultative and diagnostic at TH	Meet population demand, increase workload of specialists, and earn money; In long term allows to trace flows and revise PHC financing	670 MoH + 196 MHIF July 2017. Regulation drafted	Model amendment to statutes	No training needed	Prototype + not implemented	Low	Medium
8	Installing Branch of FMC	Roadmap for transforming GFP into branches		Guide		Paper design	Low	Medium
9	Introduction of QI mechanisms	Acquire internal quality measurement, and quality improvement	Order limited to project rayons. Order to cover entire country awaiting for signature	Methodology: Form Indicators Formula SOP	Supportive supervision / mentoring + training of dedicated MHIF or Oblast health authority represent	Mass production, conditional upon external review	• High (linked to intervention #5.2 in Figure 27) • Medium for trasnferring	High
10	Introduction of outreach services	Optimize delivery of qualify care to the population remote areas		"Crocodile": Micro-planning for optimizing patient flows Accounting & awareness tools		Mass production	• High for scaling up • Low for transferring	Medium

Products		Benefit	Composition | Requirements			Level of maturity | "liquidity"	Importance for scaling up or transfering to other project[11]	Relevance to HFA
			Norms	Instruments	Knowledge			
11	Introduction of oblast level centralized laboratory	Improve productivity and quality of laboratory services	Order of the MoH 162 27.06.2017 (limited to Issyk	Functional and structural plan Methodology of sample collection and transportation Cost of transportation	Training of laboratory specialists at all levels	Pre-prototype	Low	Low
12	Mechanisms for remuneration of staff	To a acquire fair, understandable, transparent mechanism of distributing available financial resources to pay medical staff	Order of improving methodology MOH 1214 13.12.17 + FMIH 366	Methodology + standard work agreement		Pre-prototype Linked to the order on reorganization of HCO	Low (linked to intervention #5.2 in Figure 27)	High
13	Methodology for developing SoWs	Develop SoW in a standard manner for autonomous HFs		Methodology	Not needed	Prototype	Low	High
14	SoW for public health specialists	If approved, can be used everywhere	Draft order awaiting approval			Prototype	Low	Medium
15	Consolidation of the budget	Budgeting and reporting simplified				Already "sold"		Low
16	RBF for PHC	Allows to earn additional revenues (from MHIF) and create incentives (including non-medical staff)		Methodology: formula of calculating + Score card + Verification methodology (using КИФ)	One computer 1 GFM + Internet + ability to work on computer +	Prototype	High (linked to intervention #5.1 in Figure 27)	Low
17	Guidelines for project development	Enables HF to design a project/budget and request funding		Methodology		Mass production	Medium	Low
18	Software Modules	Improves data management / supply of management information, or quality of services (patient's satisfaction)		Appointment scheduling – patient flow management system	Methodology to educate + information campaign	Will be ready for mass production	High	Low

Products		Benefit	Composition | Requirements			Level of maturity | "liquidity"	Importance for scaling up or transfering to other project[11]	Relevance to HFA
			Norms	Instruments	Knowledge			
				Laboratory information system				
19	Healthcare Rayon Committee	Advocacy mechanism attracting attention of rayon level		Statute / methodology + Guidance for citizens to participate in budgeting of FAP		Prototype (piloted)	Medium (linked to intervention #3 in Figure 27)	Medium
20	Training / Financial specialists	Professionals with hands-on experience capable to train peers				Prototype	Low (linked to intervention #5.1 in Figure 27)	High

Figure 14: Assessment of the situation with health facility autonomy in Kyrgyzstan: 2018 compared with 2013

Features		"Climate in 2013"	Climate in 2018	Changes the HFA Project made
Health Facility Autonomy				
How much decision-making authority is allowed				
1.	Human resources	1.1 Limited authority over salary levels	No change	Might change in *3 pilot districts* if the MoF signs the order on new methods of wage fund prepared by the project
		1.2 Free to hire staff on part-time contracts	The same	The same
		1.3 No authority to sanction or dismiss under-performing staff	No change	No change
2.	Budget Allocation, Financial Management and procurement	2.1 Authorized to formulate "a comprehensive budget" for all 4 sources of revenues: • Per capita or case based payments from budget & MHIF • Projected copayments (under the State GBP) • "Special means revenues"	Changed – a consolidated budget with all 4 sources. Reporting and budgeting simplified (less workload) but	Contributed to the change by piloting it (for 6 months) in *3 districts*
		2.2 Obliged to partition the expenditure budget by 4 revenue sources, and report separately for each sources		
		2.3 Difficulties in re-allocating funds between budget line items (categories)	No change	No change
		2.4 Allowed to purchase drugs and supplies	The same	The same
		2.5 Limited authority over capital expenditures (quarterly caps of 6,380 USD)	No change	No change

Features		"Climate in 2013"	Climate in 2018	Changes the HFA Project made
	2.6	PPP limited to "small" (e.g equipment leasing)	No change	No change
	2.7	Not allowed varying copayment rates under SGBP.	No change	No change
	2.8	Allowed to rent out assets, splitting 50% of revenues with the Treasury	The same	The same
	2.9	Cannot sell assets	No change	No change
Management Capacity & Vision				
3. Professional management and leadership	3.1	Managers are practicing doctors, with a part time role in management	The same	The same
	3.2	No contract from management role	No change	No change
	3.3	No clear management training and career development paths	No change	No change
	3.4	Hospital directors & deputies appointed by the MoH. *Unclear criteria for appointing or dismissing*	No change	No change
	3.5	"is not clear that the national information systems are useful for or being used by hospital managers for internal management"	No change	No change
	3.6	"Financial management capacity is variable, and the limited capacity available is wasted "	No change	Improved (allegedly)
	3.7	"HR management information is confusing and non-transparent"	No change	No change
	3.8	"limited financial means to use to introduce performance-related bonuses"	5% of the portfolio (deducted from initial allocation instead of complementary funding)	Elaborated RBF methodology for PHC, and rewards channeled to PHC in the pilot districts.
4. Management systems and use of information for internal management	4.1	"MOH regulations governing salary top-ups are based on workload indicators, without any rewards or penalties related to quality"	Changing toward quality and performance mix under RBF	Contributed to the evolution of quality dimension in the RBF methodology (for PHC)
	4.2	Managers are practicing doctors, with a part time role in management	The same	The same
	4.3	No contract from management role	No change	No change
	4.4	No clear management training and career development paths	No change	No change
	4.5	Hospital directors & deputies appointed by the MoH. Unclear criteria for appointing or dismissing	No change	No change
	4.6	"is not clear that the national information systems are useful for or being used by hospital managers for internal management"	No change	No change
5. Rewarding and sanctioning staff performance	5.1	"Financial management capacity is variable, and the limited capacity available is wasted "	No change	Improved (allegedly)
	5.2	"HR management information is confusing and non-transparent"	No change (presumably)	No change (presumably)

