Special Initiative Report
No. 19

New NGO Partners for Health Sector Reform in Central Asia: Family Group Practice Associations in Kazakhstan and Kyrgyzstan

July 1999

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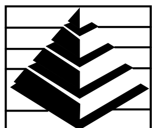

Partnerships
for Health
Reform

PHR

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In collaboration with:
Development Associates, Inc. ■ Harvard School of Public Health ■
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Funded by:
U.S. Agency for International Development

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *Better informed and more participatory policy processes in health sector reform*;
- *More equitable and sustainable health financing systems*;
- *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health service*; *and*
- *Enhanced organization and management of health care systems and institutions to support specific health sector reforms*.

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

July 1999

Recommended Citation

Brinkerhoff, Derick W. and Mark McEuen. July 1999. *New NGO Partners for Health Sector Reform in Central Asia: Family Group Practice Associations in Kazakhstan and Kyrgyzstan.* Special Initiatives Report No. 19. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.: HRN-C-00-95-00024
Project No.: 936-5974.13

Submitted to: Robert Emrey, COTR
Health Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

Economic decline in the former Soviet Central Asian republics of Kazakhstan and Kyrgyzstan is leading the governments in those New Independent States to seek private and nonprofit partners in health care delivery. Family Group Practice Associations (FGPAs)—legally sanctioned, non-governmental entities that are nonprofit, self-governing, and voluntary—are being established to serve as intermediaries between government and new, primary care-oriented family group practices.

This study looks at the development of FGPAs at the local and national levels in Kazakhstan and Kyrgyzstan. It describes the financing and structure of the FGPAs, their relationships with the state and with their members, and the role of international donors in their development. Based on interviews conducted in the region in early 1999 and on documents reviewed, the study assesses the effectiveness of the partnerships and examines conditions affecting the success and shortcomings of the collaborations. It identifies preliminary lessons learned from the Central Asian experiences and evaluates the role of the organizations for the future.

Table of Contents

Acronyms . . . v

Preface . . . vii

Acknowledgments . . . ix

Executive Summary . . . xi

1. Introduction . . . 1
   - 1.1 Objectives and Overview . . . 1
   - 1.2 State–NGO Partnerships . . . 2

2. Health Sector Reform in Central Asia . . . 5
   - 2.1 Transition from the Soviet Past . . . 5
   - 2.2 Health Sector Reform Components in Kazakhstan and Kyrgyzstan . . . 6
     - 2.2.1 Health Reform in Kazakhstan . . . 6
     - 2.2.2 Health Reform in Kyrgyzstan . . . 7

3. NGOs and Health Sector Reform . . . 9
   - 3.1 FGPAs in Kazakhstan . . . 9
     - 3.1.1 FGPA Financing . . . 10
     - 3.1.2 Structure and Organization of the FGPA . . . 11
     - 3.1.3 Relationship Between the FGPA and the Government . . . 11
     - 3.1.4 Relationship Between the FGPA and its Members . . . 12
     - 3.1.5 The National FGPA . . . 12
     - 3.1.6 Role of International Donors . . . 13
   - 3.2 FGPAs in Kyrgyzstan . . . 13
     - 3.2.1 FGPA Financing . . . 14
     - 3.2.2 Structure and Organization of the FGPA . . . 15
     - 3.2.3 Relationship Between the FGPA and the Government . . . 16
     - 3.2.4 Relationship between the FGPAs and their Members . . . 17
     - 3.2.5 Role of International Donors . . . 17

4. State–NGO Partnership for Health Reform . . . 19
   - 4.1 Defining Objectives, Roles, and Responsibilities . . . 19
   - 4.2 Linkage Mechanisms . . . 20
   - 4.3 The Legal Framework for Partnerships . . . 21
   - 4.4 From Service Delivery to Policy Advocacy? . . . 21

5. Conclusions and Lessons Learned . . . 23
   - 5.1 Lessons Learned . . . 23
   - 5.2 Prognosis for the Future . . . 25

Annex A. Defining NGOs 27

Annex B. Bibliography 29

Acronyms

FGPA	Family Group Practice Association
FGP	Family Group Practice
FSU	Former Soviet Union
JWG	Joint Working Group
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health
NGO	Non-governmental Organization
NIS	New Independent States
PHR	Partnerships for Health Reform Project
SI	Special Initiative
USAID	United States Agency for International Development
WHO	World Health Organization

Preface

Through the Partnerships for Health Reform (PHR) Project's Special Initiative (SI) on non-governmental organizations (NGOs), the project is examining innovative mechanisms and arrangements that support collaboration between public and non-governmental sector entities in the context of health sector reform efforts. Among the activities of the SI are the identification and preparation of selected case studies that illustrate innovative ways of designing and implementing public sector–NGO collaboration and partnerships. The data collection and report writing team for this case study consisted of Dr. Derick W. Brinkerhoff (Abt Associates Inc.), technical coordinator for the NGO SI, and Mr. Mark McEuen (Abt Associates Inc.), formerly with PHR but now country director for Uzbekistan for the Zdrav*Reform* Program. Mark McEuen contributed to writing the report's sections on Kyrgyzstan's experience with Family Group Practice Associations.

Acknowledgments

PHR would like to thank Mr. Robert Emrey, in AID/W's Population, Health, and Nutrition Office of the Global Bureau, and COTR for PHR; and Ms. Jatinder Cheema and Ms. Harriet Destler, USAID/Almaty, for their support. In Kazakhstan and Kyrgyzstan, PHR acknowledges the enthusiastic cooperation and support of the Zdrav*Reform* Program, particularly Ms. Sheila O'Dougherty, Zdrav*Reform* regional co-director, in proposing the reforms in the two countries as candidates for the study, facilitating the in-country data collection, and in sharing Zdrav*Reform*'s experience in health reform in the Central Asia region. Finally, the contribution of all of those interviewed is gratefully acknowledged; without their interest and input the study would not have been possible.

Executive Summary

Introduction

In many developing and transitional countries, national governments are struggling with limited resources to meet the basic health needs of their populations. Faced with declining economic conditions, budget crises, and shrinking expenditures in the social sectors, governments are turning to the private and nonprofit sectors as potential partners in health care delivery. This paper presents a comparative case study of experience with creating new non-governmental organizations (NGOs) as part of health sector reform in two of the Central Asian republics of the former Soviet Union: Kazakhstan and Kyrgyzstan. The new NGOs, Family Group Practice Associations (FGPAs), are formally established, non-governmental entities that are nonprofit, self-governing, and voluntary. They serve as intermediary institutions between government and newly created family group practices (FGPs). The study reviews the collaboration between the government and the FGPAs, assesses the effectiveness of the partnership, and examines the factors and conditions affecting the success and/or shortcomings of the collaboration. Data were collected through interviews and site visits in Kazakhstan and Kyrgyzstan during February-March 1999. These data are complemented by analysis of documents and reports, as well as review of the relevant published literature.

Background: the Soviet Legacy

The Central Asian republics inherited a health system from the Soviet Union that was centralized, hierarchical, and standardized. Policies, practices, and treatment norms were all developed in Moscow and passed to each republic for implementation by the health ministry, which in turn issued directives to oblast (province) health departments that oversaw city- and rayon (county)-level administrative units. The system emphasized tertiary care and specialty services. Hospitals and polyclinics received most of the resources, while primary care was underfunded and served mainly to refer patients upward to specialists and hospitals. The image is one of an inverted pyramid, heavy and bloated at the top, narrow and anemic at the bottom.

Health sector reform programs in the region share a number of basic features: (a) cost reduction, (b) rationalization of health facilities, (c) health insurance schemes to introduce cost-consciousness and performance incentives, and (d) separation of payment from service provision. The reforms also emphasize training of physicians and other medical personnel both to upgrade and broaden clinical skills, and to focus on strengthening primary health care in an effort to reinvert the Soviet-era pyramid. In the region, Kazakhstan and Kyrgyzstan are furthest along in creating health insurance funds and in experimenting with new provider payment mechanisms on a pilot basis.

