KfW Development Bank

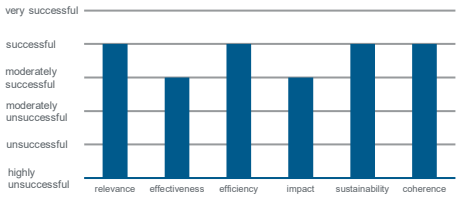
Ex post evaluation
Sectoral Programme Health I–V, Kyrgyz Republic

Title	Sectoral projects Health I – V		
Sector and CRS code	12110 Health policy and health services administration		
Project number	2005 65 994, 2007 66 535, 2011 66 396, 2013 65 469, 2015 67 510, BM: 2005 70 325, 2007 70 370, 2011 70 190, 2013 70 030		
Commissioned by	Federal Ministry for Economic Cooperation and Development (BMZ)		
Recipient/Project executing agency	Kyrgyz Ministry of Finance (MoF), Kyrgyz Ministry of Health (MoH)		
Project volume/ Financing instrument	SWAp I: EUR 14 million (inv.), EUR 2 million (CM); SWAp II: EUR 7.2 million (inv.), EUR 0.8 million (CM); SWAp III: EUR 9.2 million (inv.), EUR 0.8 million (CM); SWAp IV: EUR 5 million (inv.), EUR 0.8 million (CM); SWAp V: EUR 7.5 million (FC) grant		
Project duration	SWAp I: FC 04/2011 FI 05/2019; SWAp II: FC 04/2011 FI 05/2019; SWAp III: FC 12/2013 FI 05/2019; SWAp IV: FC 12/2013 FI 05/2019; SWAp V: FC 12/2013 FI 05/2019		
Year of report	2023	**Year of random sample**	2020/21

Objectives and project outline

The objective of the projects at outcome level was to improve access to health services by all sections of the population, to reduce financial hardship in the event of illness, and to increase the quality and efficiency of health services. The objective at impact level was to improve the health status of the Kyrgyz population. FC funds supported the implementation of the sector reform programmes in the health care sector by means of basket financing as part of a sector-wide approach (SWAp).

Overall rating:
successful



Key findings

The project was effective in terms of developmental impacts and is rated as “successful” overall:

– The SWAp and basket financing promoted ownership by the Kyrgyz partners, reduced the number of parallel projects, strengthened an active and regular exchange between all stakeholders as well as their harmonisation, and helped direct the focus towards important issues in the health care sector.

– The level of effectiveness was moderately successful. One positive aspect worth highlighting is the early achievement of SDG 3.1.2 and the fact that the partner was able to implement 95 % of the budget due to its measures and activities. However, not all indicators could be fully achieved.

– The costs associated with the health system have been reduced. The SWAp and the pooling of finances in one basket cut transaction costs for the partners and established a comprehensive sector dialogue.

– The delivery of health care and the health status of the population have improved substantially, though the quality of the health care services provided can still be improved. It was also not possible to consolidate the reduction in financial hardship on poor sections of the population with regard to the improvement and expansion of the range of services.

– The structural changes and progress with regard to the SDG agenda and its continuation as part of the subsequent promotion efforts are positive signals, though the partner’s (MoH) insufficient staffing levels remains a risk.

Conclusions

– The chance of success for the implementation of extensive sector reforms is enhanced by a sector-wide approach where the majority of donors is involved.

– The use of domestic systems enhances ownership and strengthens the capacity of the domestic administration.

– Pooling donor financing in one basket supports concentrated sector financing in key priority areas.

Ex post evaluation – rating according to OECD-DAC criteria

General conditions and classification of the project

The projects involved contributions from the German FC relating to joint financing arrangements in the health care sector in the Kyrgyz Republic. The World Bank (WB), Swiss Development Cooperation (SDC), German FC and, until 2010, the UK's *Department for International Development* (DfID)[1] and the Swedish International Development Cooperation Agency (SIDA) supported the national health care reform programmes by means of basket funding under a sector-wide approach (SWAp).

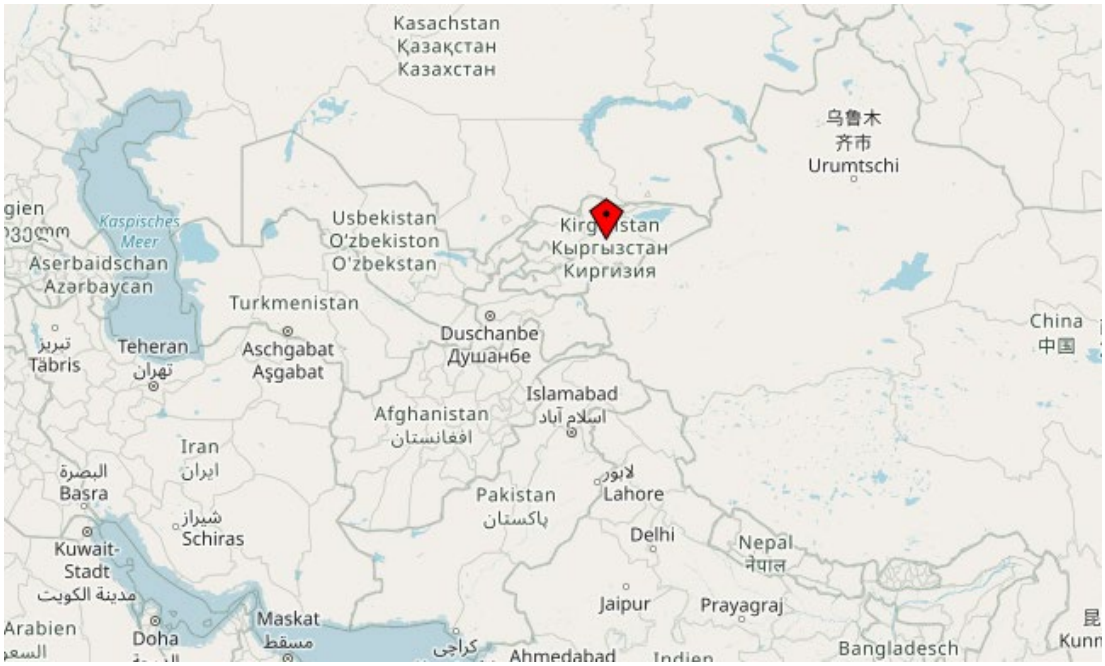
Specifically, the FC sector projects Health Care I + II (2005 65 994, 2007 66 535) supported the *Manas Taalimi* reform programme 2006–2011, while the FC sector projects Health Care III-V (2011 66 396, 2013 65 469, 2015 67 510) supported the follow-up programme *Den Sooluk* 2012–2016, which was implemented following a delayed start from 2014 to 2018.

The financial contributions to the SWAp were regulated by a Memorandum of Understanding (MoU) between the Kyrgyz government and the financiers. Complementary measures (CM: 2005 70 325, 2007 70 370, 2011 70 190, 2013 70 030) strengthened the staff's ability to analyse the equipment situation in the sector and to develop rational, cost-effective recommendations. The present evaluation comprises the projects under the sectoral projects Health Care I + II and III-V as well as the corresponding assigned CMs.

Brief description of the project

To help improve the health status of the Kyrgyz Republic's population as a whole, the national health reform programmes were supported (as described above) by means of basket financing as part of a SWAp. In addition to financing, the Kyrgyz partners received continuous support in the administrative and technical planning and coordination of the reform process. The project's target group was initially the Kyrgyz Republic's population as a whole, with special attention paid to poor sections of the population. After the mid-term review in 2016, the focus was directed towards mothers and children.

Project country map



Source: OpenStreetMap.

[1] Today: Foreign, Commonwealth & Development Office (FCDO), https://www.gov.uk/government/organisations/foreign-commonwealth-development-office

Breakdown of total costs

The following are estimated values from the WB based on prospective financial planning by the Ministry of Finance. According to the final inspection (PCR), it is not possible to provide precise information on the actual total costs due to constant exchange rate fluctuations over the years.

		Projects (planned)	Projects (actual)	Complementary measure (planned)	Complementary measure (actual)
Investment costs (total)	**EUR million**		X	X	X
Manas Taalimi		1,053			
Den Sooluk		1,369.7			
Counterpart contribution	EUR million		X	X	X
Manas Taalimi		926			
Den Sooluk		1,140			
Basket funding	EUR million		X	X	X
Manas Taalimi		77.4			
Den Sooluk		49.5			
of which budget funds (BMZ)	EUR million				
Manas Taalimi: BMZ no.: 2005 65,994; 2007 66,535; CM: 2005 70 325; 2007 70 370		21.2	21.2	2.8	2.8
Den Sooluk: BMZ no.: 2011 66,396; 2013 65,469; 2015 67,510; CM: 2011 70 190; 2013 70 030		21.7	21.7	0.8	0.8

Rating according to OECD-DAC criteria

Relevance

Policy and priority focus

In 1991, when the Kyrgyz Republic gained independence from the Soviet Union, it inherited a health system characterised by comprehensive health care and free access for all citizens.[2] The health system was centralised, input-oriented and had by a high level of bureaucracy with corresponding costs and inefficiencies.

With independence and following the end of state allocations from the Soviet system, the public finances were not in a position to maintain the system in the long term. The health indicators deteriorated noticeably and general life expectancy decreased. In 1996, in response to the crisis, the Ministry of Health initiated a major restructuring of the health system.

In the period from 1996 to 2006, the *Manas* National Health Reform Programme was[3] developed and implemented with the support of WHO, the main objective of which was to unbundle the health system. The main characteristics of the 'Manas' reforms and the subsequent 'Manas Taalimi' were (i) the development and maintenance of needs-based infrastructure, (ii) the decentralisation of administration and the strengthening of the administrative and financial autonomy of health organisations, (iii) the merger of health[4] funds, (iv) a results-based remuneration mechanism for service providers and (v) the division of the health sector into providers and consumers of services. Furthermore, the reforms led to a shift from specialist care to family medicine, the introduction of a basic

[2] The health system in the Soviet Union was often called the Semashko system, named after the Soviet Union's first health minister from 1918–1930, Nikolai Semashko

[3] https://apps.who.int/iris/handle/10665/108088

[4] Since 2001, the Mandatory Health Insurance Fund has been responsible for pooling health budget funds and pooling the financing flows from insurance, state and regional budgets.

benefits package, reforms in health care financing, including the introduction of *contracting*[5] and a consolidated payment system, as well as the liberalisation of the pharmaceutical market.

As part of the reorganisation, the highly hospital-intensive care system was to be developed with a focus on outpatient family medicine. Family medicine centres (FMC[6]) and feldsher-akusher (midwife) points (FAP[7]) were established to reinforce the role of primary health care.

Financing the services was a key challenge for the initial reform. Households who used the health services were heavily burdened in a financial sense by formal out-of-pocket payments and high informal payments. On the other hand, public health expenditure was underfunded and low in relation to the overall budget and GDP. In addition, external support from the cooperation partners was poorly coordinated.

With this in mind, the government and the cooperation partners decided to address these challenges by taking a sector-wide approach (SWAp) in the form of the health reforms, *Manas Taalimi* (2006–2010) and *Den Sooluk* (2012–2016). The majority of external financing was pooled (DfID, SDC, SIDA, WB and KfW)[8] and a joint results matrix was developed. The development partners not only provided financing, but lent close and continuous support to the Kyrgyz partners in the administrative and technical planning and coordination of the health reform process. GTZ[9][10], WHO[11], USAID[12] and UNICEF[13] also supported the programme with specific technical advice and support programmes. Other development partners, such as Turkey, India, Japan, Russia, and the Russian-Kyrgyz Development Fund, also supported the health sector with project aid without actively participating in the regular meetings between the government and the partners on the issue of health[14].

Manas Taalimi focused on the Millennium Development Goals (MDG 4, 5, 6)[15] to reduce child and infant mortality, improve maternal health, and reduce HIV/AIDS and other communicable diseases. Furthermore, the

[5] The Health Insurance Fund (MHIF) is the only public payer for virtually all hospitals and primary care providers. The MHIF concludes annual contracts with the health care facilities financed under the single-payer system, with 185 pharmacies contractually bound to the MHIF.

[6] FMC are the largest outpatient health care facilities and offer medical services ranging from general medical care to specialist care and diagnostics, including X-ray and ultrasound. As FMC have often replaced smaller hospitals or outpatients' clinics, smaller operations can also be carried out on their premises. Each FMC usually has 10–20 medical specialists.

[7] FAPs are responsible for providing comprehensive primary health services for the whole family. They have at least one doctor and/or feldsher, as well as nurses and midwives. Although they are independent entities, they remain part of the FMC responsible for them.

Another medical institution in the Kyrgyz Republic is the network of village health committees, community-based organisations that are independent of the formal health system and local self-government bodies but that work closely with both7. They cover around 85 % of villages in all districts and serve around 3.3 million people. Their main task is to raise the health awareness of villagers and promote healthy behaviour. Staff from primary health care organisations regularly visit the Village Health Committees and provide training on organisational development and health campaigns. They play a special role in HIV education.