Features		"Climate in 2013"	Climate in 2018	Changes the HFA Project made
6. **Patient and community feedback and engagement**	6.1	VHC in rural areas having potential to play a role in providing feedback & support to FMC	Cannot be assessed (presumably, the potential is still there)	Cannot be assessed (presumably, the potential is still there)
	6.2	In hospitals, no organized system for patient feedback or community oversight of services	No change (presumably)	No change
	6.3	"there is a perception that communities and local political leaders are very strongly resistant to changes in service delivery"	Cannot be assessed	Cannot be assessed
HF Accountability Regime				
Are health facilities held accountable for all the domains of performance in the health sector strategy?				
7. Service Outputs	7.1	"accountable for aggregate measures of output or workload – number of registered patients for FMCs, and aggregate case volume for hospitals – not for delivery of specific services, specialties or interventions"	The same with some minor improvements related to RBF	The same with some minor improvements related to RBF
8. Access	8.1	"no regular monitoring of informal payments"	No change	No change
	8.2	"no monitoring indicator related to waiting times for planned, non-urgent services."	No change	Was in the project, but then removed, so cannot be assessed
9. Patient Experience	9.1	Lack of good indicators of the quality of patient experience in the monitoring system	No change	No change
	9.2	Existing complaints mechanisms to the MOH are "likely to be difficult for the poor and rural population to use"	No change (presumably)	No change (prsumablyo
10. Clinical Safety and quality	10.1	Major deficiencies in the management acute CVD admissions	No change (presumably)	Controversial results
	10.2	Unnecessary hospital admissions (for Hypertension or TB) "still need to be reduced"	No change (presumably)	Controversial results, inpatient care/admissions reduced presumably thanks to emergency departments and day care capabilities, not because of improved case management (and active prevention of CVD complications)
	10.3	"Monitoring of hospital acquired infections and adverse safety incidents has not yet been instituted systematically"	No change (presumably)	Was envisaged by the project, but the indicator was removed, so cannot be assessed
11. Efficiency and productivity	11.1	"Existing norms on facilities structure and staffing need updating, and so monitoring of compliance with norms is a poor indicator of efficiency"	No change (presumably)	No change
	11.2	MHIF targeted audit of admissions <3 days "had tended to give hospitals an incentive to keep patients" longer	No change (presumably)	No change (presumably)
12. Financial control	12.1	Two levels external control (by the MHIF for use of pooled funds and by the Chamber of Accounts) focusing on the compliance with	No change	No change

Features		"Climate in 2013"	Climate in 2018	Changes the HFA Project made
		regulations/norms "sometimes holding facilities accountable for the wrong things".		
How effective are the institutional arrangements/mechanisms for checks and balances & holding the hospital accountable?				
13.	**Supervisory board**	13.1 No supervisory boards in hospitals and FMC	No change	No change
		13.2 Public observation committees/councils "not very active and do not have a clearly defined responsibility"	No change	Rayon Health Councils, with some mandate to supervise or discuss, but no authority to intervene
		13.3 Oblasts coordinators in charge of "convening a commission to carry out monitoring visits… are not independent, have limited expertise, have limited authority and they themselves lack accountability."	No change (presumably)	No change
14.	**Internal audit**	14.1 No internal audit units in Hospitals	No change presumably)	No Change
15.	**MOH, LG and MHIF oversight**	15.1 Lack of coordination and "conflict about the roles and responsibilities of MHIF vs MoH and LGs as hospital founders in regulating and holding hospitals and clinics accountable for performance, including fiduciary control and quality"	No change	No change
		15.2 "MHIF's contract monitoring and control functions focus on financial aspects. Contracts have little specificity on quality standards, the range of services to be provided, or service development goals."	Some improvement related to RBF	Some improvement related to RBF
		15.3 "lack of engagement of local government leaders in the health sector."	No change	No change
		15.4 "Where MHIF or Chamber of Accounts identify a problem with a health facility's financial performance, there is also ambiguity about who should be held responsible and how to carry out any follow up enforcement action"	No change	NO hange
16.	**Regulation, inspection and enforcement**	16.1 No independent agency responsible for monitoring and inspecting health facilities for safety and quality	No change (presumably)	No change (prsumablyo
		16.2 "is lack of clarity about who is responsible and about the process of feedback and escalation to sanctions where inspection finds problems"	No change	No change
17.	**Reliable timely information**	17.1 HIS provides reasonably timely data of the core data set, though… "the performance indicators for hospitals need review"	Some improvements related to RBF	Some improvements ralted to RBF
		17.2 "On the financial side, delays in approval and issuance of budget ceilings also contribute to delays in financial reporting in the first half of the fiscal year"	Cannot be assessed	Cannot be asssed
Incentives Facing Health Facilities				
How effective are incentives facing health facilities in promoting quality, efficiency, and access?				

Features		"Climate in 2013"	Climate in 2018	Changes the HFA Project made
18.	**Provider payment incentives**	18.1 "There is no payment incentive for quality improvement (but a pay-for-performance pilot project)"	Improvement due to RBF	Improvement due to RBF
		18.2 MHIF "contracts do not have clear requirements about the range of services to be provided or service quality or access standards"	Cannot be assessed	Cannot be assessed
		18.3 "There is no payment incentive for specialist ambulatory care in FMCs or hospitals, nor for hospitals to carry out one-day surgery or establish emergency reception units to assess patients before deciding whether admission is needed"	No change	An attempt to introduce these incentives thanks to opening emergency departments. Results are not conclusive yet
		18.4 "The primary care system under … [the current] payment method would be expected to have incentives to refer patients to hospital and to under-provide specialist outpatient services, unless these specialists are able to generate significant informal or special revenues"	No change	No change
		18.5 "It has created some incentives to reduce lengths of stay, though clinical protocols are also a major influence on appropriate length of stay, and outdated protocols, together with unintended incentives created by audit practices, generates some barriers to significant further reductions in length of stay"	No change (presumably)	No change (presumably)
		18.6 "However, case payment also creates incentives to increase volume of hospital admissions - filling every hospital bed, and always having beds available to fill"	No change	Might improve with the roll out of emergency and day care capabilities
		18.7 "Case payment for inpatients only can thus act as a disincentive to reduce admissions by development of ambulatory care alternatives."	No change	Insufficient evidence to make a conclusion
		18.8 "Even though there is no payment to hospitals for specialist ambulatory services, in principle, hospitals could have a financial incentive to develop ambulatory services for pre-assessment of patients before they are admitted (e.g. for planned surgery) and post-discharge follow-up of inpatients if this would reduce ALOS significantly"	No change	Happening in the pilot districts (pre-assessment), but not early discharge because of post-discharge follow oup by outpatient service providers
		18.9 "This type of service change may require capital investment outside the case payment and above the hospital's authority. It would require one-time management/development costs that are unfunded, and would require revisions to the norms/regulations for calculating staff workload and pay."	No change	Improvements in the pilot districts (including one time investment in management and equipment)
		18.10 "Case payment is calculated to cover all recurrent costs, including salaries, but excludes capital. In practice, the level of payment is such that even maintenance and repairs are inadequately funded, and non-capital development expenditures (e.g. training and development for staff) – with the result that there is little autonomy or incentive to maintain or improve quality"	No change	No change

Features	"Climate in 2013"	Climate in 2018	Changes the HFA Project made
	18.11 "Informal payments for doctors and sharing of these with other staff and managers generate fee-for-service incentives which may dominate the financial incentives facing senior staff in some hospitals. This can make it difficult to align hospital managers' financial incentives with good hospital performance, but on the other hand, in FMCs it may reduce incentives to refer patients to hospital"	No change (presumably)	No change (presumably)
Is the health facility "residual claimant": can it keep any savings or surpluses and is it responsible for its deficit/debt?			
19. Flexibility and incentives to re-allocate savings from one budget line item to another to increase efficiency and quality of care	19.1 "The restrictive rules and procedures on the allocation and re-allocation of funds between the four revenue sources attenuate managers' incentives for efficient resource allocation and so for making efficiency gains."	No change	No change
	19.2 "the rules on combining posts to increase salaries give managers a disincentive to re-allocate any HR savings to non-wage budget lines."	No change	No change
20. Retaining surpluses at the end of the fiscal year	20.1 "even savings made in one quarter cannot be kept and used in the next quarter. All health facilities have to return any surpluses in their Treasury account for budget revenue (which is the majority of their revenue) at the end of the fiscal year"	No change	No change
	20.2 "Facilities are permitted to retain surpluses in their Treasury accounts for revenue from MHIF contributions (the social fund from health payroll taxes for formal sector) and copayments"	No change	No change
	20.3 Health facilities …"retain special revenues in a separate commercial bank account and carry them forward to the next fiscal year, but they pay a 20% tax to the Treasury on these revenues"	No change	No change
	20.4 "50% of any income from renting out property has to be paid to the Treasury or the municipality (in Bishkek and Osh)"	No change	No change
21. Responsibility for debts	21.1 "Under law, all health facilities as public institutions, have their debts guaranteed by the state"	The same	The same
	21.2 "Outside of Bishkek, facilities visited report that oblast and rayon governments lack sufficient funds to provide any support to health facilities, and in any case, see them as a republican responsibility"; the health facilities have limited opportunities to borrow money to improve cash flow to manage temporary financial difficulties	No change	No change