Reform in Kazakhstan

Following some strategic planning and the passage of enabling legislation, reform activities began in the 1990s when four oblasts introduced health insurance mechanisms and new service delivery arrangements. This led to the establishment of a mandatory health insurance fund (MHIF), a capitated provider payment system, and development of a basic benefits package. FGPs were created to provide primary care through contracts with the MHIF. The city of Zhezkazgan, one of the original experimentation sites where one of the most forward-thinking health administrators in the country began testing new approaches, is among the vanguards of health sector reform. International donors are actively supporting Kazakhstan's health sector reform program.

The oblast-level experimentation with decentralized service delivery that led to the creation of FGPs also set the stage for FGPAs. The study focuses on Zhezkazgan, where an FGPA was first established. Working closely with government health services, the FGPA participates in direct service provision and in health status monitoring and reporting. It has played a minor role in health policy advocacy. The FGPA's relationship with its members centers on capacity-building to help the FGPs make the transition to viable private providers of quality primary care services to families. The association has been instrumental in obtaining donor resources, through grants, for FGP strengthening. Another aspect of the association's relationship with its members deals with self-policing, regulation, and quality assurance.

A national FGPA was established in late 1998. However, the nascent national FGPA is too new to have developed a program of activities, and much of its founders' energies are directed toward resolving the legal and organizational issues concerning its relationship to local-level FGPAs.

Reform in Kyrgyzstan

In the mid-1990s Kyrgyzstan's health ministry developed a master plan whose short-term objectives deal with establishing new sectoral priorities, rationalizing service provision, and pilot-testing new financing mechanisms and service delivery modes. Medium-term objectives concentrate on financing innovations, decentralization and hospital autonomy, information systems, and capacity-building. The plan's long-term objectives extend primary care coverage via FGPs to the entire country, expand the use of purchaser-provider contracts, and institutionalize social insurance. A World Bank-funded project, the Manas Health Care Reform Program, provides the umbrella under which a number of donors have come together to work with the Kyrgyz health system.

The first pilot site for introducing reforms is Issyk-Kul oblast, where capitated health insurance and primary care provision is being tested. Similar to Kazakhstan, FGPs were formed to provide primary medical care to all family members from a single location. The government is now multiplying the number of demonstration sites beyond Issyk-Kul to Bishkek City and Chui, Osh, and Jalal-Abad oblasts. Activities include: development of FGPs, formulation of new provider payment methods, creation of a case-based hospital payment system, creation of a

financial intermediary to pay FGPs and hospitals, and development of clinical and financial information systems.

In October 1995, a FGPA was established in Issyk-Kul oblast to support the formation and development of new FGPs, help to coordinate health sector reform, and improve the quality of primary health care. Additional FGPAs were set up in new demonstration sites. The relationship of the FGPAs and their members focuses on resources identification and capacity-building: equipment procurement, clinical and management training, and organizational support. As in Kazakhstan, the FGPAs have been reticent to take on a lobbying and advocacy function. In 1997, a national-level FGPA was established, and existing oblast-level FGPAs will become affiliates.

Selected Findings

The creation of FGPAs in both countries emerged from the search by health care reformers for alternative modes of service delivery in a context of public sector downsizing and cutbacks. Privatization and a diminished role for the state opened up space for FGPs and associations of FGPs in support of their operations. However, the state, with international donor assistance, was a major force in setting up FGPAs.

Besides the FGPAs' involvement in service delivery and support to FGPS, devolution of some regulatory functions and shared approaches to quality assurance and monitoring brought them new roles and responsibilities in setting quality-of-care standards, monitoring performance, and accrediting health care providers. Donor resources and technical assistance have been instrumental in allowing FGPAs to fulfill these new roles and responsibilities. These have been important in providing the means to enable the associations to demonstrate to government officials that they can be effective partners in health sector reform.

Although nominally both the Kazakh and Kyrgyz FGPAs' roles include representing the interests of their members, and lobbying for policy and procedural changes in support of those interests, to date in neither country has this role induced much advocacy activity. The study shows that the associations have for the most part avoided advocacy and lobbying in favor of capacity-building and participation in service delivery. When donors talk of FGPAs as health policy advocates and representatives of an emerging voice of civil society in policy dialogue, they are anticipating what may evolve in the future rather than describing their current activities.

Lessons Learned

- A supportive legal framework is central to facilitating the emergence of viable NGOs and a vibrant civil society, and to creating effective partnerships.
- In terms of state–NGO relations, as exemplified by the FGPAs and their member FGPs, the weight of the past hangs heavily over how the state interacts with these new entities.

- The successful initiation and continuation of the reforms in general and the FGPAs in particular depend upon the actions of key individuals, and groups, who can serve as champions for change.

- NGOs established by government agencies with donor support will pursue objectives that fit closely with the desires of their creators. In the countries of the former Soviet Union, where civil society is underdeveloped, NGOs have limited experience with alternative models of action.

- In partnerships where the state holds the vast majority of power, the NGO partners are unlikely to be anything but docile and cooperative. In both countries, the FGPA and FGPs tread warily in the partnership.

- The medical staff operating within FGPAs and FGPs are behaving differently in response to new incentives than they did formerly as members of the public sector health establishment. The flexibility, autonomy, and responsiveness that the non-governmental structures offer have made a difference in the speed and effectiveness of primary health care services reform.

- The cases show that NGO capacity can be created using facilitative technical assistance and external resources. However, FGPAs will continue to require outside help and infusions of funds for several years to come; sustainability will not be immediate.

- FGPAs were initially formed at the oblast level as one of the institutional innovations in the health reform demonstration sites. National FGPAs came later. Federated structures on the NGO side of the partnership are likely to provide a better fit with the decentralized public sector structures because they allow for integration of national and oblast activities while at the same time permitting adaptation and autonomy locally.

Conclusion

This study provides evidence that the approach to NGO formation and interaction in health reform policy implementation being applied in Kazakhstan and Kyrgyzstan is leading to effective partnerships. The reasons for exploring partnership models of health sector reform that involve NGOs are both instrumental and value-based. On the instrumental side, NGOs can potentially contribute flexibility, responsiveness, adaptability, and efficient and effective performance to health sector reform. Given the limitations of the bureaucratic, rules-driven, and control-oriented public institutions in both Kazakhstan and Kyrgyzstan, inherited from their Soviet past, these instrumental pluses can be very important for making progress with reforms. The value-based reason for a model that incorporates NGOs into health sector reform is the potential contribution to democratization. Creating and strengthening NGOs increases opportunities for citizens to participate in decisionmaking and action relating to policy formation and implementation. Thus NGOs are critical to developing new patterns and practices of governance.

1. Introduction

Around the world there is wide recognition that societal problems cannot be solved by governments acting alone; interest in cooperation between state and non-state actors has grown appreciably over the past decade or so. In the health sector in many developing and transitional countries, national governments are struggling with limited resources to meet the basic health needs of their populations. Faced with declining economic conditions, budget crises, and shrinking expenditures in the social sectors, governments are turning to the private and nonprofit sectors as potential partners in health care delivery. Partnerships incorporate features such as performance contracts with non-governmental organizations (NGOs) for service delivery, sharing of staff between public sector agencies and NGOs, institutional innovations intended to increase incentives for service providers, decentralization, and the involvement of NGOs in health sector policymaking. Health sector policy reforms often include new roles for their various partners, but in many countries lack of experience, capacity, and trust can make the reform process a challenging one at best, and at worst a failure. A critical problem, then, in health sector reform is how to make these expanded policy and implementation partnerships successful.

1.1 Objectives and Overview

This paper presents a comparative case study of experience with creating new NGOs as part of health sector reform in two of the Central Asian republics of the former Soviet Union: Kazakhstan and Kyrgyzstan. The objectives of the study are the following:

- To review the collaboration between the government and these new NGOs,
- To assess the effectiveness of the partnership, and
- To examine the factors and conditions affecting the success and/or shortcomings of the collaboration.