[8] UK Department for International Development (DfID), Swiss Development Cooperation (SDC), Swedish Development Cooperation Agency (SIDA), World Bank (WB)

[9] https://www.giz.de/en/downloads/giz2021-en-promotion-of-primary-healthcare-in-kyrgyzstan.pdf

[10] Involvement of GIZ towards the end of Den Sooluk

[11] https://www.who.int/kyrgyzstan/about-us

[12] USAI: HIV Flagship project (2015–2020), HIV REACT Project (June 2014-June 2019), Challenge TB (2015–2019), Defeat Tuberculosis (2014–2019), HIV Investment Approach (October 2012-September 2017), LEADER for People Living with HIV (August 2014-August 2017), The Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project (August 2014-September 2016), Health Finance & Governance: TB Strategic Purchasing (2014–2017), Quality Health Care (September 2010–2015)

Dialogue on HIV and Tuberculosis (September 30, 2009 -March 31, 2015), TB Care I (August 2011- September 2014), USAID WHO Tuberculosis Grant (January 2014 – January 2015), Demographic Health and Survey (DHS) (January 2011- September 2014), Maternal and Child Health Integrated Project (September 2011 – April 2014)

[13] Health and child survival, https://www.unicef.org/kyrgyzstan/health-and-child-survival

[14] https://www.who.int/countries/kgz, HEALTH SECTOR COORDINATION IN KYRGYZSTAN, Further Strengthening the SECTOR-Wide Approach Final Report

[15] https://www.euro.who.int/__data/assets/pdf_file/0008/163088/03_MDG-report_17Apr2012.pdf

programme aimed to reduce cardiovascular disease, which is the most common cause of premature death in the Kyrgyz Republic.[16]

Manas Taalimi's objectives included improving access to health services, reducing the financial burden on the population, increasing the efficiency of the health services and improving the quality of the health services. A gradual increase in public expenditure in the health sector to 13 % of the total budget, in addition to budget execution of at least 95 %, was agreed as a budget rule for the basket funding from the Joint Financiers.

Den Sooluk was seen as a logical continuation of the previous reform and aimed at social health protection in the sense of universal coverage, equal access to services, burden-sharing in financing, better training processes for health personnel and improved financial management and procurement.

In this respect, the project's objective to contribute to improving the health status of the population of the Kyrgyz Republic coincided with the Kyrgyz reform objectives and was aligned with the partner country's policies and priorities.

The project's objective was also in line with the BMZ's regional strategy and the German Federal Government's 2015[17] action programme, as well as with the BMZ's objectives to support its partner countries in building inclusive, digital and resilient health care systems and provide primary health care.[18] The objectives of this support were based on the Millennium Goals (MDGs)[19] (as well as the *Sustainable Development Goals* (SDGs) later on) and followed the principles of the Paris Declaration and the Accra Agenda for Action[20] with regard to the requirements for a) ownership and self-financing, b) use of the partners' financial systems, and c) harmonisation. In addition, the Kyrgyz Republic was one of the DAC/OECD harmonisation pilot countries[21], which agreed to take part in facilitating country-level harmonisation as part of the Rome[22] Declaration.

Focus on needs and capacities of participants and stakeholders

The target group of the reform programmes, and therefore the projects, is the entire population of the Kyrgyz Republic, which at the time comprised around 5 million inhabitants, with particular focus[23]on low-income sections of the population, estimated at one third. This is reflected in the Kyrgyz population's universal claim to a state-guaranteed benefits package (SGBP) that would provide free primary outpatient care and inpatient services largely subject to co-payments. The guaranteed basic care programme provides for a wide range of special regulations for particularly vulnerable people and those in need of care, such as children, women of childbearing age and older patients or patients with life-threatening illnesses or highly contagious diseases (exemption or reduction in user fees, payment of health insurance contributions covered by the social fund and subsidised or free provision of medicine).

Following the realisation during the mid-term review of *Den Sooluk* in 2016 that the wide-ranging clinical and social objectives could likely not be achieved, the focus of the joint financing was placed on maternal and child health through to the end of the 2018 term, the objectives of which seemed most likely to be achieved. Overall, it must be verified that the objectives relating to this measure were geared towards the developmental needs of the target group.

Appropriateness of design

The underlying results chain, according to which the aim was to contribute to improving the health status of the entire population of the Kyrgyz Republic (impact objective) through the use of improved access to health services for all sections of the population, the reduction of financial hardship in the event of illness, the increase in the efficiency and quality of health services, as well as improvements in patient orientation and the transparency of the

[16] Age-standardised death rate due to cardiovascular disease, cancer, diabetes or chronic respiratory disease in adults aged 30–70: 20.3 (in 2019). Target value: 9.3.
[17] A programme for implementing international community goals, drawn up in 2004. The Federal Republic of Germany had committed itself to play its part in achieving the Millennium Goals, which were negotiated in Johannesburg in 2002.
[18] https://www.bmz.de/resource/blob/121224/233cfbd1506e34d04f387e383767abe5/schwerpunkte-unserer-entwicklung-spolitik-de-data.pdf
[19] https://www.un.org/millenniumgoals/
[20] https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm
[21] https://www.oecd.org/dac/effectiveness/35036791.pdf
[22] https://www.oecd.org/dac/effectiveness/31451637.pdf
[23] https://www.adb.org/countries/kyrgyz-republic/poverty

health care system (outcome objective) is plausible and clear (see reconstructed results chain in the figure on the next page).

Specifically, the FC measures supported the *Manas Taalimi* state reform programmes and the follow-up programme *Den Sooluk*, all of which were intended to achieve the above mentioned objective by creating an efficient, comprehensive and integrated system for the provision of individual and public health services. The health reform policy was thus directed at (i) improving access to health services, (ii) reducing the financial burden on patients, (iii) increasing the effectiveness of the health services delivery system and (iv) improving the quality of health services. This is reflected in the formulation of the objectives at outcome level.

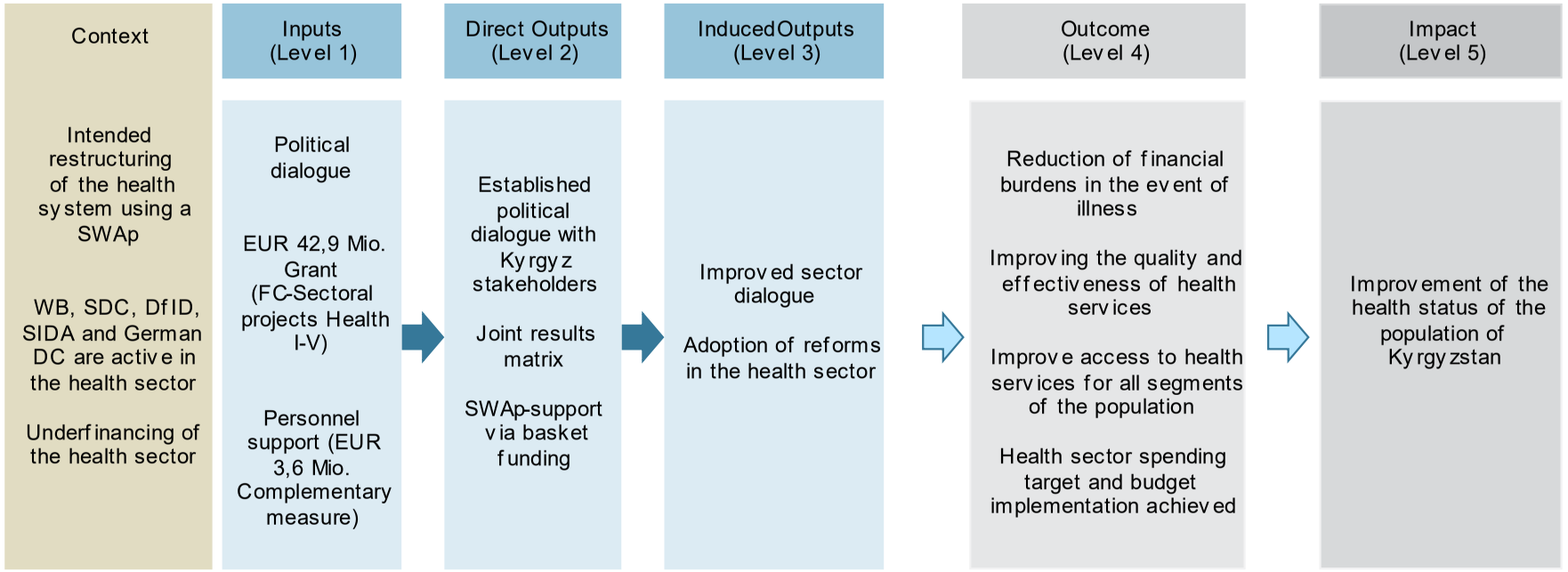
The DC programme's objective of improving access for all population groups and genders, particularly in rural areas, to primary health services that are based on international standards and sustainably financed (output level) therefore correlates directly to the formulated objective at outcome level.

In terms of improving health outcomes, *Den Sooluk* focused on i) cardiovascular disease, which is the main cause of premature death in the Kyrgyz Republic, ii) maternal and child health, iii) tuberculosis and iv) HIV/AIDS. During a restructuring project in 2016, its scope was focused on contributing to improving the quality of maternal and child health care. Public expenditure on the health sector in the Kyrgyz Republic prior to the implementation of the *Manas Taalimi* reform programme was below WHO's recommended minimum value of 3 % of GDP.[24] To promote steady growth in health expenditure – and to maintain the principle of additionality of donor funds especially – all disbursements as part of the basket funding had to comply with budget rules. Specifically, the following two budget rules were agreed: Under the *Manas Taalimi* programme, the first rule was to increase the proportion of health expenditure in the budget by 0.6 % every year, with the aim of reaching 13 % by 2010. Under the *Den Sooluk* programme, this value was to be consolidated at 13 %. Under the second rule, actual annual expenditure was not to fall below 95 % of the planned budget appropriations (budget execution).

To support the implementation of the reform, funds were provided for the complementary measure (consulting)[25] as part of the respective FC investment commitments. Throughout the durations of *Manas Taalimi* and *Den Sooluk,* extensive consultancy services were made available to the Ministry of Health and the MHIF Health Fund, including on issues relating to the rationalisation and optimisation of hospital services, maintenance and repairs, hospital financing and personnel standards. In addition, nationwide health care facilities and hospitals as well as employees from the Ministry of Health were to be advised and trained on the subjects of financial management and procurement. An accompanying measure by the FC included financing the mid-term review of *Den Sooluk* in June 2016, part of which involved adapting and realigning the strategy.[26] A detailed feasibility study on the creation of a public-private partnership in the health sector was also carried out as a reform project, albeit with support from the Studies and Experts Fund. This was based on a preliminary study financed by a complementary measure with the intention of contributing to the first public-private partnership in the sector (dialysis services from Fresenius[27]).

[24] https://apps.who.int/gho/data/node.main.GHEDGGHEDGGESHA2011?lang=en
[25] CM for Manas Taalimi EUR 2.8 million; for Den Sooluk EUR 0.8 million.
[26] BMZ No. 2011 70 190
[27] https://www.nephrocare.de/clinic/dialysiscenterllcfreseniusmedicalcarekgz-bishkek2

Reconstructed logic of results



The sector-wide approach was fundamentally suitable for contributing to solving the core problem. However, it could have been expected that a sector strategy would take into account the extent to which the capacity of the administration (MoH) has grown due to the complexity of a reform that covers the entire sector.

Altogether, the concept was designed to create structures that would be retained even after the projects ended; accordingly, it considers sustainability of the intended improvements. By simultaneously pursuing social objectives and promoting financial sustainability through the development of corresponding structures, a holistic and correct approach was chosen in the design of the projects.

Response to changes/adaptability

In 2016, the mid-term review[28] of *Den Sooluk* found continued poor quality of treatment and insufficient results in the health indicators, such as for maternal mortality, as well as the continued spread of multidrug-resistant tuberculosis.[29] The weakness of primary health care was seen as the core problem. For example, only 4 % of all cases of high blood pressure were diagnosed, while around 80 % of all adults with high blood pressure remained untreated. Although the share of financing for primary care from the State Guaranteed Benefits Package (SGBP) had been increased to 32.5 %[30] in 2018, it had not improved training, quality incentives or monitoring at the same time.

As part of the mid-term review, it became clear that some of *Den Sooluk's* targets could not be achieved. For this reason, following the joint decision of the Ministry of Health and the international donor group, it was agreed that, for the remaining term of the programme until the end of 2018, basket support would focus on the priorities of maternal and child health and strengthening of essential health services. This was based in particular on the World Bank's successful results-based financing [31] project to improve mother-child services. At the same time, it paved the way for the new Kyrgyz health reform programme Healthy Person, Prosperous Country[32] and the Program-for-Results concept[33], which was established as a logical continuation of the basket funding. Instead of the previous sector-wide approach, both programmes have explicitly focused on improving basic health care.