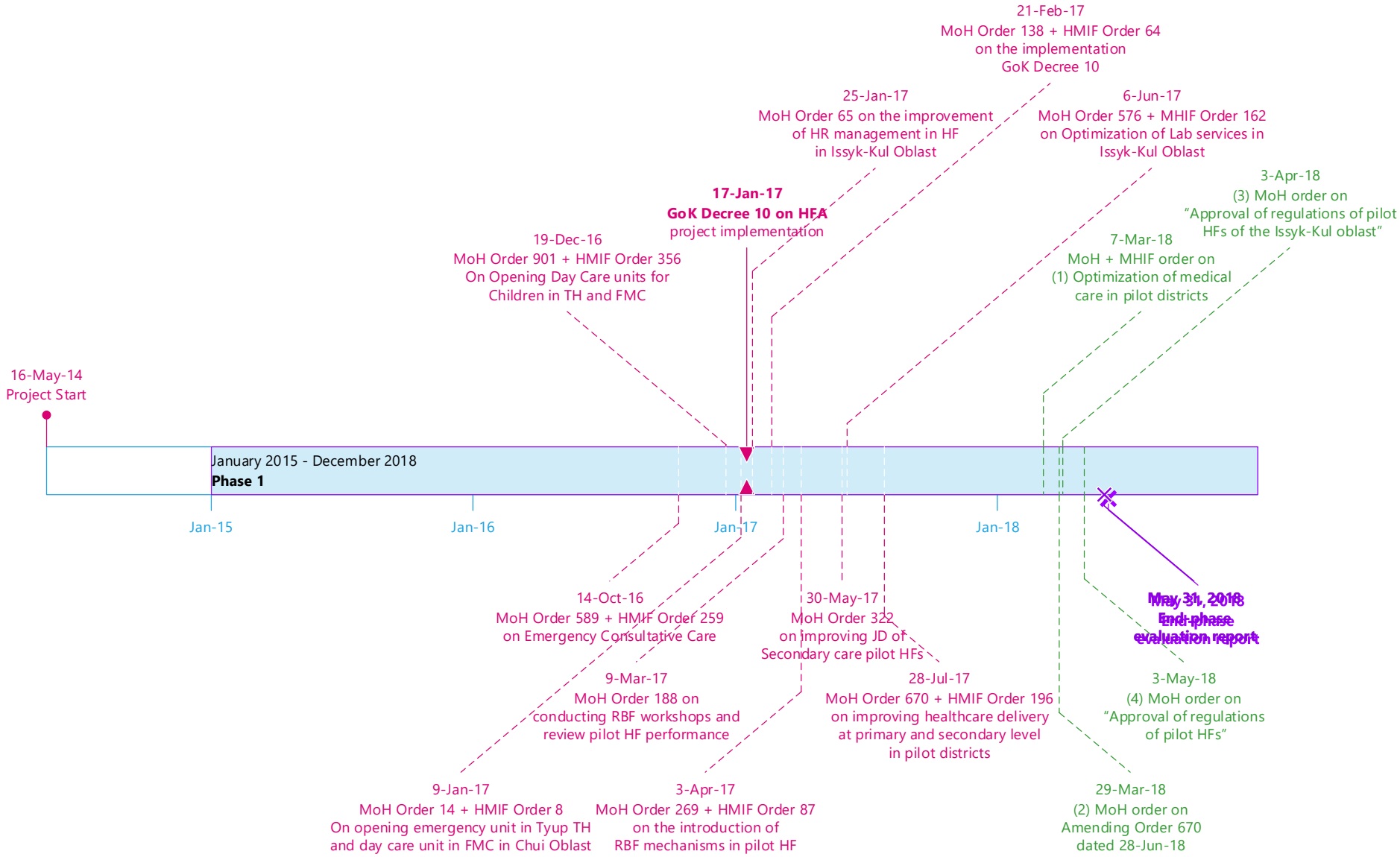
Figure 15: The list of regulations prepared and submitted by the project team awaiting the Ministry of Health approval

Name of the draft regulation	Key provisions, issues covered	Date of submission	Response from the officials (concerns, issues to be fixed, other)
1 Joint order of MoH KR and MHIF "Improvement of the system of medical in pilot health facilities of the Issyk-Kul oblast".	Goal: development of the regulatory framework for the implementation of a "new" system of remuneration in the pilot HF's that expanding the powers of managers in the independent determination of the number and qualifications of staff. Approve optimized structure, the list of structural units and list of positions in the pilot HF's (EMCD, relocate emergency care and consultation of outpatient patients in hospital).	2018 March,7	Comments of the Legal Department of MOH KR: • Cancel participation of MHIF in the Order, as MHIF has no authority to change the structure of HF. • Structure of HF defined and approved by the manager of HF. • Revise regulations of all HF's and reflect all proposed structural changes in it. Re-register new regulations of HF's.
		Re-submitted on 2018 March, 12	Comments of the Legal Department of MOH KR: Develop two separate orders of the MOH KR. • Separately approve regulation of HF with the changed structure (for re-registration) • Separate order on relocation of emergency care and functions of narrow experts from PHC level in hospital.
2 Draft of joint order of MOH KR and MHIF on «Amendments in the joint order of the MOH KR from July 28, 2017 # 670 and MHIF from July 31, 2017 # 196» "Improvement of the system of providing medical care in pilot health facilities of the Issyk-Kul oblast".	Goal: cancellation of a pre-structure of pilot HF's with regard of clarification of the regulation structure of HF's. Lawyer's comments were taken into account	2018 March, 29	Comments of the Legal Department of MOH KR: • "change the preamble to the Order"
		Resubmitted on 2018 April, 11	Comments of the Legal Department of MOH KR: • Submit draft order and revised regulations to the MOH KR for the approval.
	Approval of regulations of HF's including structure, the list of structural units and list of positions in the pilot HF's (EMCD, relocate emergency care and consultation of outpatient patients in hospital).	2018 May 10	Comments of the Legal Department of MOH KR: "Accidentally" the lawyer of the MOH KR found that the MOH KR has the right to approve the structure and recommended to include a paragraph on approval of the structure of the Ministry of health.
3 Draft order of the MOH KR "Approval of regulations of pilot HF's of the Issyk-Kul oblast".	Approve regulations, which include optimized structure of pilot HF's (on the recommendation of the Legal Department of MOH KR).	2018 April,3	Comments of the Legal Department of MOH KR: • Comments to the regulations with the participation of the lawyer of the MOH KR; • Within 3 weeks, due to the lack of time of lawyer of the MOH KR various small comments was made.

Name of the draft regulation	Key provisions, issues covered	Date of submission	Response from the officials (concerns, issues to be fixed, other)
4 Draft order of the MOH KR **«Approval of regulations of pilot HF's of the Issyk-Kul oblast»**	Approval of regulations of HF's including structure, the list of structural units and list of positions in the pilot HF's (EMCD, relocate emergency care and consultation of outpatient patients in hospital).	2018 May 3	Comments of the Legal Department of MOH KR: • Review regulation of the Issyk-Kul oblast hospital, in connection with the relocation of the laboratory service of pilot HF's to the level of the Centralized laboratory in Issyk-Kul oblast hospital • Submit regulation of the Issyk-Kul oblast hospital for the approval together with regulations of pilot HF's. • Cancel joint draft order of the MOH KR # 567 and MHIF # 162 from June 6, 2017 on establishment of centralized laboratory due to structural transformations are not functions of MHIF. The MOH KR inadvertently missed the above Order earlier. • Order on centralized laboratory submit for the approval after signing orders with regulations of HF's and Issyk-Kul oblast hospital.