The case study is based on data collected through interviews and site visits during fieldwork in Kazakhstan and Kyrgyzstan during February-March 1999. These data are complemented by analysis of documents and reports, as well as review of the relevant published literature.

These new NGOs, Family Group Practice Associations (FGPAs), are formally established, non-governmental entities that are nonprofit, self-governing, and voluntary (see Annex A). They serve as intermediary institutions between government and newly created family group practices (FGPs). These new entities seek to provide basic primary health care within the context of a health financing framework intended to reverse the incentives that in the past have led to significant overinvestment in expensive tertiary care structures (hospitals and polyclinics) and underinvestment in preventive and primary care. The FGPAs are intended to fulfill both technical and policy advocacy functions. NGOs in general, and in the health sector in particular, are new institutional actors throughout the former Soviet Union, and confront experience, capacity, and

trust gaps. This paper explores how the FGPAs are dealing with these problems as they operate within Kazakhstan's and Kyrgyzstan's health sector reform programs.

This first section introduces the report and discusses key issues in government–NGO partnerships. Section 2 briefly overviews health sector reform in Central Asia. Section 3 recounts the story of FGPAs in Kazakhstan and Kyrgyzstan, and reviews reform implementation experience to date. Section 4 analyzes the cases in terms of selected variables important to effective collaboration, focusing on partnership objectives, partner roles and responsibilities, linkage mechanisms, and the evolution from service delivery to policy advocacy. The last section presents conclusions and lessons learned. It looks at the enabling environment, the legacy of past practices, capacity issues, and technical assistance and concludes with some observations for the future.

1.2 State–NGO Partnerships

As elaborated in Brinkerhoff (1999), state–NGO partnerships can be defined as cross-sectoral interactions whose purpose is to achieve convergent objectives through the combined efforts of both sets of actors, but where the respective roles and responsibilities of the actors involved remain distinct. The essential rationale is that these interactions generate synergistic effects; that is, more and/or better outcomes are attained than if the partners acted independently. This definition suggests a set of factors that partnership arrangements need to address in order to contribute effectively to policy implementation. These include: specification of objectives, mechanisms for combining effort and managing cooperation, determination of appropriate roles and responsibilities, and capacity to fulfill those roles and responsibilities.

Specification of objectives: Establishing compatible and convergent objectives is the starting point for any partnership. Several considerations are important. First is the multiplicity of actors and their range of interests, which can make it difficult to reach agreement on policy and program objectives. Second is the power differential among the various actors, which arises as a function of differences in resource levels, operational capacity, and political clout. Third is the tendency for partners' objectives to shift and potentially diverge over time.

Mechanisms for combining effort and managing cooperation: Making cross-sectoral, multi-actor arrangements operate effectively is key to the success of any policy implementation partnership. Coordination can be accomplished by a variety of linkages: e.g., information sharing, resource sharing, and joint action. These linkage mechanisms can vary in the extent to which they: are formal or informal, focus on administrative or technical tasks, emphasize control and monitoring or assistance and facilitation, connect one or two organizations or many organizations, and are temporary or permanent and ongoing. The various features of the mechanisms used in partnerships create different patterns of incentives, which are the essential lubricant that makes partnerships possible. Positive incentives provide the stimulus that impels partners on both the state and non-state sides of the equation to work together; negative ones discourage them from doing so.

Determination of appropriate roles and responsibilities: In most developing and transitional economies the state, until recently, assumed major responsibility for policy formation and implementation. Resource constraints, advice and pressure from the international donors and

multilateral development banks, international market forces, and citizen demand for democracy have all combined to force a fundamental rethinking of the appropriate roles and responsibilities of the state. The thrust here has been on limiting and circumscribing the role of the state so as to create space for other actors. Politically, this has meant creating a legal and institutional framework that establishes civil liberties and public accountability. Economically, the major vehicles for reducing the role of the state have been market liberalization and privatization. In combination, these measures define a role for the state in policy formulation and implementation where the state undertakes the direct provision of a limited set of essential goods and services, and facilitates and encourages the engagement of civil society and the private sector across a wide range of social and economic sectors.

The scope of non-state actors' role in policy formulation and implementation is highly dependent upon the discretion of the state, at least initially (see Coston 1998). To the extent that political and economic liberalization establishes new boundaries and interaction patterns and opens the door to institutional pluralism, potential opportunities are created for a larger role and new responsibilities for NGOs and the private sector. Over time, interactions can reshape those boundaries and enlarge (or shrink) the space available for non-state actors. In many developing countries, however, the determination of appropriate roles and responsibilities is contested territory, with significant differences in points of view among governments, NGOs, and international donors. Governments are in some cases mistrustful of NGOs or the private sector, and worried about political opposition, competition for service delivery, and/or venal profit-making. NGOs sometimes view collaboration with government with suspicion, concerned about loss of autonomy or interference. Private sector groups tend also to be suspicious, seeing government as anti-business, overly controlling, and/or inept.

Capacity to Fulfill Roles and Responsibilities: For partnerships to function effectively, the state needs both the willingness and the capacity to work with NGOs. If government is providing grants or contracts for NGOs, then basic administrative capacities are needed, such as accounting and payment systems. Strategic planning and program design capacities are also important. Policy partnerships call for capabilities in consultation, communications, outreach, social marketing, and outcome monitoring and evaluation. For their part, NGOs need analogous capacities to interact effectively with state partners. In many cross-sectoral collaborations, NGOs serve as the intermediaries between community beneficiaries and the state. Thus they are called upon to work effectively at the local level—mobilizing and organizing community groups, assessing and responding to local needs, providing services—and to interface with public sector service providers and decision makers.

2. Health Sector Reform in Central Asia

The 1991 breakup of the former Soviet Union (FSU) set the New Independent States (NIS) on a voyage into uncharted waters. Among the NIS, the Central Asian republics—Kazakhstan, Kyrgyzstan, Turkmenistan, Tajikistan, and Uzbekistan—are the least developed and the least prepared to manage the reforms associated with political and economic liberalization. Central Asia's economies are weak, dependent upon the extraction and processing of a small number of natural resources, and unable to rely upon Moscow for the financing and delivery of most basic services as in the past. This historical legacy has left these countries with economic over-reliance on a few basic commodities, severe environmental degradation, shredded social safety nets, outmoded and crumbling infrastructure, plus top-heavy and cumbersome state bureaucracies.

The health sector in the Central Asian republics has been hard hit by the Soviet Union's collapse. Health statistics reveal declines in life expectancy, increases in chronic respiratory infections, poor maternal and child health, etc. The following sections briefly review the reforms underway to restructure the health sector and develop sustainable health care delivery systems.

2.1 Transition from the Soviet Past

The health system inherited from the Soviet Union was centralized, hierarchical, and standardized. Policies, practices, and treatment norms were all developed in Moscow and passed to each republic, where the health ministry was charged with implementation. Centralization, hierarchy, and standardization were replicated within the individual countries, where the national health ministry passed directives to oblast (province) health departments that in turn supervised city- and rayon (county)-level administrative units. The system emphasized tertiary care and specialty services. Hospitals and polyclinics received the lion's share of health sector resources, while primary care was underfunded and served mainly to refer patients upward to specialists and hospitals. Shortages of resources, equipment, and pharmaceuticals at the lower levels of the system reinforced the tendency for patients to end up at the highest-level facilities no matter what their medical problem. The result was a health care system that employed large numbers of narrowly trained physicians, maintained a huge physical infrastructure of facilities, provided fragmented care via a pattern of multiple referrals, and was extremely expensive to operate.

The image is one of an inverted pyramid, heavy and bloated at the top, narrow and anemic at the bottom. In many of the FSU countries, even prior to 1991, this costly and inefficient health system had been under significant strain, suffering from underinvestment, poorly trained and underpaid personnel, and crumbling infrastructure. Within the sector, these problems were not evenly distributed; state enterprises and the military provided heavily subsidized parallel health care to their workers and personnel. With the dissolution of the Soviet Union and the economic crisis that confronted each of the NIS, the unsustainable nature of the health system quickly became apparent.