Summary of the rating:

The second and third sector reforms were implemented as part of a sector-wide approach, which included the Ministry of Health of Kyrgyzstan and important international donors such as the WB, DfID, SDC, WHO, UNICEF and the German FC. The funds were pooled as part of basket funding. Both approaches promoted ownership of the reform process by the Kyrgyz partners, especially in the Ministry of Health and the Ministry of Finance, reduced the number of parallel projects by international partners, helped establish a focus on the top issues in the health sector, and reinforced active and regular exchanges between all stakeholders and their harmonisation. The approach was highly important, justified and pertinent and is still relevant from today's perspective.

The objectives of the programmes took into account the needs of the population, as they were aligned with the political priorities and realities of the country. The results chain is plausible. The main impact of basket funding is to provide sustainable support for the implementation of reforms in the health sector, which primarily aims to improve the quality of health care and to develop the solidarity-based financing of healthcare. Basket financing is also an important instrument in the discussion of sectoral measures and budgeting. However, the limitations to consider are that the resilience of health personnel was overestimated, bureaucracy was cumbersome,

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28 SECOND HEALTH AND SOCIAL PROTECTION PROJECT (SWAP2) (IDA CREDIT 5235-KG, IDA GRANT H8390-KG, TF015135) MID-TERM REVIEW JUNE 15 – 28, 2016 AIDE MÉMOIRE

29 According to WHO, 26 % of all newly reported cases and 61 % (2017) of all retreatment cases were MDR-TB. MDR-TB is a special form of tuberculosis and is caused by mycobacteria that are resistant to the most effective anti-TB drugs, namely isoniazide and rifampicin. https://www.euro.who.int/__data/assets/pdf_file/0017/310076/TB-surveillance-report-2016-Kyrgyzstan.pdf

30 https://openknowledge.worldbank.org/bitstream/handle/10986/33096/Toward-a-More-Pro-Poor-and-Explicit-Health-Benefit-Package-in-the-Kyrgyz-Republic-A-Critical-Review-of-the-State-Guaranteed-Benefit-Package-and-Options-for-Its-Revision.pdf?sequence=1&isAllowed=y

31 https://www.rbfhealth.org/project/kyrgyz-republic

32 https://www.uhc2030.org/news-and-stories/news/kyrgyzstan-government-and-partners-agree-a-joint-statement-on-health-sector-coordination-555271/

33 The characteristics of the Program-for-Results (PforR) include the use of the recipient country's institutions and processes and the direct linking of disbursements with the achievement of specific programme results. The approach contributes to building capacity within the country, improving effectiveness and efficiency. PforR supports government programmes and promotes harmonisation of external support.

coordination within the Kyrgyz government was challenging and incentives to perform were too low. However, we rate the relevance of the project as successful overall.

Relevance: 2

Coherence

Internal coherence

Within the German DC, there were links between the FC support through basket funding and the TC project "Promotion of primary health care" in terms of content. Although the Kyrgyz Republic has succeeded in achieving the targets for sustainable development in health, there are still problems in guaranteeing the basic supply of medical services. The ongoing TC project addresses this problem and focuses on improving the quality and accessibility of medical care, particularly in the area of maternal and child health. The TC project is therefore in line with the National Development Strategy 2018–2040[34] and the National Health Strategy 2019–2030[35] and complements the FC project.

The basket is at the heart of the donor community's policy and sector dialogue with the government. Their participation in basket funding enables the German DC to have a significant say in reform development and thus have considerable influence on the design of improved framework conditions in the health sector. Under the SWAp, the bilateral FC and TC projects (as well as other donors) are also involved in the reform programme and sector dialogue, and are given greater weight through participating in the basket.

External coherence

Joint financial support through the basket funding totalling USD 77.4 million *(Manas Taalimi)* and USD 49.5 million (*Den Sooluk)* enabled the partner country to play a leading role in programme design and implementation. The programme's ongoing dialogue promoted the harmonisation of external support. In addition to their contributions to the basket fund, several financiers provided bilateral support to individual areas of the reform programmes. All these contributions were part of the overarching SWAp planning and were implemented in close coordination with the Kyrgyz government.

The procurement of capital goods and consumer goods, primarily medical equipment and consumables, the organisation of consulting services, and the conducting of studies and medical training were implemented according to annual plans, which were coordinated with the financiers in the Joint Annual Reviews (JAR). As part of the fiduciary risk control, procurement and financial management were closely monitored by the WB on behalf of all financiers. The implementation of the reform measures in the sector was monitored and inspected with the help of annual external financial and operational audits.

The follow-up and evaluation of the programme's progress with regard to target achievement centred around the established JARs, which were carried out jointly by the government and the donor community and their results recorded in the respective summary notes (aide-memoires).

By signing a Memorandum of Understanding (MoU) between the government and the development partners (DfID, SDC, SIDA, WB and Germany's FC), the harmonised financing mechanism (basket fund) was aligned directly with the objectives set out in the reform strategy.

In terms of the approach, using joint financing to implement the project eased the burden on the partner and made it easier to harmonise the external support.

[34] http://donors.kg/en/strategy/5174-national-development-strategy-of-the-kyrgyz-republic-for-2018-2040

[35] https://www.who.int/europe/news/item/23-01-2019-kyrgyzstan-adopts-new-health-strategy-for-2019-2030

Summary of the rating:

In summary, it can be stated that the measure was consistently oriented towards the partner's own efforts and complemented the promotion of other donors. Against this background, we rate the coherence of the project as successful.

Coherence: 2

Effectiveness

Achievement of (intended) targets

The objective adjusted as part of the EPE was: Use of improved access to health services for all sections of the population, a reduction of financial hardship in the event of illness, an increase in the efficiency and quality of health services as well as improvements in patient orientation and transparency of the health care system.

The achievement of objectives at outcome level is summarised in the table below:

Indicator	Status during PA	Target value acc. to PA/EPE	Actual value at final inspection (optional)	Actual value at EPE
Indicator 1 Share of planned expenditure for the health sector as measured in relation to the total budget	7.1 %	13 %	13.1 % (2018)	9 % (2019)[36]; 10 % of the budget is foreseen for the health care sector for the 2023 fiscal year. The indicator was not achieved.
Indicator 2 Budget implementation in the health sector	93.6 %	≥ 95 %	96.4 % (2018)	The indicator was achieved (see text).
Indicator 3: Out-of-pocket (self-financing) expenditure in % of total health care expenditure	42.6 % (2005)	While there are no target values here, self-financing should be kept relatively low	54.5 % (2015)	46.2 % (2019)[37] The indicator was not achieved (see text).
Indicator 4: Full immunisation of children under 2 years of age DPT3 (percentage of two-year-olds who received three doses of the combined vaccine against diphtheria, tetanus toxoid and pertussis, DPT3)	98 % (2005)	100 %	87 % (2020)	95 % (2021) The indicator has been achieved to a limited extent (see text).

[36] https://apps.who.int/nha/database
[37] WHO (2022): Health Systems in Transition Vol. 24 No. 3.

Indicator 5: SDG 3.1.2 in %: Proportion of births attended to by trained health care personnel	97.5 %	100% (SDG target)	99.8 %	The indicator was achieved: 99.8 % almost equals the target value

Contribution to achieving targets

The mid-term review of 2008 (Manas Taalimi) showed an improvement in life expectancy as well as a reduction in child mortality and tuberculosis mortality, which was continued until Den Sooluk came to an end. In fact, the Kyrgyz Republic achieved MDG 4 (reduction of child mortality by 2/3 between 1990 and 2015). The evaluation of the implementation of Manas Taalimi in April 2011 also pointed to improved financial protection in the event of illness, with patient out-of-pocket payments falling by 11.4 % between 2006 and 2009.

However, the mid-term review of Den Sooluk in June 2016 found continued poor quality of treatment and insufficient results in the health indicators. The high maternal mortality rate (WHO 2015: 76/100,000) and the further spread of multi-resistant tuberculosis were alarming. In particular, the weakness of primary health care was seen as a core problem. For example, only 4 % of all cases of high blood pressure were diagnosed, while around 80 % of all adults with high blood pressure remained untreated.

Following the results of the mid-term review, there was considerable doubt that Den Sooluk's target would be achieved. It was therefore jointly agreed with the Ministry of Health and the international donors that for the remaining term of the programme until the end of 2018, the basket fund would focus on the priorities of maternal and child health and the strengthening of essential health services. This was based in particular on the World Bank's successful results-based financing project to improve mother-child services in the country. At the same time, it paved the way for the new health reform programme Healthy Person, Prosperous Country and the Program-for-Results concept, which explicitly focused on improving basic health care and distanced itself from the sector-wide approach.

The share of financing for primary care from the SGBP had already been increased from 26.4 % to 37.9 % between 2004 and 2007, but it had not improved training, quality incentives and monitoring at the same time.

Indicator 1: Share of planned expenditure for the health sector as measured in relation to the total budget funds

In the MoU, the spending target for the health sector was stipulated between the government and the financiers of the two sector-wide programmes with the aim of securing the additionality of external financing. It was agreed that the government budget would earmark at least 13 % of the total funds for the health sector from the end of the first basket funding through the term of the second basket funding. According to information from the WB, the indicator was consistently achieved from 2013 to 2018.[38] According to WHO, the target of 13 % was not achieved in 2019. For the 2023 fiscal year, 10 % of the budget is earmarked for the health sector.[39]

Even though the indicator value for the share of planned expenditure for the health sector compared to the total budget was not met, the percentage health expenditure by the Kyrgyz government fell within the European midfield, according to WHO Europe, and was thus significantly ahead of the neighbouring Central Asian countries of Uzbekistan and Tajikistan. Particularly noteworthy is the fact that the budget discipline was maintained in the revolutionary year of 2010 with the fall of the president and the subsequent ethnic unrest in the south of the country.

Indicator 2: Budget implementation: Health sector – Budget

Another condition of the donors involved in the health financing under the SWAp was the actual implementation of the public health budget of at least 95 %. The indicator's target was achieved. The 2021 PEFA study also[40] [41]

[38] World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2

[39] https://unsdg.un.org/sites/default/files/2022-06/Kyrgyzstan_Cooperation_Framework_Results_Framework_2023-2027.pdf

[40] Public Expenditure and Financial Accountability is an institution and method that assesses the quality of public financial management.

[41] PEFA (2021): Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report https://www.PEFA.org/node/181

confirms that, in general, 90 % to 110 % of the planned expenditure is implemented on an aggregated basis, both for current expenditure and investments.

Indicator 3: Out-of-pocket (self-financing) expenditure in % of total health expenditure

The costs of the Kyrgyz health care system are financed from various sources, including out-of-pocket payments by patients (48 %), statutory health insurance funds (45 %), government funds and external grants (7 %)[42]. The Mandatory Health Insurance Fund (MHIF)[43] is the sole payer for public health services. The MHIF pools statutory health insurance funds, government grants and other funds allocated to health care providers. The challenge for health insurance is that only 69 % of the population is insured, partly due to the fact that the informal sector makes up a high proportion of the economy. The benefits package in the state-guaranteed health programme defines the scope, nature and conditions of the health services which are free or subject to a co-payment. Primary care, outpatient specialist care in primary care facilities and basic laboratory tests are free to citizens who are registered with the primary care providers. Outpatient specialist care in hospital outpatient clinics and inpatient hospital services are generally subject to a co-payment, unless the patients belong to one of the 30 categories based on social status or the 16 categories based on clinical indication that entitle them to free services. Statutory health insurance policyholders are entitled to a 50 % discount on health care costs.

Entitlement to free treatment at the outpatient level and in hospitals[44]

Based on social status	**Based on clinical indications**
1. Participants of the Great Patriotic War. 2. Persons who became disabled as a result of participating in the Great Patriotic War and the 1999 Batken conflict.[45] 3. Citizens affected by operational activities in the fight against international terrorism. 4. Citizens awarded orders and medals of the USSR during the Great Patriotic War. 5. Former concentration camp prisoners. 6. Survivors of the Siege of Leningrad. 7. Labour veterans older than 70 years. 8. Persons awarded with the “Baatyr Ene” Order and the “Mother Heroine” Order. 9. Citizens who were illegally and forcibly mobilised to labour camps during the Great Patriotic War and subsequently rehabilitated. 10. Heroes of the Soviet Union and persons awarded with the Order of Glory, third grade. 11. Heroes of Socialist Labour. 12. Citizens honoured with the highest merit of Kyrgyzstan. 13. Participants in hostilities on the territories of other states. 14. Citizens affected by the Chernobyl nuclear power plant accident. 15. Persons with disabilities who have been wounded and injured when performing military service. 16. Citizens affected by the events of 17 March 2002 in the Aksy district of Jalal-Abad province, 6 April 2010 in Talas province, 7 April 2010 in the cities of Bishkek and Naryn, 13, 14 and 19 May 2010 in Jalal-	1. Women registered for pregnancy 2. Women with pregnancy pathologies under hospital care (for the main diagnosis) 3. Women admitted for pregnancy termination by social and medical indications 4. Women admitted for childbirth 5. Women with postnatal complications within 10 weeks after childbirth 6. TB patients 7. Bronchial asthma patients 8. Cancer patients in the terminal stage 9. Patients with mental diseases (paranoia, chronic delirium, affective disorders) 10. Epileptic patients 11. Diabetes mellitus patients 12. Diabetes insipidus patients 13. Contact persons and patients with diseases caused by high-threat infections requiring quarantine (typhoid fever, paratyphoid, anthrax, plague) 14. Rabies patients and persons who had contact with the patient and may have been infected with rabies 15. Patients with meningococcal meningitis 16. Haemophilia patients

[42] Health Financing case study no.16, Kyrgyzstan’s health financing system, WHO 2020

[43] https://m4health.pro/health-insurance-fund-in-kyrgyzstan/

[44] Status in 2021, see WHO (2022): Health Systems in Transition Vol. 24 No. 3.