Source: *Prepared by the project team*

Figure 16: Progress in changing the legislation – approved norms and draft pending the ap[12]proval



[12] Green color denotes drafts submitted by the project pending the approval of the Ministry of Health described in detail in Figure 15 on page 57.

Figure 17: A synthesis of a chain of results and "strategic framework" with timeline

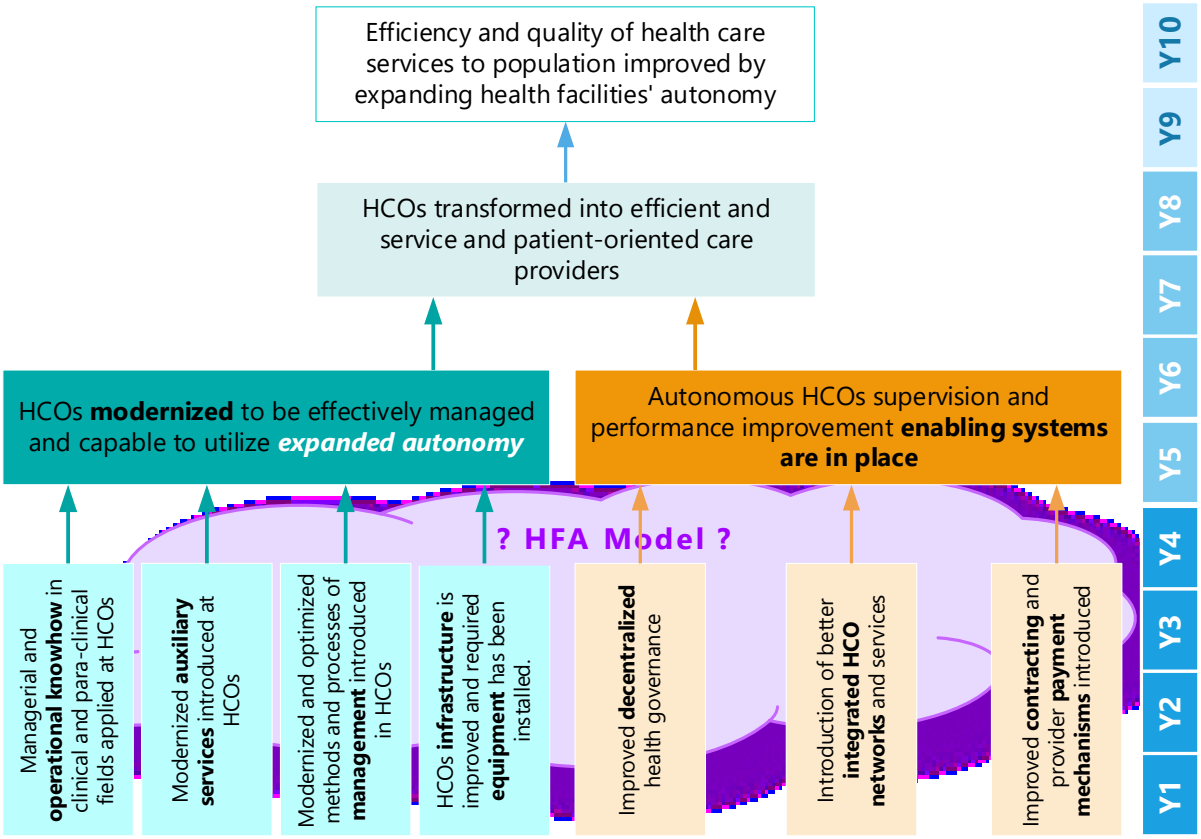
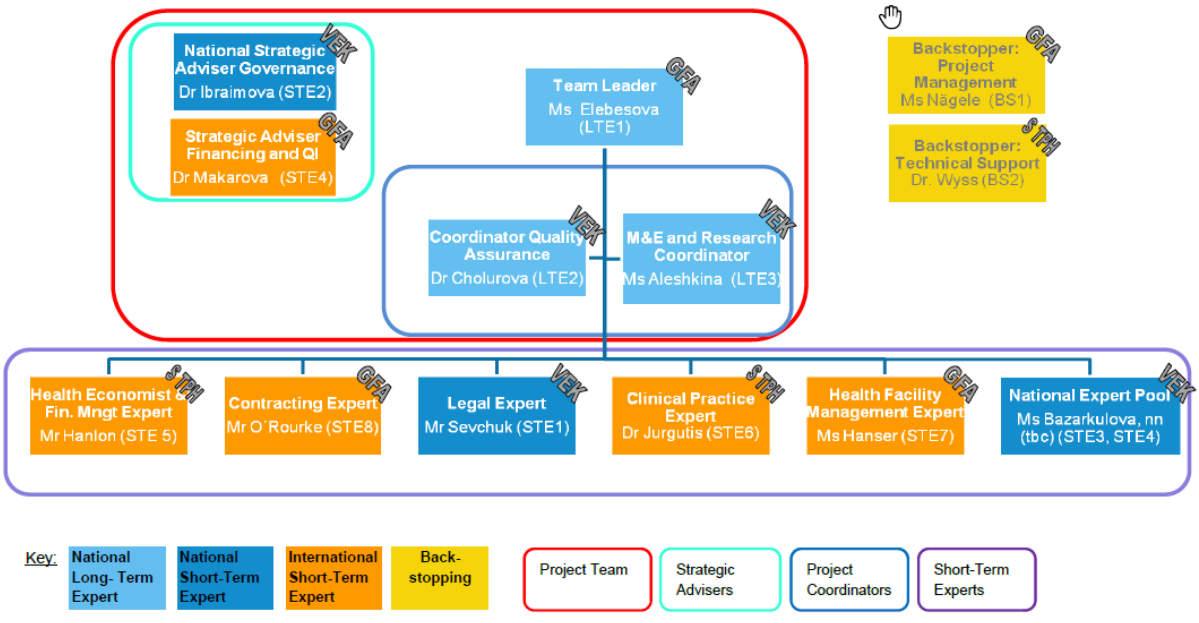
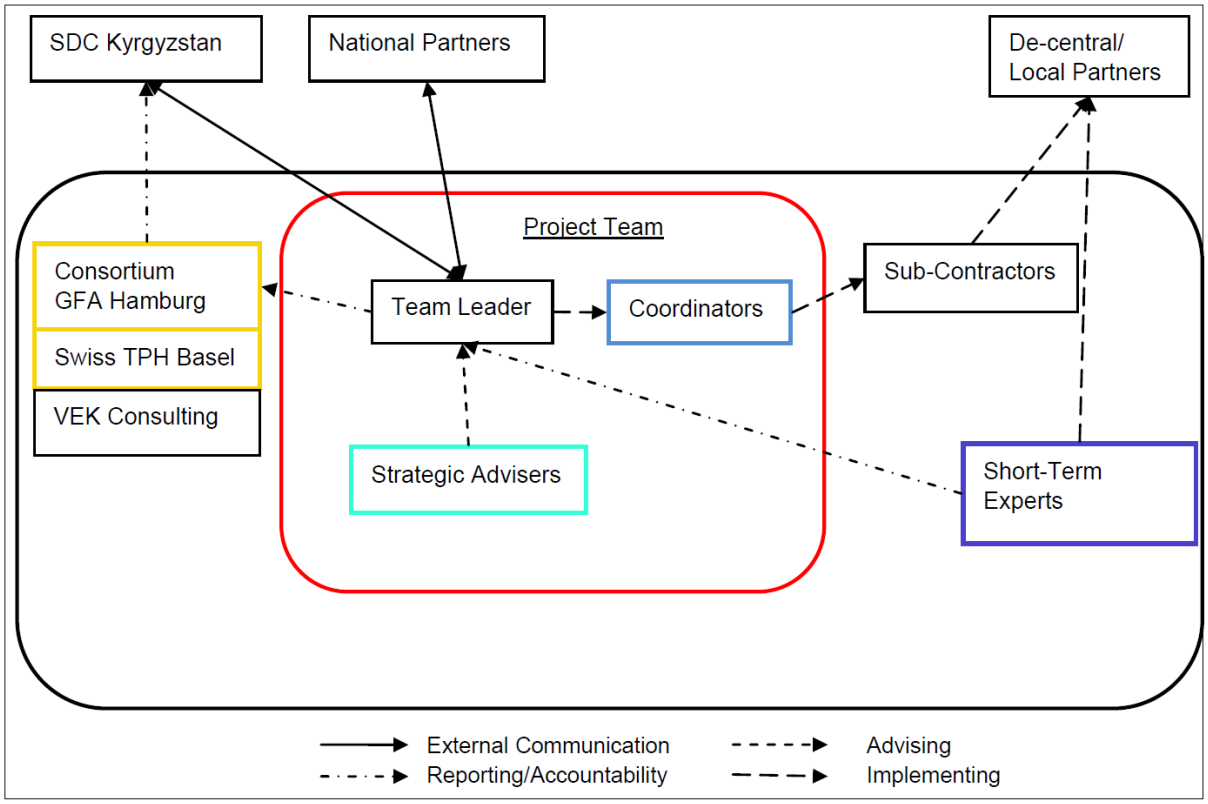