2.2 Health Sector Reform Components in Kazakhstan and Kyrgyzstan

Health sector reform programs in the region share a number of basic features. They focus on reducing costs and rationalizing health facilities; this involves closing some facilities such as underutilized and excessively expensive hospitals and polyclinics, and overhauling the financing system. All the Central Asian republics are experimenting with new health insurance schemes that introduce cost-consciousness and incentives, and separate payment from service provision (Ensor and Thompson 1998). Kazakhstan and Kyrgyzstan are furthest along in creating health insurance funds and in experimenting with new provider payment mechanisms on a pilot basis. The reforms also emphasize training of physicians and other medical personnel both to upgrade and broaden clinical skills, and to focus on strengthening primary health care in an effort to reinvert the Soviet-era pyramid (Klugman and Scheiber 1999, McKee et al. 1998).

2.2.1 Health Reform in Kazakhstan

In Kazakhstan, health sector reform has become an urgent necessity in the face of the significant economic downturn in the 1990s, which led to steep reductions in health care budgets. The legal foundation for health reform was put in place in 1992 when the parliament passed the law on the Protection of the Population's Health, which included provision for national health insurance. In August 1994, the Ministry of Health (MOH) developed a five-to-ten year strategic vision for the health sector and elaborated a near-term action plan as part of the government's Program on Deepening Reforms. Five key areas of reform were targeted: (1) improving the organization and management of health care and its human resources, (2) restructuring health financing, (3) improving quality of care, (4) reforming and privatizing medical supply and pharmaceuticals, and (5) increasing scientific research capacity (Akanov 1999, see also Sharmanov et al. 1996).

Reform activities began with restructuring health sector management through decentralization to the oblast level, where in 1994-95 four oblasts began experimentation with health insurance mechanisms and new service delivery arrangements. These included the oblasts of Kokshetau, South Kazakhstan, West Kazakhstan, and Zhezkazgan. Based on these experiments the government issued a decree in June 1995 establishing a mandatory health insurance program, with a national fund and local offices in each oblast. Contributions to the fund are made by employers, government, and individuals. The establishment of the mandatory health insurance fund (MHIF) was accompanied by changes in how providers are paid—based on a capitated system, development of a basic benefits package—a contentious issue among members of the medical establishment, and by the creation of new primary care service delivery entities—family group practices. Hospital payments were also changed to a case-based system away from the old chapter budgeting that rewarded over-capacity.

FGPs constitute the major organizational innovation in the health sector reform strategy of reinverting the health care pyramid, and rationalizing service provision to concentrate on primary care. The senior medical staff of these primary care units consist of a pediatrician, an internist (called a therapist in the region), and a gynecologist; they are supported by practice nurses and a practice manager. FGPs are to be paid from the MHIF based on the capitation system, which will pay a fixed amount per person enrolled with the FGP. Under partial fundholding the FGPs provide primary care services and purchase diagnostic and outpatient specialty services. Under

eventual full fundholding, FGPs would receive funds to purchase inpatient hospital services for their enrollees as well.

Kazakhstan is a large country, and implementation has proceeded at different paces in various oblasts, with rural versus urban differences as well (Ensor and Rittmann 1997). Zhezkazgan, one of the original experimentation sites where one of the most forward-thinking health administrators in the country began testing new approaches in the early 1990s, is among the vanguards of health sector reform (see Telyukov 1996, Horst 1998). Concerning the shift to FGPs, 20 were created in Zhezkazgan City in 1995 and assigned a population of about 4,000 people each. It quickly became apparent that this number resulted in too many small, non-viable units, so through consolidation the number was reduced to nine with a catchment population for each of around 10,000. In March 1996 polyclinics were reorganized into FGPs, leading to creation of 47 FGPs. In 1997, 22 more FGPs were established, bringing the total in Zhezkazgan to 78. A public information campaign was conducted in March-May 1997, followed by an open enrollment campaign in December 1997, which sensitized the population to the new approach to primary health care, acquainted people with the various FGPs, and permitted them to sign them up for services wherever they wanted. A second open enrollment was held a year later. Gradually during the period 1995-97, the FGPs were privatized and purchased by their managing physicians. The vast bulk of their funding comes from contracts with the oblast MHIF.

The MHIF, recently renamed the Center for Health Purchasing Services, is at the hub of the reformed health financing system. The oblast fund uses financial and clinical information systems to track patient flows and referrals; debit and credit FGP, polyclinic, and hospital fund accounts; and monitor a set of health status indicators. These data feed into national level systems to assist the MOH in managing the health sector nationwide. At present, the allocation of resources to the fund comes from the government health budget, rather than from taxes on enterprises and employee contributions.

International donors are actively supporting Kazakhstan's health sector reform program. The World Bank is a major donor through its Health Reform Project. The United States Agency for International Development (USAID)-funded regional Zdrav*Reform* Program, now headquartered in Almaty, has provided assistance since mid-1994 that will continue until mid-2000. It operates in a number of demonstration sites around the country, one of which is Zhezkazgan, to support reforms in service delivery and financing; and at the national level to create the legal framework and public awareness necessary for successful implementation. Other assistance is provided by the World Health Organization (WHO), the European Union, and various bilateral donor agencies. Gradually reforms are beginning to spread from the various demonstration sites around the country. For example, a 1998 estimate put the number of FGPs nationwide at around 1200 (Abzalova et al. 1998).

2.2.2 Health Reform in Kyrgyzstan

Kyrgyzstan, like Kazakhstan, suffered an economic decline during the 1990s that created numerous problems across many sectors, including health. In 1992, the government enacted three laws that laid the legal groundwork for health reform: the People's Health Protection Act, the Medical Insurance Law, and the Sanitation Law. These laws called for priority attention to health promotion and disease prevention, an emphasis on primary care and family-based treatment,

privatization of health sector institutions, new financing arrangements, and the creation of a mandatory health insurance fund in each oblast. The government developed a ten-year master plan for health reform, with WHO assistance, that specified targets for the short, medium, and long term. The plan also unified previously piecemeal international assistance under a multi-donor umbrella program funded mainly by the World Bank: the Manas Health Care Reform Program (see Langenbrunner et al. 1994, WHO 1996, World Bank 1996, TICA n.d.).

The master plan's short-term objectives deal with establishing new sectoral priorities and rationalizing service provision so as to generate savings that can then be redirected to new uses. An important component focuses on consolidation of hospitals and reduction in the number of hospital beds. Pilot-testing of financing mechanisms and of FGPs is also included. Medium-term objectives continue the prioritization and rationalization processes, and concentrate on financing innovations, decentralization and hospital autonomy, information systems, and capacity-building for further implementation. The plan's long-term objectives envision the consolidation of earlier reforms, extension of primary care coverage via FGPs to the entire country, extensive use of purchaser-provider contracting, and the operationalization of social insurance and full fundholding (see Kasiev 1999).

The Kyrgyzstan Ministry of Health selected Issyk-Kul oblast as a demonstration site for health insurance and primary care provision through FGPs. A task force was established in 1994 to plan and oversee the experimentation. Similar to Kazakhstan, FGPs were formed by bringing together and retraining internists, pediatricians, obstetrician-gynecologists, intermediate and junior medical personnel, and managers to provide primary medical care to all family members from a single location. FGPs will eventually serve as fundholders, receiving funds through contracts with the oblast MHIF on a capitation basis, and will be responsible for providing primary care and for procuring emergency, specialty, and hospital care for their patients.