[45] The Batken conflict was an armed conflict between the Islamic movement of Uzbekistan, an Islamist militia, on the one hand, and the Kyrgyz armed forces, with the support of the Uzbek armed forces, on the other.

Abad province and the June 2010 events in Osh city, Osh and Jalal-Abad provinces. 17. Persons with disabilities of disability groups I and II, due to work-related injuries, occupational or general illness. 18. Persons with sight and hearing impairments. 19. Persons with disabilities since childhood. 20. Children with disabilities under 18 years. 21. Children up to 6 years of age. 22. Orphans living in state orphanages, family orphanages (foster families), residential homes for orphans and children deprived of parental care. 23. Citizens living in residential homes for older people and people with disabilities. 24. Citizens subject to call-up for active military service sent by military medical boards. 25. Service personnel. 26. Persons living with HIV/AIDS. 27. Children from low-income families under 16 years. 28. Retired people over 70 years. 29. Persons under pre-trial investigation and persons serving their sentence. 30. Leavers of orphanages and boarding houses without parental care, aged under 23 years.	

Persons not included in the categories listed in the table have to make co-payments for hospital services. The minimum level of co-payment for services amounting to KGS 330 (EUR 1 = 92.94 KGS, 1 KGS = EUR 0.1008)[46] in outpatient clinics and for inpatient procedures amounting to KGS 430 is paid by pensioners under the age of 70, persons awarded with the "Veteran of Labour" medal and persons receiving social benefits. (For information: the minimum monthly wage in 2022 is KGS 1,970.)[47]

Co-payments for hospital services[48]

	Inpatient facilities that are not state hospitals	State hospitals
Co-payments for general services	Minimum KGS 330 Average KGS 840 Maximum KGS 2,650	Minimum KGS 330 Average KGS 1,160 Maximum KGS 2,980
Surgical co-payments	Minimum KGS 430 Average KGS 1,090 Maximum KGS 3,440	Minimum KGS 430 Average KGS 1,510 Maximum KGS 3,870

According to data from the *Mandatory Health Insurance Fund* for 2019,[49] around 65 % of hospital patients were exempt from co-payments. Of all hospital patients in 2019, 76 % were covered by statutory health insurance. However, co-payments and statutory health insurance do not cover the costs of expensive diagnoses or treatments, which must be covered by private payments.

According to WHO, private payments are primarily made for health care items and drugs[50]. The majority of public funds were spent on inpatient and outpatient care, although households already paid a considerable amount of the expenditure for inpatient and outpatient care out of their own pocket.

The Additional Drug Package (ADP) is an additional services system that solely concerns drugs in the outpatient sector. For drugs on the ADP list, eligible patients (i.e. the approx. 69 % of the Kyrgyz population registered with

[46] https://www.finanzen.net/waehrungsrechner/som_euro

[47] https://wageindicator.org/salary/minimum-wage/minimum-wages-news/2022/minimum-wage-increased-in-kyrgyzstan-march-17-2022

[48] https://www.oecd.org/countries/kyrgyzstan/Social_Protection_System_Review_Kyrgyzstan.pdf

[49] https://www.devex.com/organizations/mandatory-health-insurance-fund-kyrgyzstan-130160

[50] Status in 2019: 46.3 % of total health care expenditure

the MHIF) pay the difference between the "base price" (the fixed reimbursement rate covered by the MHIF) and the pharmacy sales price. Drugs prices are not regulated in the Kyrgyz Republic. The SGBP provides drugs for certain diseases free of charge, although in reality the reimbursement rate is 80–90 % of the sales price. In 2015, 87.9 % of the costs for drugs were covered under the SGBP.[51]

Studies show that between 2000 and 2006, *the proportion of the population who became poorer or even impoverished (Catastrophic Health Expenditure) as a result of expenditure on their health* [52]decreased at the same time as the reforms to introduce the unit contribution and steady improvement in living standards. The ratio then increased again to 12.8 % between 2009 and 2014[53], mainly due to expenditure on medicines and medical equipment.

Although poverty has generally fallen, the frequency of catastrophic expenditure in the poorest quintile remained high. In 2014, 40 % of households in the poorest quintile faced catastrophic expenditure on health, compared to 13 % of all households in the Kyrgyz Republic. In addition, among households with catastrophic expenditure, the average amount spent out of pocket rose particularly sharply as a proportion of the household's total expenditure between 2009 and 2014 in the poorest quintile.[54]

Although there was no quantitative requirement with regard to the indicator, it is assessed as not achieved, as the intended reduction in self-financing was not permanent and the "*Catastrophic Health Expenditures*" among the poor rose again after 2009.

Indicator 4: Full immunisation of children under 2 years of age DPT3 (percentage of two-year-olds who received three doses of the combined vaccine against diphtheria, tetanus toxoid and pertussis, DPT3).

The Kyrgyz Republic traditionally has a high vaccination rate for routine childhood vaccinations. In total, 96 % of infants received the first dose against measles in 2019 (compared to 95 % in the WHO European Region) and 98 % of children received the second dose (compared to 91 % in the WHO European Region). [55] The routine vaccinations for children are free, the first vaccinations are carried out at birth in the maternity clinics and then by the primary care providers.

The DPT3 immunisation rate was always above 95 %, but fell to 88.8 % in 2021 as a result of lockdowns and COVID vaccination priorities during the COVID-19 pandemic. Although the numbers are declining here, the immunisation rate in the Kyrgyz Republic remains above the global average, and, according to a recently published modelling study[56], the estimated vaccination rate for DTP3 worldwide in 2020 was 76.7 %. For the DTP3 vaccination, this means a deficit of 7.7 % compared to estimates made without the impact of the pandemic.

Although the indicator is achieved, the SDG target indicates that further action is required.[57]

Indicator 5: Proportion of births attended to by trained health care personnel

The proportion of births cared for by qualified health care personnel (SDG indicator 3.1.2) was generally over 90 %, and this high level was maintained over the years. At the same time, the percentage of normal deliveries performed in district hospitals according to clinical protocols increased from 5.7 % in 2014 to 84 % in 2019, exceeding the target of 58 %[58]. The percentage of complicated deliveries in district hospitals performed according to clinical protocols increased from 2.5 % in 2014 to 43 % in 2019, reaching the internal target of 43 %.

[51] WHO (2022): Health Systems in Transition Vol. 24 No. 3.
[52] Catastrophic Health Expenditure (CHE) refers to all medical expenses that can threaten a household's financial capacity to support itself. CHE is not necessarily associated with very high health expenditure. It occurs when people have to spend large sums on their health in relation to their income. Total health expenditure of 10 % or more of total income is often seen as an indicator of CHE, WHO definition.
[53] https://apps.who.int/iris/handle/10665/329444
[54] Can people afford to pay for health care? New evidence on financial protection in Kyrgyzstan, WHO; https://apps.WHO.int/iris/handle/10665/329444
[55] https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-kyrgyzstan
[56] https://www.pharmazeutische-zeitung.de/rueckschritt-bei-routineimpfungen-in-der-pandemie-127012/seite/2/
[57] https://dashboards.sdgindex.org/profiles/kyrgyz-republic
[58] World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2

Quality of implementation

The Ministry of Health was in charge of implementing the SWAp, as the donor group had explicitly decided not to set up a project implementation unit (PIU) at ministry level. Although this slowed down the implementation of programme measures in some cases, especially in connection with public procurement, it brought about in a learning experience towards greater personal accountability and ownership.

The six-monthly coordination meetings on the joint annual review promoted political dialogue and an exchange of expertise between the development partners and the Ministry of Health.

Domestic systems were used for implementation of the SWAp (procurement, financial management as well as monitoring and evaluation). Challenges arose at the beginning of the support, particularly in the area of procurement and financial reporting; the annual work plans were given low priority and often exceeded the funds available. In the medium term, however, use of the systems strengthened the Ministry of Health's capacity[59]. However, given the wide range of tasks, the multitude of interfaces and the complexity of the reform programme, capacities were stretched. This led to delays in programme implementation, particularly with respect to large tenders. Despite frequent changes at the management level of the Ministry of Health, capacities could be built up at mid-level, which certainly benefited the implementation of the project. Based on the interviews conducted, the 2010[60] revolution had a negative impact on the implementation of the reforms, when a large proportion of employees, especially at ministerial level, left the ministry.

The Ministry of Health's financial management and all procurements in the sector were subject to close monitoring by the World Bank. Regular internal and external audits were carried out for fiduciary risk control. By and large, the external audits and sector studies by external international firms contained a number of operational and financial recommendations, but did not at any time reveal evidence of concrete and/or deliberate misuse of funds.

In fact, the Kyrgyz SWAp under *Manas Taalmi* was regarded as a best practice example internationally. In a 2009 study by an "independent evaluation group" from the World Bank,[61] the Kyrgyz SWAp received the best rating, as a country-led partnership between government and donor community, for management and coordination, in a global comparison of six health SWAps. In addition to procurement and financial management capacity, the Kyrgyz model was the only SWAp to have been verified as successfully establishing a monitoring and evaluation system for the reform implementation.

The sector dialogue was perceived as qualitatively high by all those involved, which was confirmed by the GIZ paper on behalf of the BMZ: *Staying the course: how a SWAp has sustained Kyrgyz health reforms*[62].

Unintended consequences (positive or negative)

The project's direct effects on human rights, apart from the right to[63]health, cannot be demonstrated, whereas gender equality and inclusion, anti-corruption and indirect poverty reduction are parts of the project and are therefore intended. The same applies to the promotion of digitalisation, which is being pushed forward by the government as part of electronic patient registration.[64]

Summary of the rating:

The effectiveness is rated as moderately successful. One positive aspect worth highlighting is the early achievement of SDG 3.1.2, as well as the fact that the partner was able to implement 95 % of the budget due to its measures and activities. However, it was not possible to fully achieve the objective of comprehensive financial protection for patients, co-payments remained high and the share of catastrophic health expenditure was barely

[59] https://documents.worldbank.org/pt/publication/documents-reports/documentdetail/784391479824724822/kyrgyz-republic-kyrgyz-second-health-and-social-protection-project-p126278-implementation-status-results-report-sequence-08

[60] The 2010 Kyrgyz revolution (also known as the Melon Revolution) overthrew President Kurmanbek Bakiyev. The crisis was triggered by dissatisfaction with corruption, rising prices and a lack of government policies to deal with the consequences of the economic crisis.

[61] https://openknowledge.worldbank.org/handle/10986/28064?locale-attribute=fr

[62] https://health.bmz.de/studies/staying-the-course/

[63] According to the United Nations Universal Declaration of Human Rights, everyone has the right to a standard of living that ensures health and well-being. Such a standard of living includes adequate and good food, clothing, housing, health care and the necessary social benefits.

[64] https://24.kg/english/193802_Electronic_patient_records_to_appear_in_Kyrgyzstan_by_end_of_2021/

reduced (according to WHO, 13 % of households were forced to carry out catastrophic health spending in 2014). In addition, staff turnover in the Ministry was sometimes high, which hindered the continuous development of human resource skills. In total, two out of five indicators were fully achieved.

Effectiveness: 3

Efficiency

Production efficiency

In accordance with the Ministry of Health's annual work plan, donor contributions were disbursed in appropriate instalments to an account held by the Ministry of Finance with the National Bank, where the funds were converted into Kyrgyz Som (KGS) and passed on to the Ministry of Health. The investment funds for all commitments were disbursed within the respective reform periods, with a few exceptions.

A microeconomic assessment is not possible due to the basket funding approach. At macroeconomic level, the project achieved positive effects in terms of a general improvement in the health of the population, which, however, cannot be allocated due to the nature of the financing and can therefore not be quantified.

The number of hospitals were reduced from 450 to 135 between 1997 and 2019[65], with the aim of reducing costs and strengthening primary health care and prevention. Specialised facilities were merged and general profile hospitals created, while inefficient small hospitals were transformed into subdivisions of regional hospitals or into primary care providers (family medicine centres, FMC). This reduction in the number of hospitals was reinforced by a change in the way that hospitals are paid by the MHIF, with the introduction of case-based payments in 2001.

The remaining hospitals are distributed across the country, with hospitals in all seven oblasts and 40 (areas) rayons and smaller-scale hospitals in remote villages. The number of hospital beds per 100,000 population has declined dramatically since the early 1990s, decreasing from 1,206 hospital beds per 100,000 population in 1991 to 704 in 2000 and 407 in 2019.[66]

Publicly financed outpatient medicines require a prescription, but only account for a small share of the medicines market; other medicines can be obtained without a prescription. Growth in household spending on outpatient medicines was much faster for medicines obtained without a prescription than for prescribed medicines between 2006 and 2018.[67] The cost of medicines has been increasing, largely, on the one hand due to the absence of regulation of wholesale and retail prices and pharmacy mark-ups, and on the other due to devaluation in a market heavily reliant on imported medicines. Another major cost driver is the high irrational prescribing of medicines, but also the irrational private procurement of medicines, although there is far from any kind of evidence.