Figure 18: Project team structure



Source: *The Project Document (page 67)*

Figure 19: Internal organization of the Project



Source: *The Project Document (page 67)*

Figure 20: Key phases of the project as planned in 2013

4 months	4 years	4 years	2 years
Detailed planning, Communication Strategy	Implement elements as pilot	Roll out to other districts	Final evaluation
Design HFA building blocks, interventions	Monitor & evaluate, Disseminate results	Continuous monitoring,	Define continuity and sustainability measures

Source: *Bernard F. Couttolenc, PROJECT DESIGN FOR HEALTH FACILITY AUTONOMY IN KYRGIZSTAN. November 2013. (Table 5 on Page 32)*

Figure 21: The list of key informants met, and sites/organizations visited

Organization	Position	Name
MoH	Head of the strategic planning and policy development department	Ismailov Mederbek Adishevich

Organization	Position	Name
	The first Deputy Minister	Murzaliev Amangeldi Zholdoshbekovich
Issyk-Kul Oblast Merged Hospital	Director	Maanaev Toktobai Israilovich
The Swiss Embassy	Deputy Head of Mission	Danielle Meuwly
	SDO	Elvira Muralieva
MHIF	Director	Kaliev Marat Temirbekovich
	Head of Finance	Burchuebaeva Gulmira
World Bank	RBF Project TTL	Sargaldakova Asel
	RBF Project Secretariat	Oskombaeva Klara
World Health Organization	Representative	Jarno Habicht
USAID TB Project	Chief of Party	Ainura Ibraimova
Family Medicine Group Burkut	Family doctor	Alybaeva Ainur Skakovna
Tor Rayon Hospital	Director	Sukaeva Jenishgul Jumamidinovna
Tor Rayon's Family Medicine Center	Director	???

Figure 22: Summary of Outcome level indicator evaluability assessment and project performance (against outcome level targets)

		Target	Relevance	Attributio	Status	Usefuluness
Outcome 1	Ind 1		Zero	Zero	Removed	
	Ind 2		Zero	Zero	Removed	
	Ind 3	Not Achieved	Zero	Low		
	Ind 4		High	Medium	Removed	No data
	Ind 5	Not Achieved	Zero	Medium	New	Hard to interpret
	Ind 6	Not Achieved	Zero	Medium	Moved a level down	
	Ind 7	Not Achieved	Low	Medium		Hard to interpret
	Ind 8	Not Achieved	Low	Medium		Hard to interpret
	Ind 9	Achieved partially	Low	Medium		Hard to interpret
Outcome 2	Ind 1		High	Medium	Removed	No data
	Ind 2		High	Medium	Removed	No data
	Ind 3		Low	Low	Removed	No data
	Ind 4		Zero	Low		Not assessable
	Ind 5	Not Achieved	Zero	Low		
	Ind 6		Low	High		Not assessable
	Ind 7		Low	High		Not assessable
	Ind 8		Medium	Medium		Not assessable

Figure 23: Summary of output level indicator evaluability assessment and project performance under outcome 1

		Target	Relevance	Specificity	Status	Usefuluness
Output 1 (1.1)	Ind 1	Achieved	Zero	Low		
	Ind 2		Zero	Low	Removed	Not assessable
	Ind 3		High	Medium	Removed	No data
	Ind 4	Achieved	Low	Low		
	Ind 5		High	High		No data
	Ind 6	Not Achieved	Medium	Low	Replaced (inadeq)	
	Ind 7	Not Achieved	High	High	New	Hard to interpret
	Ind 8	Not Achieved	Medium	High	New	Hard to interpret
	Ind 9	Achieved	Low	Zero	New	Hard to interpret
	Ind 10		Low	Medium	New	No data
Output 2 (1.2)	Ind 1	Achieved	Low	Low		
	Ind 2	Achieved	Low	Low		
	Ind 3	Achieved	Low	High	New	
	Ind 4	Not Achieved	Medium	High	New	Hard to interpret
	Ind 5	Achieved partially	Medium	High	New	Hard to interpret
Output 3 (1.3)	Ind 1		High	Medium	Removed	No data
	Ind 2	Not Achieved	Zero	High	Removed	
	Ind 3		High	High	Removed	No data
	Ind 4	Achieved	Zero	Medium		
	Ind 5	Not Achieved	Medium	Medium		Hard to interpret
	Ind 6		Zero	Zero		Not assessable
Output 4 (1.4)	Ind 3	Achieved	Medium	High	New	
	Ind 4	Achieved	High	Medium	New	
	Ind 5	Not Achieved	High	High		Hard to interpret
	Ind 6	Achieved	High	High		Hard to interpret

Figure 24: Summary of output level indicator evaluability assessment and project performance under outcome 2

		Target	Relevance	Specificity	Status	Usefuluness
Output 5 (2.2)	Ind 1		Low	High	Replaced (inadeq)	No data
	Ind 2	Achieved	Medium	High	Removed	
	Ind 3		Low	Medium	Replaced (inadeq)	No data
	Ind 4		Medium	High	Removed	No data
	Ind 5		Low	High	New	Not assessable
	Ind 6	Achieved	Low	High		
	Ind 7	Achieved	Low	High		
	Ind 8		Medium	High	New	Not assessable
	Ind 9		Medium	High	New	Not assessable
	Ind 10		Low	Medium	New	Not assessable
Output 6 (2.2)	Ind 1		Low	Zero	Removed	
	Ind 2	Not Achie	Low	Low	Removed	
	Ind 3	Achieved	Medium	Medium		Hard to interpret
	Ind 4	Achieved	Low	Low	New	Hard to interpret
Output 7 (2.3)	Ind 1		Medium	Low	Removed	No data
	Ind 2		Medium	Low	Removed	No data
	Ind 3	Achieved	Low	Low	Removed	
	Ind 4	Achieved	Low	Low	New	
	Ind 5	Achieved	Zero	Zero	New but missing in the PF	Hard to interpret
	Ind 6	Achieved	Zero	Zero	New but missing in the PF	Hard to interpret
	Ind 7	Achieved	Zero	Zero	New but missing in the PF	Hard to interpret
	Ind 8	Achieved	Zero	Zero	New but missing in the PF	Hard to interpret
	Ind 9	Achieved	Zero	Zero	New but missing in the PF	Hard to interpret