Beginning in 1995 in Karakol City and its surrounding rayons, the Issyk-Kul demonstration effort, supported by USAID's Zdrav*Reform* Program, led to the creation of 16 FGPs. Over the ensuing four years, the number of FGPs increased from 16 to 81. Currently 86 percent of the eligible oblast population is enrolled in FGPs, and referrals to polyclinics and hospitals by primary care physicians have been cut by 10 percent. In addition, hospital admission rates and length of stay have been reduced by 20 percent, and the number of hospital beds has been reduced by 10 percent. Twenty health care facilities in the pilot area have improved information systems and 12 local FGP managers have been recruited and trained to use these new systems.

The government is now multiplying the number of demonstration sites beyond Issyk-Kul to Bishkek City and Chui, Osh, and Jalal-Abad oblasts. Activities include: (1) development of FGPs; (2) formulation of new capitation provider payment methods; (3) creation of a case-based hospital payment system; (4) creation of a financial intermediary to pay FGPs and hospitals; and (5) organization of the necessary infrastructure for the new payment systems, primarily clinical and financial information systems. The Zdrav*Reform* team is providing technical assistance for this expansion. The project is replicating the Issyk-Kul model simultaneously in these new sites. As a result, 425 FGPs currently exist in Kyrgyzstan. Each is an independent entity registered with the Ministry of Justice. However unlike the status of their counterparts in Kazakhstan, the Kyrgyz FGPs have not been privatized. They are still part of the public sector, and many FGPs continue to be affiliated with or located in existing polyclinics.

3. NGOs and Health Sector Reform

An important component of Central Asian health sector reforms deals with redefining the role of the public sector in health care—e.g., from universal coverage to protecting vulnerable populations, from direct service provision to financing—and with restructuring service delivery in ways that make primary health care more cost-effective, flexible, and responsive. Semi-autonomous and privatized FGPs are the major new organizational entity intended to provide basic services. In support of these new entities, in both Kazakhstan and Kyrgyzstan NGOs have been established: Family Group Practice Associations (FGPAs).

To increase the efficiency and cost-effectiveness of the FGPs without sacrificing quality of care, physicians need an adequate level of clinical, financial, and administrative flexibility to find and develop innovative ways to provide primary care services. This shift requires a number of financial, technical, and training resources. As FGPs were formed, physicians began to see the need to organize themselves into an association through which they could receive material, financial, technical, and training support for the development of primary care. In addition they wanted a means to organize themselves to represent their views, concerns, and needs to policymakers.

3.1 FGPAs in Kazakhstan

The oblast-level experimentation with decentralized service delivery that led to the creation of FGPs also set the stage for FGPAs. The discussion here focuses on Zhezkazgan, the pioneer site where an FGPA was first established. The impetus for setting up the Zhezkazgan FGPA came from the oblast health department director, who had taken the lead in the reform process. In a meeting with the head physicians of the new FGPs, he suggested that they consider forming an association. The association would serve a number of functions: represent the interests of FGPs, identify common issues facing FGPs and develop solutions, serve as an interface between the government health sector and the private sector, facilitate resources to assist with reform implementation, and serve as a quality control over the operations of FGPs. The FGP physicians took the oblast health department director's advice, and in 1996 the Zhezkazgan FGPA was organized and officially certified as a non-governmental association by the oblast department of the Ministry of Justice in October of that year. At the FGPA's first annual general meeting in November, the attendees elected a president for a three-year term.

The international donors supported the creation of FGPAs because, unlike FGPs, as non-governmental associations they could receive donor grants, donations, and equipment. The Zhezkazgan FGPA provided a very direct organizational mechanism through which donors could provide resources to help to strengthen FGPs and have an impact on primary health care at the local level. USAID, through the Zdrav*Reform* Program, enlisted the Zhezkazgan FGPA in helping the FPGs to prepare for open enrollment and then in orchestrating the primary care public information and marketing campaign that culminated in the December 1997 open

enrollment. Subsequently, USAID and other donor resources have been funneled through the FGPA for training and equipment that has been distributed to the Zhezkazgan FGPs.

The Zhezkazgan FGPA plays a highly active role in the oblast health reform effort, working closely with government health services. The association's technical staff provide technical training for, and oversight of, family physicians in the region. For example, in cooperation with the oblast health department, the FGPA set up a traveling lecture series on "The Family Physician," conducted by the Kazakh Institute for the Advanced Training of Physicians with USAID funding. The association's technical staff are involved in direct service provision; for example, helping to organize inoculation campaigns and medical examinations for schoolchildren. The association has an important role in health data collection, monitoring, and reporting. The FGPA's pediatrician, for example, gathers information on children's health status for the city of Zhezkazgan; prepares monthly, quarterly, and annual reports that are submitted to the municipal health department; and convenes hearings of the committee on childhood mortality in cases of death due to negligence. The association also works with the oblast MHIF on the information system for tracking and analysis of activities and outcomes of the FGPs. Another role involves health services quality control. The FGPA collaborates with the MHIF on using the information system to monitor quality of services provided by FGPs. Independently, the association, through its internal oversight, regulates quality of care provided by its members.

The FGPA has engaged in some policy advocacy in favor of family medicine, primary care, and FGPs. The FGPA-led public information and enrollment campaign had an advocacy component along with its education function for Kazakh citizens; this relates to the reform goal of getting people to take greater responsibility for their own health and become more active participants in health care. The major instance of the Zhezkazgan FGPA performing an advocacy function was at the time that the oblasts of Karaganda and Zhezkazgan were merged in May 1997, which resulted in health officials in Karaganda having supervisory authority over those in Zhezkazgan. Bureaucratic politics among the health sector actors in the two oblasts created a situation where the reform in Zhezkazgan was criticized as a failure and a danger to the health of the population. The FGPA helped to publicly counter the misinformation and criticism, marshaled evidence in favor of the reform and its results, wrote letters and met with health officials and international donors, and rallied support for continuing the reform process. Overall, however, the FGPA's role in policy advocacy and lobbying has been relatively circumscribed and limited.

The Zhezkazgan FGPA is serving as a model for the establishment of associations in other cities and oblasts. The Zhezkazgan association has worked with FGPs in the nearby city of Satpaev to establish a FGPA there, which was officially registered in March 1998. In addition, people from other oblasts have contacted the Zhezkazgan FGPA for advice on setting up associations.

3.1.1 FGPA Financing

The charter of the Zhezkazgan FGPA indicates that its financing is derived from member contributions and grants from international organizations. To date, the association is almost completely dependent upon donor funds for its operations. USAID's Zdrav*Reform* Program supports basic administration and operations. The FGPA has won three grants that have provided

physician training and computer equipment and related training for FGPs. There are future plans for a formalized dues structure that member FGPs would pay based on some percentage of the capitation revenues received from the MHIF. This takes place currently on an ad hoc basis, but nothing concrete regarding formalization has been decided at this point. Another revenue source under discussion is fees for training and professional development activities organized by the FGPA for its members. As noted during interviews, however, FGPs are still struggling to establish themselves as financially viable service providers, and their capacity to pay the full costs of training and skill upgrading is extremely limited and likely to remain so for an extended period of time.

3.1.2 Structure and Organization of the FGPA

As provided for in its charter, the Zhezkazgan FGPA has an elected president, who designates an executive director and a manager. The heads of the nine municipal FGPs constitute a steering committee for the association; there is a plan for the future to set up a more formal board of directors. The association has a technical staff of four: a physician for adolescents, a pediatrician, a nursing supervisor, and a nurse in charge of inoculations. The manager handles day-to-day operations, working in close coordination with the president and the executive director. The association's management operates very much in a team mode, with little recourse to hierarchy. The president takes pride in her collaborative and open management style, a counterpoint to the old Soviet-era habits of directive and secretive administration. Budgets and financial information are shared with members on a regular basis. Weekly meetings for the membership are held every Tuesday.

3.1.3 Relationship Between the FGPA and the Government

As previously noted, the Zhezkazgan FGPA has a close relationship with government agencies in the health sector. These connections deal primarily with information provision and reporting. The association's president attends the weekly meetings of senior health facility managers convened by the Zhezkazgan city health department, where she reports on FGP activities, health status of covered populations, and other related issues. The FGPA's technical staff also provide information on indicators related to their areas of work: adolescents, young children, and inoculations.