Medicines are also becoming more expensive due to inefficiencies in their procurement. Only a few medicines are procured centrally by the Ministry of Health. Hospitals often procure their medicines individually; the smaller batches are usually expensive; volume discounts are usually lost[68]. Attempts to centralise procurement in hospitals have failed in the past due to the high transport costs to more remote hospitals.[69] The pharmaceutical market in the Kyrgyz Republic is private; there is almost complete dependence on imports with the remainder (3 %) domestic production.[70]

Allocation efficiency

The basket was set up to provide a harmonised funding mechanism to implement reforms and reduce direct funding driven by individual donor preferences. In addition, the actual costs of the reform agenda could be

[65] https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-kyrgyzstan
[66] WHO (2021): Health systems in action, https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-kyrgyzstan
[67] https://apps.who.int/iris/bitstream/handle/10665/343014/WHO-EURO-2021-2604-42360-58654-eng.pdf?sequence=1&isAllowed=y
[68] https://www.devex.com/organizations/mandatory-health-insurance-fund-kyrgyzstan-130160
[69] Ref, footnote 49
[70] http://en.kabar.kg/news/kyrgyzstan-produces-only-3-of-medicines-remaining-97-imported-from-abroad/

reflected in the budget, which is not usually the case for direct financing and *standalone* projects. Furthermore, this approach allowed all aspects of the reform programme to be addressed.

The agreement between the development partners and the Kyrgyz government to hold regular health summits, six-monthly meetings at which the main actors involved in the reform programmes met for a detailed progress review, was particularly important. The health summits have proven to be the cornerstone of the entire health sector reform process and have been instrumental in keeping the reform agenda on track.

The spring health summits conclude the Joint Annual Review (JAR) and address both progress in the programme and compliance with the projects. The autumn reviews focus on looking ahead to the work plan for the coming year. The meetings usually last a full week and are held as peer review meetings, in which the progress of the programme is outlined and analysed together. The Ministry of Health is responsible for reporting on programme implementation and results in accordance with the work programme. Development partners have the opportunity to reflect on achievements and challenges, voice concerns and express their views on new policy issues and future directions. In turn, the government has the opportunity to respond to this feedback and adapt the programme in line with the overarching agreement with the development partners.

The harmonised approach enabled transaction costs to be reduced for the partner. This approach made it easier for agreement on the content and sequencing of reforms, as it no longer had to be conducted through individual donors in separate meetings, even though bilateral talks between donors and the MoH continue to be held. Whereas transaction costs related to bilateral dialogue and the projects were reduced, those surveyed from the Ministry of Health[71] agreed that the workload resulting from taking over key functions previously assigned to a project implementation unit (in particular procurement and financial management) as well as donor coordination activities had risen significantly.

It can be assumed that there was no real alternative to participation in the SWAp, as all donors working in the health sector signed the SWAp. In addition, the Kyrgyz Republic was one of the DAC/OECD harmonisation pilot countries in 2006. With regard to basket financing, the leverage effect as a member of the basket was greater than with parallel financing. It is highly doubtful that implementation through a stand-alone project would have been more efficient.

Summary of the rating:

The Kyrgyz administration has succeeded in reducing costs in the health care system under the *Manas Taalimi* and *Den Sooluk* programmes. The number of hospitals as well as the number of beds per 100,000 citizens was reduced by two thirds between 1997 and 2019. The merging of specialised facilities reduced costs, while inefficient small hospitals were integrated into subdivisions of regional hospitals or transformed into primary care providers (family medicine centres, FMC). However, medicine prices remain a challenge. Although the costs for coordination on the part of the partners rose, the SWAp and the pooling of financing in one basket cut transaction costs and enabled a constructive sector dialogue.

Efficiency is rated as successful.

Efficiency: 2

Impact

The objective at impact level was: Improving the health status of the population.

[71] Verbal messages from former MoH employees to the evaluation mission.

The achievement of objectives at the impact level can be summarised as follows:[72]

Indicator	Status PA	Target value at PA	(Optional) actual value at final inspection	Actual value at EPE
(1) SDG 3.2.1: Mortality rate of children under 5 years of age SDG 3.2.2: Newborn mortality	SDG 3.2.1 31.5 (2007) SDG 3.2.2 21.1 (2007)	Goal description 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-5 mortality to at least as low as 25 deaths per 1,000 live births.	SDG 3.2.1 17.6 (2018) SDG 3.2.2 11.9 (2018)	SDG 3.2.1 17.9 (2021) SDG 3.2.2 11.9 (2021) The indicator was achieved.
(2) (Originally: Improve maternal health (MDG 5)) SDG 3.1.1: Maternal mortality per 100,000 births	51.9 (2007)	Reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030	38.5 (2015)	33.3 (2021) The indicator was achieved.
(3) SDG 3.3.1: Number of new HIV infections per 1,000 uninfected population by sex, age and key populations	0.08 (2007)	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases	0.13 (2018)	0.13 (2021) The indicator was not achieved.
(4) Reduce morbidity and mortality in cardiovascular diseases (CVD) SDG 3.4.1: Age-standardised death rate due to cardiovascular disease in adults aged 30–70 per 100,000	338 (2007)	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being	266 (2018)	297.1 (2021) The indicator was not achieved.
(5) Life expectancy at birth SDG	69.2 (2010)	Increasing	71 years 4 months (2015)	71 years 6 months (2021) The indicator was achieved to a limited extent (see text).

[72] https://sustainabledevelopment-kyrgyzstan.github.io/en/3/

(6) Universal health coverage (UHC)[73] index of service coverage SDG 3.8.1	61 (2010)	100 (optimum target)	69 (2015)	70 (2019) The indicator was achieved to a limited extent (see text).

Indicator 1:

Kyrgyz Republic is one of the 24 low middle-income countries and 64 countries worldwide that have achieved the goal of reducing child mortality by more than two thirds since 1990 (MDG 4). According to UNICEF's global *Promise Renewed*[74] report, child mortality has fallen from 65 per 1,000 live births in 1990 to 21 per 1,000 live births in 2015. The mortality ratio of children under the age of 5 – based on SDG 3.2.1 – fell from 31.5 in 2007 to 17.6 in 2021 and, based on SDG 3.2.2 "Newborn mortality", from 21.1 in 2007 to 11.9 in 2021.

Indicator 2:

MDG 5 stipulated a reduction in maternal mortality of ¾ between 1990 and 2015, which according to WHO was not achieved. The reduction from 82 to 76 was only 7 % compared to 54 % (from 69 to 32) in the region[75]. However, the SDG dashboard[76] for SDG 3.1.1 for 2015 shows 38.5 deaths in 100,000 births, which fell further to 33.3 in 2021, which would meet the indicator's requirements.

Indicator 3:

HIV incidences rose from 0.08 in 2007 to 0.13 in 2021, where the increase is to be seen in connection with increased labour migration.

For example, the HIV epidemic focuses primarily on drug addicts, their sexual partners, homosexual men, sex workers and migrant workers, who mainly work in Russia. Access to HIV-1 care and treatment services lags far behind the global target of 95-95-95.[77] In 2020, 76 % of people knew of their HIV status, 48 % of them received antiretroviral therapy (ART), and only 43 % of them were virus-suppressed; for pregnant women, ART coverage was 94 %[78].

Indicator 4:

According to the medical information centre in Bishkek, cardiovascular disease (CVD) is the most common cause of death and accounts for half of all deaths. In 2007, the CVD death rate was[79]338.15 (per 100,000 population), 326 in 2011 and 297.1 in 2021. More than 18,000 people in the Kyrgyz Republic die every year from

[73] Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage.

[74] https://www.unicef.org/media/50721/file/APR_2015_9_Sep_15.pdf

[75] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30460-5/fulltext

[76] https://sustainabledevelopment-kyrgyzstan.github.io/en/3-1-1/

[77] Access to health services: the '95-95-95' targets:

- 95 % of people diagnosed with HIV to receive HIV medication.
- 95 % of people taking HIV medication to have virus suppression.
- 95 % of all pregnant women with HIV to have access to measures that prevent transmission to their babies.
- 95 % of all women to have access to HIV-related services and sexual and reproductive health services.
- 95 % of the people in the key groups to use methods of so-called combined prevention, such as condoms, femidoms, HIV prophylaxis, sterile syringes and other measures to minimise harm from drug use.

[78] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554114/

[79] https://sustainabledevelopment-kyrgyzstan.github.io/en/3-4-1/

cardiovascular disease, equating to more than 50 every day. The main cause of death associated with cardiovascular disease is coronary artery disease (80 % of all cardiovascular deaths, including acute myocardial infarction)[80].

The Kyrgyz Republic has the sixth highest CVD mortality rate in Eurasia after Russia, Belarus, Ukraine, Kazakhstan and Moldova. In the standardised parameter of stroke mortality, the Kyrgyz Republic comes first in the Eurasian region with 88.5 cases per 100,000 population.

The background to this dramatic situation is high alcohol and tobacco consumption as well as culinary habits (fats, meat) and insufficient exercise. Men are affected more frequently, with a death rate of 336/100,000 in 2020, while a rate of 299/100,000 was registered for women.

WHO is tackling the problem and regularly organises anti-tobacco campaigns[81], and the important Nomadic Games also addressed the issue in 2018.

Indicator 5:

According to WHO data published in 2020, life expectancy in Kyrgyz Republic is 70.7 years for men, 77.3 years for women and 74.2 years for total life expectancy, which gives the Kyrgyz Republic a World Life Expectancy ranking of 86. The most common cause of death is coronary heart disease (see Indicator 4), stroke, liver disease and lung disease[82].

Between 2000 and 2020, men's life expectancy increased by 5.5 years and women's by 4.3 years. In men, the increase was mostly due to the decrease in mortality resulting from respiratory diseases (1.4 years), external causes (1.1 years), infectious diseases and stroke (0.9 years each), especially for men under the age of 75. Among women, the improvements in reducing mortality were predominated by strokes (1.6 years) and respiratory diseases (1.4 years). These advances suggest some improvement in the availability, accessibility and quality of health care, as deaths due to strokes, respiratory diseases and infectious diseases can largely be caught by health care interventions. However, the lack of progress in heart disease shows there is still much room for improvement, both in terms of health care system measures and in the prevention of risky behaviour, such as smoking, alcohol consumption and malnutrition, and this calls for a stricter health policy and cross-sectoral approach[83].

Life expectancy rose rather marginally from 2010 to 2020, not least due to the high levels of morbidity and mortality as a result of cardiovascular diseases (see the SDG indicator 3.4.1). The achievement of the indicator is rated as moderately successful, which is due in particular to its connection with indicator 4.

Indicator 6:

SDG target 3.8 is to achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

SDG indicator 3.8.1 specifically measures coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and service capacity and access).

The UHC service coverage index, which measures progress for SDG indicator 3.8.1, rose from a global average of 45 (from 100) in 2000 to 66 in 2017.[84] All regions and all income groups recorded gains. Progress was greatest in lower-income countries, starting from a lower base and driven primarily by interventions for infectious diseases and, to a lesser extent, for reproductive, maternal, newborn and child health services.

[80] The State of Cardiovascular Disease in the Kyrgyz Republic, Ryskul B. Kydyralieva, The National Centre of Cardiology and Internal Medicine at Ministry of Health of the Kyrgyz Republic, Bishkek, Vol. 2, No. 1 (2013), http://cajgh.pitt.edu

[81] https://www.who.int/europe/news-room/photo-stories/item/countries-of-the-who-european-region-encourage-tobacco-users-to-commit-to-quit-on-world-no-tobacco-day

[82] https://www.worldlifeexpectancy.com/kyrgyzstan-life-expectancy

[83] WHO (2021): Health systems in action: Kyrgyzstan.

[84] https://www.who.int/publications/i/item/9789240029040

The rate of coverage in the Kyrgyz Republic has improved moderately in the past 10 years, with the indicator rising from 48 (2000) to 70 (2019). It is above the global average, but below the WHO European Region. The main driver of the improvement should be attributed to the SGBP with the Additional Drug Package, as well as the introduction of health insurance (MHIF) and the restructuring of the sector towards primary care delivery. The 2019 WHO assessment of sexual and reproductive maternal, newborn, child and adolescent health in the context of the UHC in the Kyrgyz Republic showed that, although maternal and child health is a high priority for the country, there are significant shortcomings, particularly with regard to the lack of adolescent services in the area of sexual and reproductive health, problems with the efficient transportation of newborns, and poor quality of care in the treatment of common childhood illnesses and in antenatal care. Moreover, according to the *Voluntary National Review on the Implementation of SDG 2020,*[85] challenges remain with delivery in rural areas and in the lack of adherence to international standards by laboratories of the public health service, which affects the quality and effectiveness of the system of public anti-epidemic efforts as a whole (as licensing standards do not meet current requirements for the quality of laboratory diagnostic services).