Figure 25: Achievement of output level targets by outcome 1 and outcome 2

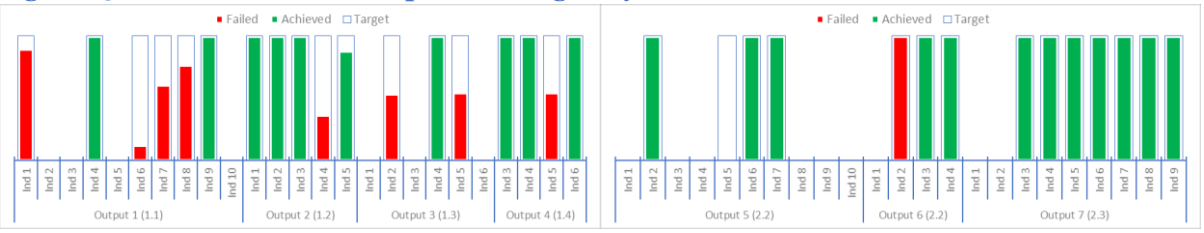
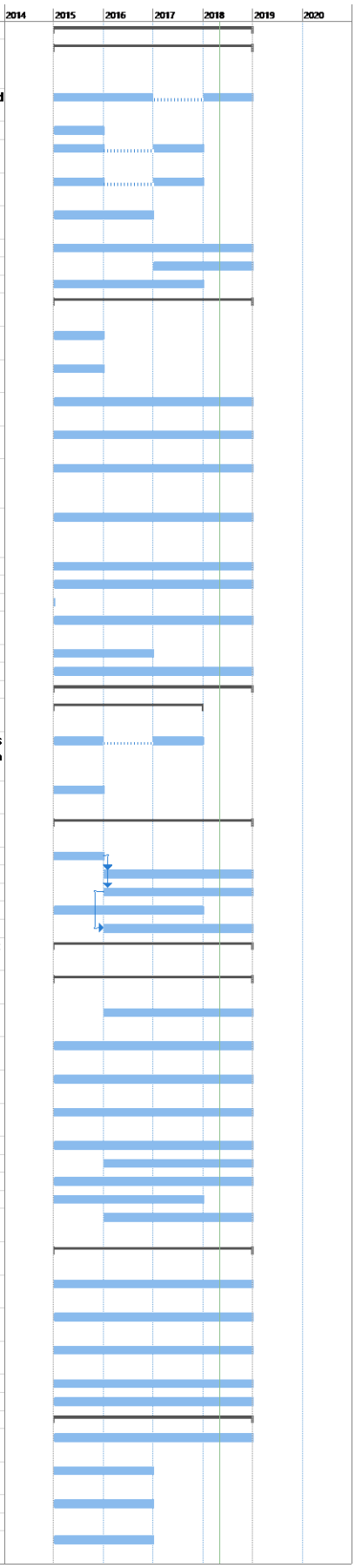
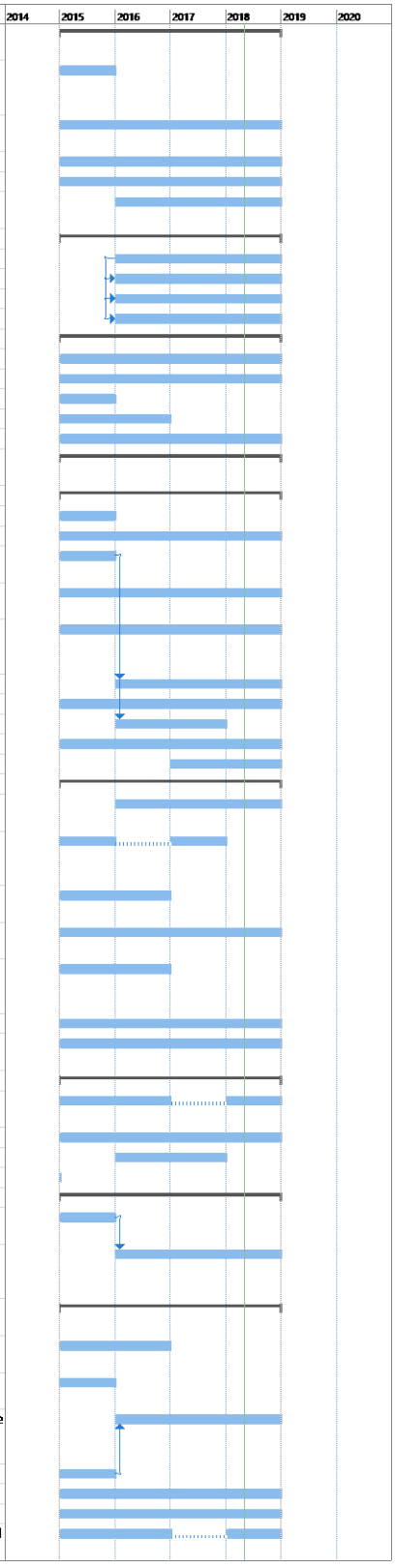