Through these technical staff, the FGPA participates in direct service provision, and in a sense serves as an extension of the government health agencies in the city. Because of the downsizing that has taken place and the closing of public sector facilities, the FGPA is filling in with services that the state no longer provides. For example, the association's physician for adolescents evaluates the status of preventive and curative care, organizes medical examinations, and deals with the admission and transfer of adolescents within the school system. The nurse in charge of inoculations, for example, collaborates with the Sanitation and Epidemiological Station, a government entity, on preparation of immunization schedules and monitoring of inoculations done by FGPs. She provides reports to the Sanitation and Epidemiological Station and the oblast health department on a monthly basis. The FGPA staff also collaborate with various public sector educational institutions, such as the previously noted Kazakh Institute for the Advanced Training of Physicians, in providing training for FGP physicians.

The FGPA works closely with the MHIF as cited above. This relationship concerns mainly information provision and reporting, but association staff contributed as well to developing analytic tools for synthesizing and using the information. The FGPA on occasion lobbies the MHIF on behalf of the FGPs when capitation payments are late.

3.1.4 Relationship Between the FGPA and its Members

The Zhezkazgan FGPA's relationship with its members centers on capacity-building to help the FGPs make the transition to viable private providers of quality primary care services to families. The association has been instrumental in obtaining donor resources, through grants, for FGP strengthening. These resources have allowed FGP physicians to receive training, to purchase computers and lab equipment, and to train office managers and other technical staff. By convening discussions of the health reform and related issues among government officials, public sector health providers in hospitals and polyclinics, and FGP staff, the association has facilitated understanding of the reform and joint problem-solving among members. The FGPA is beginning to play a more forceful role in helping FGPs and family physicians identify issues of mutual concern and to become more of an interest group for lobbying and advocacy with government and other actors. The FGPA management is quite sensitive to the need to tread lightly in this area, citing the limited track record of FGPs, their nascent capacity, and powerful conservative interests who oppose the reforms (though usually not openly).

Another aspect of the association's relationship with its members deals with self-policing, regulation, and quality assurance. At present, as mentioned above, the FGPA monitors performance among its FGP members and in cases of problems seeks to resolve them. On occasion the association has issued warnings or reprimands, but on a very limited basis. The government would like to see this aspect of the association's activities formalized and strengthened in future.

3.1.5 The National FGPA

A national FGPA was established recently, in late 1998. Following a WHO-sponsored conference of the Association of Physicians and Pharmacists, a group of 25 doctors, who represented 10 oblasts, held an organizational meeting that led to the creation of the national FGPA and the election of officers. It is registered as an association of family practitioners; thus the members are individuals, not "juridical entities." According to the Ministry of Justice, the new national FGPA cannot incorporate existing local NGO associations—that is, the current FGPAs in the oblasts—but must create affiliates. The national association must have representatives from at least half of the oblasts in the country. At present the national FGPA covers its operating expenses from a small grant from the Royal College of General Practitioners in the United Kingdom, and the national-level MHIF is donating office space and use of a computer.

The nascent national FGPA is too new to have developed a program of activities, and much of its founding members' energies are directed toward resolving the legal and organizational issues concerning its relationship to local-level FGPAs. As one of the founders admitted, the

national association is still very weak, and needs to sort out these basic issues before it can proceed.

3.1.6 Role of International Donors

International donors have been critical both to the formation of FGPAs in the first place, and to their ability to function. As various observers have pointed out, the NGO sector in all of the FSU countries is weak and relatively undeveloped, and Kazakhstan is no exception. The international community has been the major interlocutor with the government on the role of NGOs and civil society in socioeconomic development and democratization (see Counterpart Consortium 1999). The Zhezkazgan FGPA depends heavily upon the funding and technical assistance it has received from USAID's Zdrav*Reform* Program, and the grants it has obtained from several international NGOs as well. Replication of the FGPA model in other oblasts, as well as the institutionalization of the national Kazakh FGPA, will require further donor assistance in the future.

3.2 FGPAs in Kyrgyzstan

In October 1995, a FGPA was established in Issyk-Kul oblast as part of the pilot project there and registered with the Ministry of Justice. The FGPA was established to support the restructuring of primary health care in Issyk-Kul oblast, the implementation of new incentive-based provider payment systems, and the development of FGP infrastructure and management. As reforms were rolled out to other oblasts, a national-level FGPA was formed in December 1996 following a competitive process to select a leader. The national FGPA was officially established and registered in October 1997, with the FGPAs in Issyk-Kul, Osh, and Jalal-Abad oblasts designated as affiliates.

The FGPA was formed with the purpose of assisting in all aspects of the formation and development of new FGPs. The FGPA Charter states that the FGPA is a nonprofit coalition of legal entities that has united health care system facilities on a voluntary basis, founded to coordinate efforts in the area of health sector reform, create conditions that favor the development and functioning of FGPs within Kyrgyzstan, ensure the protection and strengthening of public health, and improve the quality of primary health care. These latter functions provide a role for the FGPA, along with the Hospital Association and the Licensing and Accreditation Commission, in standard-setting and quality assurance.

The FGPA was spun off from the Ministry of Health's (MOH) temporary reform committee and the health coordination unit under the World Bank (the Manas Health Reform Project) as an NGO in order to enhance the sustainability of the reform process in the long term. Once the Manas Reform Project is concluded, the FGPA will continue to support FGPs under the newly reformed system with the long-term purpose of serving as an advocate for FGPs and providing services to FGPs, such as continuing education and the development of quality management techniques. The FGPA has been designed to gradually function more like an association, representing providers and providing services to members consistent with its mission statement.

During the start-up phase, the FGPA developed operational plans to guide its activities in support of health sector reform. However, the FGPA management team members soon realized that they needed a strategic plan to define their goals and vision. In June 1997, a Zdrav*Reform* Program consultant facilitated a workshop to discuss the Issyk-Kul FGPA's strengths and weaknesses, and to identify opportunities and threats in the association's operating environment. They used this strategic assessment as a framework to begin development of their mission, vision, critical issues, objectives, and strategies.

The national FGPA members incorporated this assessment into their own organizational development. In 1997, the national FGPA visited Issyk-Kul and met with the Issyk-Kul FGPA five times before they presented a clear concept of the vision and mission of their organization to the MOH and started a public awareness campaign about the reforms, the FGPs, and the FGPA. They visited all types of facilities, met with doctors all over the country, and presented the mission and functions of the FGPA.

As a result of these activities, with further Zdrav*Reform* technical assistance and continued dialogue with the MOH, the FGPA agreed to provide services to members and the health reform unit in the following six areas: FGP establishment (including formation, location, renovation, and equipment); clinical training; marketing and enrollment; financial and clinical information systems; ensuring understanding and effective implementation of new provider payment systems; and establishment of a viable legal framework for the existence and functioning of the FGPs.

After much dialogue between the Issyk-Kul and national associations, it was agreed that the oblast-level associations will be affiliates of the national-level FGPA, with the agreement that the national FGPA would set norms and standards while the oblast-level FGPA affiliates would act as implementing organizations. Each oblast FGPA will elect a representative to serve on the Board of Directors of the national FGPA, eliminating the need for separate boards of directors for each FGPA, such as the one that exists in Issyk-Kul oblast.

National FGPA workplans are developed annually and approved by the director of the Manas Reform Project Technical Coordination Committee. The workplans include a description of activities, proposed timing, and person(s) and organization(s) responsible for implementation. Next steps for the FGPA in 1999 include taking inventory and conducting a needs assessment of equipment in FGPs in Bishkek City and Issyk-Kul, Osh, Jalal-Abad, and Chui oblasts in order to help procure and distribute additional equipment needed by FGPs. In addition, the FGPA will work on training FGPs in concepts of clinical, managerial, and financial autonomy; and on explaining their rights under the new system regarding MHIF financing and relations between FGPs and the chief physicians of polyclinics and Central Rayon Hospitals to whom they currently report (in Bishkek City and Osh, Jalal-Abad, and Chui oblasts).