As there is no quantitative indicator target, success is measured by the improvement interms of global progress and the result is assessed as moderately successful.

Contribution to overarching developmental changes (intended)

The improvement in structural quality in terms of the framework conditions that are necessary for medical care, as well as the way in which services are provided (process quality), have a direct influence on the quality of results from health care services. All three dimensions aim to improve access to health care for all citizens, reduce financial burdens in the event of illness, increase the efficiency and quality of health care services, and improve patient orientation and the transparency of the health care system. These are key criteria for improving the health status of the population.

Contribution to (unintended) overarching developmental changes

The evaluation did not reveal any unintended changes, either in a negative or a positive sense.

Summary of the rating:

Since 2006, both health care and the health status of the population in the Kyrgyz Republic have improved substantially. Child and neonatal mortality has decreased and the relevant SDG and MDG targets and indicators have been met. The same applies to maternal mortality targets.

Regarding the trend towards improved access to health care services, it was not possible to consolidate the gains initially achieved with the financial burden on particularly poor sections of the population.

Despite a positive development, the high mortality rate due to cardiovascular disease is problematic, as is the prevalence of HIV. Against this background, we assess the impact of the measures as moderately successful.

Impact: 3

Sustainability

Capacities of participants and stakeholders

The Kyrgyz government is also continuing to comply with the reform process following the conclusion of the SWAp programme. The Healthy Person, Prosperous Country reform programme is a 12-year strategy for the further development of public health and health systems. Following the *Manas Taalimi* and *Den Sooluk* programmes, the 2018–2030 strategy continues to aim to improve access to primary health care, reduce financial hardship on patients and achieve universal health coverage (UHC) by 2030. The Kyrgyz Republic has joined the UHC 2030 International Health Partnership and has signed the United Nations Global Compact[86].

[85] https://sustainabledevelopment.un.org/content/documents/26458VNR_2020_Kyrgyzstan_Report_English.pdf
[86] https://www.unglobalcompact.org/what-is-gc/our-work/environment/health-is-everyones-business

The relaunch of basket funding in the health sector, led by the World Bank as a Program for Results (PFR), was implemented in 2020. In addition to the World Bank as lead partner, the SDC and German FC are continuing to participate as basket partners, paying their contributions via a multi-donor trust fund managed by the World Bank.

The World Bank's Primary Health Care Quality Improvement Program (2019–2024, USD 20 million) has moved away from general sector-wide support and focuses on primary care and prevention within public health.

Following the end of the project support, the majority of SDG 3 indicators continued to improve, in particular maternal mortality, neonatal mortality and mortality rates in children under the age of five. However, the age-standardised mortality rate due to cardiovascular disease continued to increase, which is partly due to better statistical pattern recognition.

Joint Annual Reviews (JARs) of the implementation of the reform agenda resumed in November 2022 following an interruption due to COVID-19. This meant the political and technical dialogue was continued and consolidated.

One challenge for the sector remains is the poor payment of medical personnel in the public sector, as well as those nearing pension age and the distribution of personnel across urban and rural areas[87]. In 2021, doctors were concentrated in Bishkek and Osh (225 and 246 per 100,000 population, respectively), while some rural areas only had 70 doctors per 100,000 population (equivalent to one doctor per 1,429 population). In 2021, there were 2,194 general practitioners in the country, which corresponds to 33 doctors per 100,000 population. In the cities, a general practitioner provides care for 4,000–5,000 people. This number rises to over 7,000 in remote areas. The COVID-19 pandemic has exacerbated geographical imbalances as doctors left primary care in rural areas to accept better paid jobs in hospitals.

In terms of sustainability, the health sector's dependence on external financing is problematic, which was generally around 10 %[88]. Based on current macroeconomic and macro-budgetary outlooks, growth could remain limited and the need for external financing high[89].

The high turnover of personnel and the migration of qualified personnel to Russia or Europe is also problematic. Despite efforts to address this problem, the availability of sufficient qualified personnel in all relevant health care facilities remains a major challenge for the ongoing implementation of government reforms and the improvement of health care.

One remaining challenge is the population's financial protection in the event of illness. The initial downturn in out-of-pocket payments and the reduction in *catastrophic health expenditure* could not be maintained. Effects include a significant increase in treatment options in terms of quantity and quality and, with this, costs. This development was faster than the increase in average household income, especially in the lower quintile.

Contribution to supporting sustainable capacities

The project strengthened the MoH's management and control functions as well as its institutional capacities. The use of domestic systems for procurement, financial management and strategic management, supported by a learning-by-doing approach, has contributed to sustainable capacity development. The measures have strengthened the partners institutionally along with the professional capacities of the ministry's officials and staff. At the same time, this has helped to reduce fiduciary risks.

Durability of impacts over time

However, the results achieved are still not without risks, including socio-economic and geographical inequality, low public service salaries and resulting problems in retaining personnel in the country. In addition, the health service has an ageing workforce, with around a quarter of doctors set to retire in the next few years[90]. The perceived challenges are the quality of health services, which is still in need of improvement, the lack of emphasis on practical skills in the curricula for health care providers, the weak integration of primary care services, the high turnover of health workers in remote areas, the understaffing of MoH units at oblast level and the inconsistent

[87] WHO (2022): Health Systems in Transition Vol.24 No.3.
[88] https://apps.who.int/iris/handle/10665/108590
[89] https://www.imf.org/en/Countries/KGZ
[90] WHO (2022): Health Systems in Transition Vol.24 No.3.

commitment to addressing health problems at local government level. We currently consider the internal risks for the continuity of reforms to be medium.

External risks that could affect the country's economic development include current global political upheavals, rising global inflation, Russia's economic situation with declining remittances of Kyrgyz workers in Russia, increasing dependence on China, price trends, and the availability of raw materials and food.

Summary of the rating:

By continuing the reform agenda in the area of public health, the Kyrgyz government is showing its willingness to further expand and consolidate what has been achieved to date. Structural changes and progress regarding the SDG agenda and its continuation following the end of the funding are positive results, although staffing levels remain a challenge. Against this background, we rate the project's sustainability overall as successful.

Sustainability: 2

Overall rating: 2

The objective of the FC measures at outcome level, the provision of improved access to health services for all sections of the population, the reduction of financial hardship in the event of illness, the increase in the efficiency and quality of health services as well as improvements in patient orientation, and the transparency of the health care system was partly achieved in cooperation with the Kyrgyz partners and the committed donors.

The project's relevance was understood, with it starting at the right points. The harmonisation of promotional approaches reduced duplicates, while the use of domestic systems increased ownership and strengthened the partners' management and implementation skills.

The population's access to health services was broadened by the guaranteed minimum services under the SGBP and the Additional Drug Package (ADP). The geographical distribution of health facilities (FAP, FGP, family medical centres and hospitals) ensured access to primary care for most people, even though access to health services is difficult in remote areas. While care by doctors is considered critical, care by nurses is generally considered to be sufficient.[91]

The introduction or development of compulsory health insurance (MHIF) has substantially expanded the population's access to health care. However, only three quarters of the population are registered, and the range of secured care remains limited.

The SGBP package only guarantees unrestricted access to primary services. Services beyond these were and remain subject to additional payments. In some cases, this leads to severe financial hardship, especially for low-income households. Households are forced to turn to coping mechanisms such as savings, reducing spending, family support or selling assets. This situation has only temporarily eased due to the implementation of the reform programmes.

The efficiency of the system has improved, and instead of expensive specialist hospital care, care has increasingly been moved to the primary area, with noticeable savings in inpatient treatment. At the same time, the allocation efficiency of external support was improved by the sector-wide approach and pooled financing. Transaction costs have been reduced.

The modalities and instruments developed with the support of the project will continue to be employed beyond the end of the measure and will serve as the basis for further reforms. Against this background, we evaluate the project overall as successful.

Contributions to the 2030 Agenda

The programme was based directly on the implementation of SDG 3: "Ensure healthy lives and promote well-being for all at all ages".

[91] WHO (2021): Health Systems in Action, Kyrgyzstan.

The project used domestic systems for the implementation of this goal. The awarding of public contracts followed national guidelines and used their system. The project was implemented through joint financing involving other donors and development partners. It was based on a harmonised matrix of measures, objectives and indicators. Monitoring took place in joint meetings and discussions, both at the political and practical level.

Project-specific strengths and weaknesses as well as cross-project conclusions and lessons learned

The project had the following strengths and weaknesses in particular:

Strengths:
- Donor alignment with the domestic approach
- Ownership of reforms by the partner
- Harmonisation of donor approaches
- Results-oriented objectives
- Mutual accountability
- Regular constructive sector dialogue
- Review of priorities and adjustment, reprioritisation of the indicators as part of the mid-term review
- The basket's long-term financial support from the three main partners (WB, Switzerland and KfW), as well as the long-term capacity development support measures from the UN organisation and KfW

Weaknesses:
- The sector reform programme may have been too ambitious
- Inadequate payment of staff and therefore brain drain of qualified staff to neighbouring countries
- Partner staff trained through the complementary measures (awarding of contracts, financial management, etc.) often moved on to better paid jobs, causing the institutional memory in the ministries to remain low and rudimentary through to the present

Conclusions and lessons learned:

- The chances of major sector reforms succeeding are increased through a sector-wide approach, which involves the majority of donors.
- The use of domestic systems enhances ownership and strengthens the capacity of the domestic administration.
- External support in finance, accounting and procurement is of key importance, especially when using domestic systems.
- The additional working pressure from the reforms on those involved must be evaluated at an early stage and compensated for if necessary.

Evaluation approach and methods

Methodology of the ex post evaluation

The ex post evaluation follows the methodology of a rapid appraisal, which is a data-driven qualitative contribution analysis and constitutes an expert judgement. This approach ascribes impacts to the project through plausibility considerations which are based on a careful analysis of documents, data, facts and impressions. This also includes – when possible – the use of digital data sources and the use of modern technologies (e.g. satellite data, online surveys, geocoding). The reasons for any contradicting information are investigated and attempts are made to clarify such issues and base the evaluation on statements that can be confirmed by several sources of information wherever possible (triangulation).

Documents:
KfW internal project documentation; documentation from the executing agency; public and internal documentation from the relevant institutions; information from BMZ/GIZ;

Data sources and analysis tools:
Databases from relevant donors as well as national and international institutions

Interview partners:
Project executing agency, national statistics body, other donors and DO, employees of municipal health facilities, consulting firm

The analysis of impacts is based on assumed causal relationships, documented in the results matrix developed during the project appraisal and, if necessary, updated during the ex post evaluation. The evaluation report sets out arguments as to why the influencing factors in question were identified for the experienced effects and why the project under investigation was likely to make the contribution that it did (contribution analysis). The context of the development measure and its influence on results is taken into account. The conclusions are reported in relation to the availability and quality of the data. An evaluation concept is the frame of reference for the evaluation.

On average, the methods offer a balanced cost-benefit ratio for project evaluations that maintains a balance between the knowledge gained and the evaluation costs, and allows an assessment of the effectiveness of FC projects across all project evaluations. The individual ex post evaluation therefore does not meet the requirements of a scientific assessment in line with a clear causal analysis.

The following aspects limit the evaluation:
The institutional recollection of the project both on the partner side and co-financiers' side had faded four years after the end of the project. At the time of the evaluation, a large proportion of those responsible at the time were no longer in office and were not available.

Access to documents in the Ministry of Finance was almost impossible, as the 2023 budget was prepared during the evaluation mission, meaning that a meeting with those responsible did not happen. Furthermore, the latter were not prepared to provide documents.

Methodology used to evaluate project success

To evaluate the project according to OECD-DAC criteria, a six-step scale is used for all criteria except for the sustainability criterion. The scale is as follows:

Level 1 very successful: result that clearly exceeds expectations

Level 2 successful: fully in line with expectations and without any significant shortcomings

Level 3 moderately successful: project falls short of expectations but the positive results dominate

Level 4 moderately unsuccessful: significantly below expectations, with negative results dominating despite discernible positive results

Level 5 unsuccessful: despite some positive partial results, the negative results clearly dominate

Level 6 highly unsuccessful: the project has no impact or the situation has actually deteriorated

The overall rating on the six-point scale is compiled from a weighting of all six individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a "successful" project while rating levels 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally “successful” only if the achievement of the project objective (“effectiveness”), the impact on the overall objective (“impact”) and the sustainability are rated at least “moderately successful” (level 3).

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List of annexes:

Target system and indicators annex

Risk analysis annex

Project measures and results annex

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Evaluation questions in line with OECD DAC criteria/ex post evaluation matrix annex

Target system and indicators annex

Project objective at outcome level	Rating of appropriateness (former and current view)
For project appraisal phase 1 and 2: Improved access to health services for all sections of the population, the reduction of financial hardship in the event of illness, an increase in the efficiency and quality of health services as well as improvements in patient orientation and the transparency of the health care system. After the mid-term review in 2016, it was agreed that basket support would focus on maternal and child health and strengthening the system behind primary health care services for the remaining term of the programme through to the end of 2018.	The objective remains relevant, but is supplemented by the aspect of use.
During EPE (if target modified) Use of improved access to health services for all sections of the population, a reduction of financial hardship in the event of illness, an increase in the efficiency and quality of health services as well as improvements in patient orientation and transparency of the health care system.	