Figure 26: The project phase 1 work plan – Gantt Chart

ID	Task Name
1	**1 Managerial and operational knowhow in clinical and para-clinical fields applied at HCOs**
2	**1.1 Revise existing and implement updated and upgraded clinical and para-clinical (pharmacy, health technology, hazard waste) activities, functions, work processes and procedures based on evaluated efficiency and quality of existing practices**
3	1.1.1 Review service utilization by HCOs, staff productivity and map of clinical pathways of rayon patients to identify and assess problem areas and determine opportunities for improving efficiency and quality of health care
4	1.1.2 Review job descriptions (JDs) and duties of medical professionals in pilot HCOs
5	1.1.3 Assess procurement practices, prescription of medicines practices, stock management, management of medical equipment and infrastructure/assets, management of hazardous waste
6	1.1.4 Develop and agree a proposal for revision of core clinical and para-clinical activities and work procedures as a module of the Mid-Term Development and Operational Plan (DOP) for every HCO
7	1.1.5 Assess training needs, arrange for training through existing courses and/or develop and implement training programs to upgrade clinical competences of HCO personnel; as needed for patient centered, high quality care
8	1.1.6 Execute the Mid-Term DOPs (Module on clinical profiles and activities) with monitoring of processes and results
9	1.1.7 Adjust the Mid-Term DOPs of HCOs as necessary; prepare for rollout
10	1.1.8 Conduct Round tables
11	**1.2 Develop and introduce enhanced quality assurance and quality improvement practices in pilot HCOs by means of upgraded methods of quality management**
12	1.2.1 Review the current system of health care quality management (QM) at all levels to identify gaps and bottlenecks, opportunities for improvements and strengthening
13	1.2.2 Develop and agree on a comprehensive proposal for strengthening healthcare QM system using bottom-up approach and vision
14	1.2.3 Support in application of national clinical guidelines/protocols at pilot HCOs and establishment of feedback mechanisms
15	1.2.4 Review exiting quality indicators for HCOs at rayon level, propose and implement an enhanced indicator system. Refine indicators as necessary
16	1.2.5 Align and upgrade internal and external quality auditing / assessment and supportive supervision methods, instruments and procedures to be utilized by respected parties. Clarify roles and scope of work of agencies involved to avoid redundancies and gaps
17	1.2.6 Support the establishment and activities of Quality Committees of HCOs of the pilot rayons to address HCO-specific issues including internal audits, identification of problems and their causes, QI planning and execution of QI plans
18	1.2.7 Conduct working groups on quality improvement and health facility management
19	1.2.8 Conduct Round Tables at oblast level
20	1.2.9 ???
21	1.2.10 Contribute to strengthening continuous medical education (CME) system, its methods and practices, identify and address needs in training and upgrades of skills of pilot HCOs' staff
22	1.2.11 Development of training materials and methodology
23	1.2.12 Capacity building/training (delivered by STEs and sub-contractors)
24	**2 Modernized auxiliary services and optimized management processes (HR, IT, financial etc.) introduced at HCO level**
25	**2.1 Revise core auxiliary (patients' nutrition, laundry, non-hazardous waste management, etc.) activities, supportive functions, work processes and procedures based on evaluated efficiency and quality of existing practices**
26	2.1.1 Access core non-clinical / auxiliary activities, and supportive functions and work procedures and revise on the basis of evaluated effectiveness and quality of existing practices, including work processes and procedures to identify problem areas
27	2.1.2 Develop, discuss and agree a proposal for revising core non-clinical activities, work processes and procedures for HCOs
28	**2.2 Test updated and upgraded work processes and procedures to improve efficiency and quality of auxiliary services and to contribute to greater efficiency and better quality of clinical and para-clinical services**
29	2.2.1 Design module on the core auxiliary activities and support functions of the Mid-Term DOPs for HCOs
30	2.2.2 Develop and introduce a set of necessary guiding documentation -methodology, SOPs to execute the DOP
31	2.2.3 Execute the DOP (including prioritized investment plans)
32	2.2.4 Conduct round tables at oblast level
33	2.2.5 Monitor and evaluate, and propose adjustment and/or enhancements to the guiding documentation as necessary
34	**3 Modernized and optimized methods and process of HR management, financial management, commodity management and information system introduced at HCO level**
35	**3.1 Revise and implement methods and tools of HCO HR/Personnel management to be more effective and results oriented**
36	3.1.1 Develop and apply sound methodology to quantity staff requirements (by staff categories), including permanent and seasonal needs, as applicable
37	3.1.2 Assess, revise and introduce teamwork (and shift work) regulation and procedures to ensure greater productivity, efficiency and quality of work
38	3.1.3 Develop and test performance assessments / assessment of personnel activity to validate appropriateness of staff qualification and apply to the variable of the personnel remuneration scheme
39	3.1.4 Assess, revise and introduce methods of planning of staff remuneration / incentives that reflect staff needs and PBF concept / methodology (fixed and variable labor compensation)
40	3.1.5 Assess, redefine and introduce a revised system of professional development for personnel of pilot HCOs
41	3.1.6 Update and upgrade labor contracts. Reflect in employment contracts all relevant A.C. Hanser innovations
42	3.1.7 Conduct Working Group meeting on quality improvement and control and health facility management
43	3.1.8 Conduct round tables at oblast level
44	3.1.9 Implementation of HR development plans at HCOs. Instruct/train practitioners based on the guiding documentation as needed
45	**3.2 Upgrade financial management methods and practices to allow for effective mobilization and efficient use of resources**
46	3.2.1 Identify needs and conduct capacity-building activities for relevant HCOs, rayon and oblast specialists to upgrade knowledge and skills in budgeting and financial management
47	3.2.2 Develop, agree and test methods of resource (funds) redistribution between the HCO budget lines and across fiscal years under the condition of adequate accountability and reporting
48	3.2.3 Develop, agree and introduce a proposal on expanded rights of pilot HCOs on planning and financing of capital expenditures within a Rayon health care delivery network plan
49	3.2.4 Conduct round tables at oblast level
50	3.2.5 Develop, agree and test streamlined financial reporting of pilot HCOs
51	**3.3 Upgrade commodity management methods and practices to allow for greater efficiency and quality**
52	3.3.1 Identify needs and conduct capacity building activities for relevant HCOs, rayon and oblast specialists to upgrade knowledge and skills in procurement, inventory and commodity management
53	3.3.2 Assess procurement and supply management practices to identify problem areas and opportunities to improve procurement of assets, materials and supplies and efficient use of these inputs
54	3.3.3 Develop and testing of necessary technical and methodological documentations and tools
55	
56	3.3.4 Contribute to ensuring transparency of procurement results and actual flow of supplies, including their efficient circulation and continuous tracking of stock status and uses with HCOs



ID	Task Name
57	**3.4 Develop and apply updated modules of information system with upgraded technology, methods and tools for effective HCO management**
58	3.4.1 Assess current HMIS, including clinical and para-clinical functions, HR, drugs and consumables, equipment, fin management, procurement, inventory tracking and management tools, supervision tools and guidelines to identify gaps and future needs
59	3.4.2 Upgrade existing HMIS and develop new information modules, tools and processes as required, adapt currently available tools where applicable
60	3.4.3 Conduct Working Group meeting on quality improvement and control and health facility management
61	3.4.4 Conduct round tables at oblast level
62	3.4.5 Improve IT assessing needs and providing necessary hardware and software to pilot rayons for implementing an effective MIS to support / improvements in health care management
63	**4 HCO infrastructure is improved and required equipment has been installed. Maintenance of this equipment is ensured**
64	4.1 Physical infrastructural requirements improvements and installation of medical equipment
65	4.2 Improve Health technology and management
66	4.3 Implement Telemedicine / eLearning
67	4.4 Introduce Health
68	**4.5 Common activities under Outcome 1**
69	4.5.1 Advocacy and PR campaign
70	4.5.2 Publication and production
71	4.5.3 Assess needs of pilot health facilities of three rayons and their equipping
72	4.5.4 Equipping of pilot HFs
73	4.5.5 Monitoring
74	**5 Improved decentralized health governance with consolidated monitoring, accountability mechanism and effective communication strategy in place**
75	**5.1 Revise and use legal and regulatory framework to facilitate HFA**
76	5.1.1 Kick-off meetings with stakeholders at central and rayon level (50 participatns)
77	5.1.2 Create and maintain a database of all relevant legislative and normative acts / documents
78	5.1.3 Conduct a thorough legal and regulatory review to identify (i) bottlenecks and gaps for executing currently granted autonomy and (II) need for revising existing and developing new legal and regulatory acts
79	5.1.4 Consult with key stakeholders to agree about opportunities, sequencing and timelines to revise and or to develop needed legal and regulatory acts
80	5.1.5 Develop and agree on an action plan with a master list of revision ad development work, stakeholder involvement / participation, necessary work procedures and arrangements, timelines for drafting, reviews / submissions, hearings
81	5.1.6 Implement the AP on regulatory and legislative initiatives to support introduction of a new HFA model
82	5.1.7 Conduct working Group on legislation
83	5.1.8 Conduct Round tables for Parliamentarians
84	5.1.9 Conduct Round tables at national level
85	5.1.10 Lobby for approval of developed legal and normative acts, documents
86	**5.2 Introduce governance structures allowing decentralized management of HCOs at rayon level**
87	5.2.1 Plan and conduct information workshops / dissemination events to explain to relevant stakeholders the adopted changes / developments in regulatory and legislative basis for HCOs, their networks, governance structures, etc.
88	5.2.2 Assess current governance system (structures, roles and responsibilities, scope of functions, participation) at rayon level and identify needs, options and opportunities for introducing better coordination, supervision, M&E and accountability
89	5.2.3 Develop (elaborate) rayon health care development plan as the means to implement Den Sooluk Program at rayon level
90	5.2.4 Define and elaborate necessary elements of improvements at the oblast and national levels to support / harmonize with improvements at the rayon level
91	5.2.5 Prepare pilot rayons to introduce an improve governance system at rayon level (develop framework regulations / statutes, JDs, internal policies and procedures, methodology, work instruments / tools, etc.; train relevant personnel)
92	5.2.6 Conduct Round Tables at oblast level
93	5.2.7 Contribute to development of the effective system on (i) criteria of selection, (ii) recruitment and (iii) assessment of rayon level health managers' performance
94	**5.3 Develop and implement results-oriented rayon M&E system**
95	5.3.1 To conduct the assessment of capacity of existing M&E system: to review the M&E procedures, software, hardware, human resources
96	5.3.2 To develop the guides, tools and training program for improvement of M&E procedures
97	5.3.3 To conduct the training for HCO managers, medical statistics, LSG
98	5.3.4 Implement and enhanced M&E system at rayon level
99	**5.4 Develop and introduce participatory & effective communication strategy**
100	5.4.1 Access current communication strategy and communication means used by HCOs, health sector stakeholders within rayon, between rayon and oblast, between health professional community, civil society and the public
101	5.4.2 Develop and introduce effective communication strategy to support HFA movement and open lines of communication, feed-backing between autonomous HCOs with steering and supervising structures and population
102	**5.5 Build capacity of health policy and decision makers at all levels to provide an enabling environment for efficient provision of high quality care at rayon & HCO level**
103	5.5.1 Assess / identify capacity building and training needs in leadership, strategic planning, general management and in health care management among stakeholders of all governance levels (HCOs, rayons, oblasts, national)
104	5.5.2 Design and conduct study tours to relevant countries to familiarize key stakeholders with best applicable practices of effective health management and governance)
105	5.5.3 Develop a module based curricula for leadership and management training course applicable to KG and incorporate best international knowledge and skills and test it by modules by training relevant managers of pilot rayons, oblasts/regions, MoH, MHIF, etc.
106	5.5.4 Development of training materials and methodology
107	5.5.5 Capacity building/training (delivered by STEs and sub-contractors)
108	5.5.6 Conduct round tables at oblast level
109	5.5.7 Develop and implement a project specific mechanisms of building capacity of health policy makers and operational decision makers at all levels of the whole spectrum of innovations to introduce the HFA model