3.2.1 FGPA Financing

The FGPA charter states that the assets of the FGPA may be derived from initiation and membership fees, voluntary contributions and donations from local and donor organizations, and revenue from association activities, such as training, publishing, lectures, symposia, etc. Currently, the FGPAs are largely donor financed. The national FGPA is financed by the World Bank loan, while its affiliates in Issyk-Kul, Osh, and Jalal-Abad are financed by USAID's

Zdrav*Reform* Program. Small grants from international donor organizations have been sought and received by the FGPA and channeled to individual FGPs for equipment.

The national FGPA is working to improve sustainability of the FGPAs with plans for each FGP in the region to belong to the national association, and to pay dues from the capitated rate payment income they receive from the MHIF. Alternatively, the FGPA mentioned petitioning the MHIF directly for funding. The FGPAs will begin to receive funding from physicians for the first time in mid-1999 when they charge them a small fee for receiving their certification in family medicine. Other sources of revenue mentioned include grants for equipment and fees for all doctors in exchange for all types of training.

3.2.2 Structure and Organization of the FGPA

The charter and by-laws developed by the FGPA spell out its roles, responsibilities, and organizational structure. In general, the superior management body authorized to make decisions related to all association activities is an annual general meeting of association members. Zdrav*Reform* has been working with the FGPAs to establish an administrative staff responsible for the day-to-day management, as well as a voluntary board of directors to provide an advisory role. However, funding is not currently available for many of the staff positions that have been identified as necessary.

The FGPA in Issyk-Kul oblast has a functioning voluntary board of directors, with all members having a clear understanding of the distinction between the management functions of the staff and the governance and advisory functions of an independent voluntary board. The FGPA board participated in a training seminar in June 1998 that addressed the role of the president/chairperson, the role and number of the committees, and the role and number of staff employed. At the next board meeting, in order to clarify relationships, an organizational structure, procedures for appointments, and responsibilities/job descriptions for key positions were discussed and consensus was reached. These agreements were then written into a new charter document. This board likely will be dissolved, however, as many of its tasks now will be picked up by the national FGPA.

The national FGPA includes eight staff members appointed to serve on the board of directors, as well as three other elected board members. The practice managers in Bishkek and Chui also report to the FGPA currently as they are also supported by World Bank funding. After the national FGPA is re-registered, another election of board members is planned, with representation from each oblast on the board.

In October 1998, the national FGPA hosted the Issyk-Kul FGPA Board for two days to discuss conceptual issues as well as a national structure for the FGPA. The two associations discussed the development of a national FGPA structure including type of association (of “juridical entities,” that is, FGPs, or of individuals), its charter, board representation, and administrative staff functions. They agreed on the structure and charter and confirmed the separation of the board as a policymaking body from the administrative staff who will deal with the day-to-day management and implementation process. At this meeting the two associations agreed that a new national FGPA structure with affiliates in all oblasts, including Issyk-Kul, will

act as a catalyst for the development of FGPs and scaling-up of the Issyk-Kul model nationwide. This decision was not reached easily, largely because the FGPA in Issyk-Kul felt that the establishment of a national association risked recentralizing power that had already been devolved to the independent and autonomous FGPA in Issyk-Kul.

The new national structure means that existing FGPAs, originally registered with the Ministry of Justice as Professional Associations, must be re-registered with the Ministry as Associations, consisting of juridical entities and not individuals as members. The re-registration process involves closing the old association and opening and registering a new one. Under the new registration, the National FGPA in Bishkek will work with the 290 FGPs that have been formed in Bishkek City and Chui oblast surrounding the city. The Issyk-Kul oblast FGPA will work with 81 FGPs, while the Osh and Jalal-Abad FGPAs will support 28 and 26 FGPs, respectively.

3.2.3 Relationship Between the FGPA and the Government

Currently, the MOH has delegated authority to the national FGPA concerning the formation of FGPs. The Manas Reform Project within the MOH has officially devolved this authority to the FGPA through a 1997 resolution. In addition, the MOH and the national FGPA developed terms of reference to define its role in relation to government reforms. As mentioned above, the MOH would like eventually to delegate quality assurance and certification of physicians to the FGPA.

However, the authority of the FGPA is currently limited to an advisory role. FGPA recommendations are given to the MOH, which then issues *prekazi* (official procedural protocols) and resolutions based on these recommendations. The head of the national FGPA reported that with formal endorsement by the MOH of all FGPA recommendations and actions, the reforms are more sustainable.

The national FGPA in Kyrgyzstan works with the Manas Reform Project within the MOH and the MHIF, usually through the Joint Working Group (JWG), which includes all the major players in the health reform process. The JWG serves as a vehicle for health policy discussions and policy recommendations to the MOH, MHIF, Social Insurance Fund, finance ministry, and the government. The purpose of the JWG is to create a coordinated national policy framework for health sector reform, concentrating on the development of jointly-used systems. Many of the issues that arose in the reform process were addressed by the JWG, with the FGPA participating fully in these sessions. Consensus was built among all the key stakeholders and then reforms were implemented by the appropriate organization.

At the oblast level, FGPA affiliates work with oblast health departments and territorial MHIFs. The FGPA and oblast health departments meet regularly to discuss and agree on issues as well as to determine operational steps. The oblast health departments assign staff to work with FGPA staff on implementation. The polyclinics also play a major role in the formation of FGPs. Where FGPs are located within polyclinics, the FGPA interacts with polyclinic staff almost daily. The FGPA coordinates with the oblast MHIF, which as noted may have a role in financing the association as well as FGPs, and with the Social Insurance Fund, which is the major health tax collection and distribution organization in the oblast.

According to its charter, the FGPA also can lobby parliament on behalf of the FGPs. The FGPA members have not done this yet and feel that they first must build a strong foundation for the association and "prove" itself to ensure that it represents an "army of physicians" before lobbying the government on behalf of the membership. Currently they work with and through the MOH framework and are gaining the respect of the MOH, the FGPs, and physicians so that they have full support both from their government partners and their members before attempting to influence national policy.

3.2.4 Relationship between the FGPAs and their Members

The relationship of the FGPAs and their members focuses on resources identification and capacity-building: equipment procurement, clinical and management training, and organizational support. Initially, the FGPAs also provided information to the FGPs on the health reform process and made presentations on the range of services and support that the FGPA could provide for its members. Through these presentations, the FGPAs have clearly communicated their six main objectives to their members. In two FGPs in Chui oblast, physicians remarked that the FGPA had actively provided support for equipment procurement and in clinical training. In addition, they reported that the FGPA had introduced them to a new clinical information form and trained them in its use. Another type of relationship concerns regulation and quality assurance, as exemplified in FGPAs' role in physician certification.

3.2.5 Role of International Donors

Donors have played a central role in the creation and operation of FGPAs. Both USAID's Zdrav*Reform* Program and WHO encouraged the national FGPA to actively participate in the JWG and in health reform policy dialogue in general. USAID and WHO have also provided significant technical assistance in the formation and development of the national and oblast FGPAs. Zdrav*Reform* staff and consultants have worked with the FGPAs to conduct environmental assessments, including SWOT analyses, and provide assistance in defining the role and organization of a voluntary board of directors. WHO provides monitoring and evaluation of health sector reform in Kyrgyzstan based on the master plan for reform they helped the MOH develop between 1994-96. WHO missions evaluate progress made towards implementing the master plan twice a year and make recommendations to the FGPA on how they can actively continue to implement the reform actions for which they are responsible. Personnel from the U.S. NGOs Counterpart Consortium and Mercy Corps trained the Issyk-Kul Board of Directors in how to develop a business plan and raise funds, and how to plan and implement other NGO capacity-building activities.

4. State–NGO Partnership for Health Reform

This section looks at Kazakhstan's and Kyrgyzstan's FGPAs in terms of the features of state–NGO partnerships elaborated above. It highlights some issues related to the successful operation of the health sector reform partnerships in the two countries.