Indicator	Rating of appropriateness (for example, regarding impact level, accuracy of fit, target level, smart criteria)	PA target level Optional: EPE target level	PA status (year)	Status at final inspection (year)	Optional: EPE status (year)
Indicator 1 Share of planned expenditure for the health sector as measured in relation to the total budget	Standard indicator, appropriate, reflects the political and social importance of the health sector; in general, the aim is for this to be at least 12% of the government budget	13 %	7.1 % (2005)	13.1 % (2018)	9 % (2019)
Indicator 2 Budget implementation in the health sector	Standard indicator, appropriate, refers to planning quality and actual implementation of policies	≥ 95 %	93.6 % (2005)	96.4 % (2018)	(see main section)
Indicator 3 Out-of-pocket (self-financing) expenditure in	Appropriate indicator showing the actual financial protection of patients in the event of illness.	While there are no target values here, self-	42.6 % (2005)	54.5 % (2015)	46.2 % (2019)

% of total health care expenditure	However, it should be noted that this can be influenced multifactorially.	financing should be kept relatively low			
Indicator 4 Full immunisation of children under 2 years of age DPT3 (percentage of two-year-olds who received three doses of the combined vaccine against diphtheria, tetanus toxoid and pertussis, DPT3)	Appropriate, as this shows use of the services offered.	100 %	98 % (2005)	87 % (2020)	95 % (2021)
Indicator 5 SDG 3.1.2 in %: Proportion of births attended to by trained health care personnel	Appropriate	100 % (SDG target)	97.5 % (2005)	99.8 %	99.8 %
Indicator 6 Proportion of the population that, due to financial or geographical reasons, does not seek medical care in the event of illness in %	Indicator is appropriate at impact level, includes access in addition to financial aspects; the target level is less ambitious than at the time of the project appraisal, though the indicator is difficult to verify. Since the indicator values stopped being collected after 2009, it is no longer included in the main part, contrary to what was envisaged in the design.	< 5 %	3.1 % (2005)	4.4 (2009), after which the indicator values were no longer collected	
Indicator 7 Proportion of children under 5 years of age with diarrhoea who received oral rehydration solution and zinc	The indicator was no longer included. This is a process indicator and not an outcome indicator, since successful overall treatment is not yet reflected.	> 75 %	77 % (2005)	82.1 % (2018)	

Project objective at impact level		Rating of appropriateness (former and current view)			
During project appraisal: Improving the health status of the population		Objective is appropriate and has not been modified			
During EPE (if target modified):					
Indicator	**Rating of appropriateness** (for example, regarding impact level, accuracy of fit, target level, smart criteria)	**Target level PA / EPE (new)**	**PA status (2006)**	**Status at final inspection (2018)**	**Status at EPE (2022)**
Indicator 1 Reduction in child mortality (MDG 4) Neonatal mortality rate per 1,000 live births Then SDG 3.2.1: Mortality rate of children under 5 years of age And SDG 3.2.2 Neonatal mortality	The MDG Millennium Development Goals and their successors, the Sustainable Development Goals (SDG), in the health care sector are appropriate for health programmes per se.	Goal description 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-5 mortality to at least as low as 25 deaths per 1,000 live births.	SDG 3.2.1 31.5 (2007) SDG 3.2.2 21.1 (2007)	SDG 3.2.1 17.6 (2018) SDG 3.2.2 11.9 (2018)	SDG 3.2.1 17.9 (2021) SDG 3.2.2 11.9 (2021)
Indicator 2 (PA) Improve maternal health (MDG 5) then SDG 3.1.1	Appropriate, see above	2030: Reduction in global maternal mortality ratio to below 70 per 100,000 live births	51.9 (2007)	38.5 (2015)	33.3 (2021)

Maternal mortality per 100,000 live births					
Indicator 3 SDG 3.3.1: Number of new HIV infections per 1,000 uninfected population by sex, age and key populations	Appropriate, see above	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases	0.08 (2007)	0.13 (2018)	0.13 (2021)
Reduce morbidity and mortality in cardiovascular diseases (CVD) SDG 3.4.1: Age-standardised death rate due to cardiovascular disease in adults aged 30–70 per 100,000	Appropriate, see above	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being	338 (2007)	266 (2018)	297.1 (2021)
Life expectancy at birth	Appropriate, see above	Increase	69.2 (2010)	71 years 4 months (2015)	71 years 6 months (2021)
UHC service coverage index (universal health coverage) SDG 3.8.1	Appropriate, see above	Target 100	61 (2010)	69 (2015)	70 (2019)

Risk analysis annex

Identification of the risks that have occurred (ex ante, identified during the course of the project and ex post)

Risk	Relevant OECD-DAC criterion
Risks of implementation with regard to delays and expansion of staff capacities (ex-ante)	Efficiency
Fiduciary risk, weakness in procurement and financial management (ex-ante)	Efficiency
Risk of sustainability in terms of staffing given the continuing large agenda in the sector (ex post).	Effectiveness, Sustainability
Securing the health budget in the state budget (ex-post)	Sustainability

Project measures and their results annex

The government of the Kyrgyz Republic and the cooperation partners supported the health reforms of Manas Taalimi (2006–2010) and Den Sooluk (2012–2016) based on a sector-wide approach (SWAp). The majority of external financing was pooled (DfID, SDC, SIDA, WB and KfW), and a joint results matrix was developed. The development partners not only provide financing, but also offered continuous support to the Kyrgyz partners in the administrative and technical planning and coordination of the health reform process. GTZ, WHO, USAID and UNICEF also supported the programme through technical aid programmes.

Manas Taalimi focused on the Millennium Development Goals (MDG 4, 5, 6) of reducing child and infant mortality, improving maternal health, reducing HIV/AIDS and other communicable diseases. Furthermore, the programme aimed to reduce cardiovascular disease, which is the most common cause of premature death in the Kyrgyz Republic.

Manas Taalimi sought to increase public spending in the health sector, ensure full coordination across all health services, and limit the growing level of informal payments made by the population for access to health services.

Den Sooluk was based on the SDGs (here specifically SDG 3: Good health and well-being) and focused on improving the quality of treatment, which was still perceived as inadequate by the population and the government.

Sooluk was seen as a logical continuation of the previous reform aimed at social health protection in the sense of universal coverage, equal access to services, burden-sharing in financing, a perspective for health personnel, and the strengthening of financial management and procurement.

In terms of the approach, using joint financing to implement the project eased the burden on the partner and made it easier to harmonise the external support.

Recommendations for operation annex

No recommendations were made.

Relevance

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Policy and priority focus			2	0	
Are the objectives of the programme aligned with the (global, regional and country-specific) policies and priorities, in particular those of the (development policy) partners involved and affected and the BMZ?	Are the objectives consistent with the SDGs? Reference (SDG 3) Is there a BMZ concept for the sector? Are there specific programmes in the Kyrgyz Republic?	https://unstats.un.org/sdgs/metadata/?Text=&Goal=3 BMZ. 2030 Agenda: 17 Sustainable Development Goals. https://www.bmz.de/de/ministerium/ziele/2030_agenda/17_ziele/index.html BMZ position papier (2019): Global health – an investment in the future https://health.bmz.de/wp-content/uploads/studies/strategiepapier460-02-2019-data.pdf https://extranet.who.int/nutrition/gina/sites/default/filesstore/KGZ%202006-2010%20Manas_taalimi_Program.pdf			
Do the objectives of the programme take into account the relevant political and institutional framework conditions (e.g. legislation, administrative capacity, actual power structures (including those related to ethnicity, gender, etc.))?	Is there legislation on public health? Do the Ministry of Health and health care services have suitable capacity and are they able to implement reforms in the sector in terms of expertise, finance and personnel? Is a reform of the health system still a priority?	https://apps.who.int/iris/handle/10665/107657			

Evaluation dimension: Focus on needs and capacities of participants and stakeholders			2	0	
Are the programme objectives focused on the developmental needs and capacities of the target group? Was the core problem identified correctly?	The target group is the entire population of the country; after the mid-term review in 2016, the target group was narrowed down to mothers and children. There were no surveys of the population, but the high out-of-pocket payments still shows the social significance of health. The general health indicators are certainly in need of improvement both regionally and internationally. The core problem is the inadequate supply of medical care to the population, a fact that was correctly identified	https://extranet.who.int/nutrition/gina/sites/default/filesstore/KGZ%202006-2010%20Manas_taalimi_Program.pdf Health Systems in Transition Vol. 24 No. 3 2022			
Were the needs and capacities of particularly disadvantaged or vulnerable parts of the target group taken into account (possible differentiation according to age, income, gender, ethnicity, etc.)? How was the target group selected?	Have the needs and demands of women, children and the poor been given particular consideration in the design and implementation of the health reforms?	Project proposal (PP) and reporting.			
Would the programme (from an ex post perspective) have had other significant gender impact potentials if the concept had been designed differently? (FC-E-specific question)	Could a focus on maternal and child health – or a strategic approach – have had a strong potential for impact?				

Evaluation dimension: Appropriateness of design			2	0	
Was the design of the programme appropriate and realistic (technically, organisationally and financially) and in principle suitable for contributing to solving the core problem?	Was the sector-wide approach fundamentally suitable – also when taking into account the capacity of the MoH's administration to contribute to solving the core problem generally? What was the extent of the financial gap for Manas Taalimi and Den Sooluk?	BE			
Is the programme design sufficiently precise and plausible (transparency and verifiability of the target system and the underlying impact assumptions)?	The programme design is plausible and clear	PP and reporting			
Please describe the results chain, incl. complementary measures, if necessary in the form of a graphical representation. Is this plausible? As well as specifying the original and, if necessary, adjusted target system, taking into account the impact levels (outcome and impact). The (adjusted) target system can also be displayed graphically. (FC-E-specific question)	Improving access to health services for all sections of the population, reducing financial hardship in the event of illness, and increasing the quality and efficiency of health services result in greater use of the health facilities and, at the same time, an improvement in the quality of services for better public health.				
To what extent is the design of the programme based on a holistic approach to sustainable development (interplay of the social, environmental and economic dimensions of sustainability)?	To what extent is it taken into account whether the structures created can be maintained or continued in the long term? In addition: To what extent was the environmental degradation	https://extranet.who.int/nutrition/gina/en/node/23556 http://hpac.kg/en/our-activity/research-papers/manas-taalimi-2006-2011/			

	dimension addressed in the public health programme (environmental risks have the second highest mortality rate after CVD)?				
For projects within the scope of DC programmes: is the programme, based on its design, suitable for achieving the objectives of the DC programme? To what extent is the impact level of the FC module meaningfully linked to the DC programme (e.g. outcome impact or output outcome)? (FC-E-specific question)		PP, reporting and final inspection			
Evaluation dimension: Response to changes/adaptability			2	0	
Has the programme been adapted in the course of its implementation due to changed framework conditions (risks and potential)?		BE			

Coherence

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Internal coherence (division of tasks and synergies within German development cooperation):			2	0	
To what extent is the programme designed in a complementary and collaborative manner within the	Is there cooperation with the German development agency	PP and reporting			

German development cooperation (e.g. integration into DC programme, country/sector strategy)?	GIZ or other German development organisations? Was the BMZ Global Health concept taken into account? Is there a country strategy?				
Do the instruments of the German development cooperation dovetail in a conceptually meaningful way, and are synergies put to use?	To what extent did the GIZ project on mother-child health supplement the SWAp? Were other approaches taken?	PP https://www.giz.de/en/worldwide/14399.html			
Is the programme consistent with international norms and standards to which the German development cooperation is committed (e.g. human rights, Paris Climate Agreement, etc.)?	What standards and norms is the project based on?	PP https://sdgs.un.org/goals/goal3 https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm			
Evaluation dimension: External coherence (complementarity and coordination with actors external to German DC):			2	0	
To what extent does the programme complement and support the partner's own efforts (subsidiarity principle)?	What efforts are being made by the Kyrgyz government to improve the health status of the population and to what extent does the programme support/supplement these efforts?				
Is the design of the programme and its implementation coordinated with the activities of other donors?	Which other donors were active in the sector in addition to those participating in the SWAp? How well is the coordination of activities and their implementation functioning between the members of the SWAp, the World Bank and the Kyrgyz	The Swiss Agency for Development and Cooperation (SDC), https://www.swissaid.ch/en/swiss-agency-for-development-and-cooperation/ Foreign, Commonwealth & Development Office (FCDO), https://www.gov.uk/government/organisations/foreign-common-wealth-development-office			

	partners? How often did the Co-ordination Forum meet? Have the decisions of the Health Summit Joint Commission been adhered to?	Swedish International Development Cooperation Agency, https://www.sida.se/en https://www.Worldbank.org
Was the programme designed to use the existing systems and structures (of partners/other donors/international organisations) for the implementation of its activities and to what extent are these used?		Swiss Agency for Development and Cooperation (SDC), https://www.swissaid.ch/en/swiss-agency-for-development-and-cooperation/ Foreign, Commonwealth & Development Office (FCDO), https://www.gov.uk/government/organisations/foreign-commonwealth-development-office Swedish International Development Cooperation Agency, https://www.sida.se/en https://www.Worldbank.org
Are common systems (of partners/other donors/international organisations) used for monitoring/evaluation, learning and accountability?		Swiss Agency for Development and Cooperation (SDC), https://www.swissaid.ch/en/swiss-agency-for-development-and-cooperation/ Foreign, Commonwealth & Development Office (FCDO), https://www.gov.uk/government/organisations/foreign-commonwealth-development-office Swedish International Development Cooperation Agency, https://www.sida.se/en https://www.Worldbank.org