ID	Task Name
110	**5.6 Approve and institutionalize for use produced by the project methodology, guides, tools, SOPs, services agreements, training materials**
111	5.6.1 Approve new and revised methodology, guidelines and standard operating procedures at national level
112	5.6.2 Identify a domestic entity and work together to institutionalize new curricula on leadership and management for candidates for practicing managers of various level of the health system, prepare and launch regular training to cover the whole sector
113	5.6.3 Introduce revised and/or development training curricula, training materials and tools related to management and/or clinical training into undergraduate and post graduate education training system
114	5.6.4 Disseminate and institutionalize countrywide innovative models of quality assurance, incentive payments schemes, another successful models, and methods used in pilots
115	**6 Improved healthcare delivery established at rayon level through introduction of better integrated HCO networks and services**
116	**6.1 Define and apply an optimal scope of services within HCO for better coordination and continuous care of patients at the rayon level**
117	6.1.1 Identify barriers and enabling factors for integrating and better coordination of services to develop and agree an action plan
118	6.1.2 Define and agree an optimal scope of services within HCOs with aim to have better coordinated and continuous care of patients required coordination across all HCOs and at the rayon level
119	6.1.3 Conduct Round Tables at oblast level
120	6.1.4 Explore together with key stakeholders (MoH, Move, MHIF) rationale and opportunities to introduce financial planning / budget allocation planning for the rayon health system level to deliver scope of services guaranteed by the State BP linked +
121	**6.2 Strengthen referral system, gate keeping functions for PHC providers and contracting with oblast and national level HCO for additional health services needed**
122	6.2.1 Review existing referral system, identification of flaws and inappropriate patterns of patient flows and pathways
123	6.2.2 Revise patient referral system, gate keeping functions for PHC providers and contracting with oblast and national level HCO for additional health services of need
124	6.2.3 Introduce revised patient referral system and monitor adherence by pilot HCOs
125	**6.3 Explore rationale and opportunities for introducing HR recruiting and deployment model at rayon level**
126	6.3.1 Explore rational and opportunities for introducing HR recruiting and deployment model at rayon level (vs. recruiting at HCO level) for specialists of unique (rare) qualifications and need that can be more effectively utilized if assigned to the rayon+
127	6.3.2 Develop and test new HR recruiting and deployment model for rare specialists in pilot rayons (accordingly to their needs), including arrangements of logistics, work schedules, etc.
128	**7 Improved contracting and provider payment mechanisms introduced to support better performance at HCO and their network**
129	**7.1 Improve MHIF-HCO contracts towards better strategic purchasing characteristics**
130	7.1.1 Review and discuss existing contracts between MHIF and HCOs to identify gaps, needs for elaboration, opportunities to introduce links / references / coordination between contracts of PHC and hospitals and opportunities for introducing a master contract
131	7.1.2 Develop and test revised contracts with better strategic purchasing characteristics +
132	**7.2 Design and test effective provider payment methods to support better performance at HCOs and their networks (including introduction of RBF/PBF model / mechanisms for PHC HCOs)**
133	7.2.1 Collaborate with the WB project to support RBF implementation in pilot hospitals (as applicable), with emphasis on internal arrangements for rewards reaching personnel and related tools in financial accounting /financial management
134	7.2.2 Design and test RBF/PBF model mechanism for pilot HCO of PHC level
135	7.2.3 Monitor performance changes associated with RBF/PBF in PHC, analyze trends
136	7.2.4 Evaluate effects of RBF/PBF. Make adjustments and enhancements to RBF methodology as necessary
137	7.2.5 Design and test payment model/mechanism for outpatient / ambulatory specialist care at pilot HCOs of PHC level and at TH (as apply)
138	7.2.6 Monitor and evaluate effects of changing provider payment method (PPM) for specialist care
139	7.2.7 Conduct working group on health financing
140	**7.3 Common activities under Outcome 2**
141	7.3.1 Monitoring
142	7.3.2 Production of reports
143	7.3.3 Study trip to Europe
144	7.3.4 Steering committee meetings
145	7.3.5 Board meetings
146	7.3.6 Impact evaluation evidence sharing with stakeholders at central and rayon levels

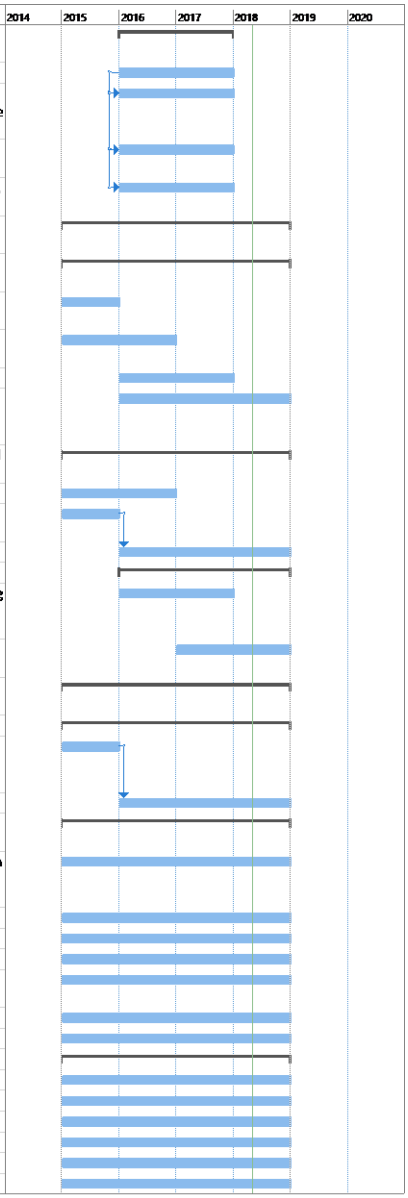


Figure 27: Options for scaling up the project interventions by the type of interventions at the national level

Directions and main interventions	Types of intervention at the national level: Advocacy & lobbying	Legislation	Inter-Sectoral Actions	Capacity building	Information Sharing
1 Investment in key human resources:					
1.1 Develop HF management training modules and institutionalize trainings					
1.2 HF Manager licensing introduced					
1.3 A critical reserve of HF managers developed					
2 Improve HFA manager selection and recruitment					
2.1 Changing rules					
2.2 Support in changing recruitment and supervision practices					
3 Promote intersectoral actions for health					
3.1 Promote "Rayon Health Councils" approach					
3.2 Support it scale up					
4 Support decentralization in healthcare by promoting ownership by local governments					
4.1 Harmonize legislation (cleaning up collisions, and filling in gaps)					
4.2 Support in separating and/or refining ownership of assets and HCOs between the MoH and LGs					
5 Promoting autonomy of healthcare organizations					
5.1 Financing					
5.2 Quality improvement					
5.3 Staffing					
6 Improve generation and use of data by HCO and local governments					
6.1 Support introduction of modern data quality assurance mechanisms					
6.2 Support HFs and LGs in the analysis and use of information for decision-making					

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