Effectiveness

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Achievement of (intended) targets			3	0	

Were the (if necessary, adjusted) objectives of the programme (incl. capacity development measures) achieved? Table of indicators: Comparison of actual/target	--	See main section, "Effectiveness"			
Evaluation dimension: Contribution to achieving objectives:			3	0	
To what extent were the outputs of the programme delivered as planned (or adapted to new developments)? *(Learning/help question)*		World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2			
Are the outputs provided and the capacities created used?	How high is the capacity of the essential health services? How is the Mandatory Health Insurance Fund (MHIF) financed? Are the contributions paid in promptly? Is the MHIF monitored? How large are the MoH's subsidies?	See main section, "Effectiveness"			
To what extent is equal access to the outputs provided and the capacities created guaranteed (e.g. non-discriminatory, physically accessible, financially affordable, qualitatively, socially and culturally acceptable)?	Has the introduction of health insurance (MHIF) improved access to health services by the poor? What is the proportion of health expenditure in the budget of poor households?	See main section, "Effectiveness" Health Systems in Transition Vol. 24 No. 3 2022; Kyrgyzstan WHO health system review			
To what extent did the programme contribute to achieving the objectives?	How is FC support (financing, complementary measure, participation in policy dialogue) assessed to	See main section, "Effectiveness and Reporting"			

	achieve the targets of the sector reforms?	
To what extent did the programme contribute to achieving the objectives at the level of the intended beneficiaries?		Reporting and final inspection
Did the programme contribute to the achievement of objectives at the level of the particularly disadvantaged or vulnerable groups involved and affected (potential differentiation according to age, income, gender, ethnicity, etc.)?		Reporting and final inspection
Were there measures that specifically addressed gender impact potential (e.g. through the involvement of women in project committees, water committees, use of social workers for women, etc.)? (FC-E-specific question)	To what extent were women involved in the design and implementation of the project/SWAp? What is the proportion of women in the Village Health Committees?	World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2 See main section, PP and FI
Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement of the intended objectives of the programme? *(Learning/help question)*	What factors have hampered the development of the quality of health services? How do the employees of the various institutions involved see themselves to have grown and prepared themselves to meet the requirements of reform formulation and implementation? How did the cooperation between the various donors work as part of the basket financing?	World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2 See main section, PP and FI

	To what extent was there a consensus between the government and donors?				
Which external factors were decisive for the achievement or non-achievement of the intended objectives of the programme (also taking into account the risks anticipated beforehand)? *(Learning/help question)*	What factors have hampered the development of the quality of health services? How do the employees of the various institutions involved see themselves to have grown and prepared themselves to meet the requirements of reform formulation and implementation? How did the cooperation between the various donors work as part of the basket financing? To what extent was there a consensus between the government and donors?	World Bank: Den Sooluk National Health Reform Program, Aide Memoire May 2018, Annex 2 See main section, PP and FI			
Evaluation dimension: Quality of implementation			2	0	
How is the quality of the management and implementation of the programme (e.g. project-executing agency, consultant, taking into account ethnicity and gender in decision-making committees) evaluated with regard to the achievement of objectives?	Were the recommendations of the GoK/donor steering group followed up? Did the MoH adopt a strong leadership role?	Interview with the PM, WHO partners, SDC, ex-World Bank members			
How is the quality of the management, implementation and participation in the programme by the partners/sponsors evaluated?	Did the biannual programme-based meetings between the MoH and donors take place regularly? Were the joint decisions followed up?	Interview with the PM, WHO partners, SDC, ex-World Bank members			

Were gender results and relevant risks in/through the project (gender-based violence, e.g. in the context of infrastructure or empowerment projects) regularly monitored or otherwise taken into account during implementation? Have corresponding measures (e.g. as part of a CM) been implemented in a timely manner? (FC-E-specific question)	Were gender-related issues specifically addressed within the framewok of the programme and reported on on a regular basis?	Interview with the PM, WHO partners, SDC, ex-World Bank members			
Evaluation dimension: Unintended consequences (positive or negative)			2	0	
Can unintended positive/negative direct impacts (social, economic, ecological and, where applicable, those affecting vulnerable groups) be seen (or are they foreseeable)?	Has the implementation of the project contributed to a general reduction in fiduciary risks in public finance management?	Interview with PM, SDC, World Bank			
What potential/risks arise from the positive/negative unintended effects and how should they be evaluated?	Were the experiences of the basket financing of fiduciary risks transferred to other projects/ministries?	Interview with PM, SDC, World Bank			
How did the programme respond to the potential/risks of the positive/negative unintended effects?		Interview with PM, GIZ			

Efficiency

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Production efficiency			2	0	

How are the inputs (financial and material resources) of the programme distributed (e.g. by instruments, sectors, sub-measures, also taking into account the cost contributions of the partners/executing agency/other participants and affected parties, etc.)? (Learning and help question)	Is there a breakdown in expenditure within the SWAp/basket financing?	Interview with the MoH,			
To what extent were the inputs of the programme used sparingly in relation to the outputs produced (products, capital goods and services) (if possible in a comparison with data from other evaluations of a region, sector, etc.)? For example, comparison of specific costs.		Final inspection and reporting			
If necessary, as a complementary perspective: To what extent could the outputs of the programme have been increased by an alternative use of inputs (if possible in a comparison with data from other evaluations of a region, sector, etc.)?		Not relevant, because basket financing is paid into the current sectoral (no alternative in the sense of a single) reform programme.			
Were the outputs produced on time and within the planned period?		Final inspection and reporting			
Were the coordination and management costs reasonable (e.g. implementation consultant's cost component)? (FC-E-specific question)		PCR			
Evaluation dimension: Allocation efficiency			2	0	

In what other ways and at what costs could the effects achieved (outcome/impact) have been attained? *(Learning/help question)*	The discussion is unnecessary against the background of the PBA approach, as the cost involved in implementing stand-alone projects by the partner (GoK) would certainly have been higher, but cannot be calculated here	
To what extent could the effects achieved have been attained in a more cost-effective manner, compared with an alternatively designed programme?	See above	
If necessary, as a complementary perspective: To what extent could the positive effects have been increased with the resources available, compared to an alternatively designed programme?	See above	

Impact

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Overarching developmental changes (intended)			3	0	
Is it possible to identify overarching developmental changes to which the programme should contribute? (Or if foreseeable, please be as specific as possible in terms of time.)	How has life expectancy changed in the Kyrgyz Republic?	https://www.worldlifeexpectancy.com/kyrgyzstan-life-expectancy			

Is it possible to identify overarching developmental changes (social, economic, environmental and their interactions) at the level of the intended beneficiaries? (Or if foreseeable, please be as specific as possible in terms of time).					
To what extent can overarching developmental changes be identified at the level of particularly disadvantaged or vulnerable parts of the target group to which the programme should contribute? (Or, if foreseeable, please be as specific as possible in terms of time).	How have the indicators for maternal mortality evolved? Is it the same as those for child mortality?	https://www.who.int/data/gho/data/countries/country-details/GHO/kyrgyzstan?countryProfileId=35da4dcc-e091-4dc2-bade-ea785f450743			
Evaluation dimension: Contribution to overarching developmental changes (intended)			3	0	
To what extent did the programme actually contribute to the identified or foreseeable overarching developmental changes (also taking into account the political stability) to which the programme should contribute?	How did the MoH, SDC and WB see the role of the German FC in the SWAp? To what extent was the basket able to contribute collectively to the effects at impact level? How was the quality and usefulness of the complementary measures perceived?	Discussions with MoH, WB and SDC			
To what extent did the programme achieve its intended (possibly adjusted) developmental objectives? In other words, are the project impacts sufficiently tangible not only at outcome level, but at impact level? (e.g. drinking water supply/health effects)	How has the population's life expectancy evolved? Is there an improvement in the indicators for SDG 3?	See the main section "Indicators: Overarching Developmental Impact"			

Did the programme contribute to achieving its (possibly adjusted) developmental objectives at the level of the intended beneficiaries?		See the main section "Indicators: Overarching Developmental Impact"
Has the programme contributed to overarching developmental changes or changes in life situations at the level of particularly disadvantaged or vulnerable parts of the target group (potential differentiation according to age, income, gender, ethnicity, etc.) to which the programme was intended to contribute?		See the main section "Indicators: Overarching Developmental Impact"
Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement of the intended developmental objectives of the programme? *(Learning/help question)*	What contribution have the programmes made to the new reform programme "Public Health Protection and Health Care System Development for 2019–2030 (SPHD2030)"?	Meetings with MoH, MHIF, KfW, WB and SDC
Which external factors were decisive for the achievement or non-achievement of the intended developmental objectives of the programme? *(Learning/help question)*	How have prosperity and poverty evolved in the Kyrgyz Republic?	SDG website, WB
Does the project have a broad-based impact? - To what extent has the programme led to structural or institutional changes (e.g.in organisations, systems and regulations)? (Structure formation)	Have the reforms been adopted by other ministries or public institutions with regard to planning/management/control of public expenditure? Is a SWAp also being considered for other sectors or has one already been applied?	Meetings with MoH, MHIF, KfW, WB and SDC

- Was the programme exemplary and/or broadly effective and is it reproducible? (Model character)					
How would the development have gone without the programme? (Learning and help question)		Meetings with PM, KfW colleagues			
Evaluation dimension: Contribution to (unintended) overarching developmental changes			2	0	
To what extent can unintended overarching developmental changes (also taking into account political stability) be identified (or, if foreseeable, please be as specific as possible in terms of time)?	Have fiduciary risks in the PFM area improved?	Reporting, World Bank's aide memoire			
Did the programme noticeably or foreseeably contribute to unintended (positive and/or negative) overarching developmental impacts?		Interviews with MoH, GIZ, KfW PM			
Did the programme noticeably (or foreseeably) contribute to unintended (positive or negative) overarching developmental changes at the level of particularly disadvantaged or vulnerable groups (within or outside the target group) (do no harm, e.g. no strengthening of inequality (gender/ethnicity))?		Interviews with MoH, GIZ, KfW PM			

Sustainability

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Capacities of participants and stakeholders			2	0	
Are the target group, executing agencies and partners institutionally, personally and financially able and willing (ownership) to maintain the positive effects of the programme over time (after the end of the promotion)?	Are coordination meetings still taking place between the MoH and MoF? In what direction have the budget and staffing levels of the MoH and MHIF changed since the end of the promotion? How is procurement structured in the health care sector? Did the WB's approach continue to be pursued and were regular audits scheduled?	MoH, World Bank, WHO, SDC, PM			
To what extent do the target group, executing agencies and partners demonstrate resilience to future risks that could jeopardise the impact of the programme?	Were coordination formats such as the Joint Annual Review (JAR) also maintained as part of the "Healthy Person, Prosperous Country" reform programme?	WHO, MoH			
Other evaluation question 1	How much dependence is there on (donor) fund allocations for upcoming reforms in the sector?	WHO, World Bank			
Evaluation dimension: Contribution to supporting sustainable capacities:			2	0	

Did the programme contribute to the target group, executing agencies and partners being institutionally, personally and financially able and willing (ownership) to maintain the positive effects of the programme over time and, where necessary, to curb negative effects?	Are the comments/findings of the audits in the MoH still being followed up? How have the findings of the audits developed?	World Bank, MoH, KfW PM			
Did the programme contribute to strengthening the resilience of the target group, executing agencies and partners to risks that could jeopardise the effects of the programme?	How much dependence is there on (donor) fund allocations to the new strategy?	WHO, World Bank			
Did the programme contribute to strengthening the resilience of particularly disadvantaged groups to risks that could jeopardise the effects of the programme?	Not directly relevant, as particularly disadvantaged groups have little to no influence on the use of funds in the MoH				
Evaluation dimension: Durability of impacts over time			2	0	
How stable is the context of the programme (e.g. social justice, economic performance, political stability, environmental balance)? (*Learning/help question*)	How much is the Krygyz Republic affected by the war currently being waged by Russia?	Public media, World Bank, IMF			
To what extent is the durability of the positive effects of the programme influenced by the context? *(Learning/help question)*	Have remittances from Russia declined noticeably?	World Bank			
To what extent are the positive and, where applicable, the negative	How high is the staff turnover in the MoH and MHIF?	Interviews with the MoH			

effects of the programme likely to be long-lasting?	How strong is the political will on the health system?	