4.1 Defining Objectives, Roles, and Responsibilities

As this study has shown, the creation of FGPAs in both countries emerged from the search within health care reform for alternative modes of service delivery in a context of public sector downsizing and cutbacks. The state, with international donor assistance, was a major force in setting up FGPAs. The issue of meshing potentially conflicting state–NGO objectives that could emerge if the partnership sought to involve an already existing association in supporting and representing FGPs did not arise precisely because the government initiated the establishment of FGPAs. This situation goes against the assumption often made that NGOs, as members of civil society, are countervailing and independent entities vis a vis government, whose decisions to enter into partnerships with the state are taken in consideration of their own interests. However, the logic behind the government-initiated creation of FGPAs in Kazakhstan and Kyrgyzstan and the resulting health reform partnership fits with the bureaucratic culture of Central Asian governments, which owes much more to the state-led Soviet and European corporatist models than to free market economic principles (see Anheier and Seibel 1998).

The roles and responsibilities for FGPAs were defined as a function of three factors:

- The redefinition and subsequent downsizing of the role of the public sector in health care, including the separation of service provision from financing;
- The resulting emergence of a new government role in regulation and governance; and
- The resources and influence of international donors in pushing for reform. Privatization and a diminished role for the state opened up space for FGPs and associations of FGPs in support of their operations.

Devolution of some regulatory functions and shared approaches to quality assurance and monitoring brought FGPAs new roles and responsibilities not just for helping to create FGPs and build their capacity, but in setting quality-of-care standards, monitoring performance, and accrediting health care providers. Donor resources and technical assistance have been instrumental in allowing FGPAs to fulfill these new roles and responsibilities. These have been important not simply in launching the partnerships, but in providing the means to enable the associations to demonstrate to government officials that they can be effective partners in health sector reform.

Although nominally both the Kazakh and Kyrgyz FGPAs' roles include aggregating and representing the interests of their members, and lobbying for policy and procedural changes in support of those interests, to date in neither country has this role induced much advocacy activity. The case study shows in fact that the associations have for the most part explicitly steered clear of advocacy and lobbying in favor of capacity-building and participation in service delivery. An intriguing question for the future is the extent to which conflicts in partnership objectives might emerge when and if FGPAs become more active—possibly even confrontational—in pursuit of their advocacy role. Can this role be pursued in a way that is compatible with FGPAs' current responsibilities in health service delivery and governance?

4.2 Linkage Mechanisms

Existing linkages between the state health system and FGPAs and FGPs can be roughly classified into four categories: information provision, technical and implementation support, policymaking support, and advocacy. In the case of Zhezkazgan in Kazakhstan, linkages concentrate on information provision and technical support for implementation. The FGPA reports regularly to the city health department and to the insurance fund on services provided, health status of the population, etc. The FGPA president in Zhezkazgan attends city health committee meetings, but more as a source of information for government management of health programs than as a participant in setting health policy. The FGPA's staff are intimately involved in technical and implementation support to the point of participating directly in service delivery in dealing with adolescents in schools and with inoculations. Apart from the one-time lobbying effort in favor of reform when Karaganda and Zhezkazgan oblasts were merged, advocacy linkages appear minimal to non-existent at present.

The case of Kyrgyzstan is similar at the oblast level. There, the FGPs have not yet been privatized, and their information provision and service delivery linkages with the public sector are direct and very tight. If the Kazakh case is anything to go by, these linkages will not change very much after privatization, since the resources for FGPs come almost exclusively from the MHIFs, and the FGPs function as implementors of government health policy. The Issyk-Kul FGPA has strong technical and implementation support linkages to the public sector as well, helping to extend health care outreach by creating new FGPs and increasing the capacity and skills of existing ones. The national FGPA participates in the implementation of the Manas reform program and further is a key actor in the JWG, which gives it links to setting as well as implementing health policy. As noted earlier, the national FGPA eschews policy advocacy linkages in favor of helping its members do the best job possible in reform implementation.

In both countries, linkages between FGPAs and their members focus mainly on information provision, technical support and training, identification of equipment needs and possible sources, facilitation of grants, etc. Efforts to organize members for input to the policy process or to develop advocacy positions and strategies on particular issues are in the very nascent stages and were discussed in interviews as a component of future plans once FGPs have a longer track record, a stronger reputation, and a more secure status.

4.3 The Legal Framework for Partnerships

An important element in determining FGPA roles and responsibilities, and the linkages between the state and the FGPA concerns the legal framework for NGOs. All the Central Asian republics share common elements of a legal framework for NGOs based on the old Soviet law on Public Associations, and most have begun to revise their laws to facilitate NGO formation and operation. Kazakhstan is the farthest along in this process, having adopted a new civil code and developed new and improved implementing legislation. Registration procedures are still relatively complex, but the number of NGOs in the country is growing. Kyrgyzstan has the reputation of being the most liberal of the republics and the most open to the growth of civil society. However, its legal framework is in need of changes to better enable NGOs to be established and to function effectively; a number of changes are currently in process.

In both Kazakhstan and Kyrgyzstan, the operational parameters of NGOs under each countries' laws contributed to the determination of the roles, functions, and membership criteria of the FGPAs. For example, under Kyrgyzstan law, NGOs can be registered either as Professional Associations or Associations. Professional Associations have individuals as members, and are intended to further the aims of these individuals in the areas of professional development, religion, politics, and social issues. They cannot receive any government money or be delegated any government functions. Associations have legal entities as members, can receive government money, and can be delegated government functions. Professional Associations are regulated by the fairly restrictive law on public organizations, while Associations are covered under the broader civil code and have more flexibility.

An assessment of these legal options led to the choice that the FGPAs should be registered with the Ministry of Justice as Associations, with FGPs as members. As noted above, this means re-registering some of the oblast FGPAs to change their legal status. In practice, having FGPs as members means that the FGPAs can be delegated more authority from the government and have a broader membership base. The MOH plans to delegate quality assurance programs and the certification of physicians to the FGPA. This delegation of authority to a Professional Association would not be possible under the law on public organizations, where public associations act mostly as trade unions. Having FGPs as members also broadens the involvement of non-physicians within the FGPs.

4.4 From Service Delivery to Policy Advocacy?

The government-FGPA partnership in health reform is strongly centered around service delivery and reform implementation. This flows naturally from the circumstances of the state-led creation of both the FGPAs and the partnership. Three generations of Soviet rule have created far more rules-minded, risk-avoiding, and control-oriented bureaucrats in all sectors than risk-taking, competitive, and/or confrontational entrepreneurs. As FGP medical personnel and FGPA members, health sector professionals are much more comfortable as subordinate partners in a state-driven reform process than in competition or confrontation with the state health establishment. Given the power differentials, they are understandably cautious, and as the institutional "new kids on the block," are anxious to gain the respect and support of those in positions of authority and power before considering anything of a challenging nature. The push and pull of interest-based policymaking and sectoral politics is unfamiliar territory to all

concerned, both state and civil society actors. When donors talk of FGPAs as health policy advocates and representatives of an emerging voice of civil society in policy dialogue, they are speaking less of what is than of what may evolve in the future.

In Kazakhstan, the Zhezkazgan FGPA's efforts at the time of the oblast merger to maintain momentum for health reform when Karaganda officials were questioning its utility and accomplishments show that a potential for policy advocacy exists. Through their actions in support of reform and their participation in the public information campaign for FGP open enrollment, FGPA members in Zhezkazgan have gained experience in crafting policy messages and mobilizing opinion. This experience, although limited, at least contributes to beginning to build a base for greater participation in policy dialogue and advocacy at some later date.

Based on civil society experience elsewhere, associations like FGPAs hold the potential to help bridge the power differences between the state and non-governmental groups (see Brown 1998). However, certain features of the Central Asian republics' administrative and political environment make the bridging task particularly difficult (see Hensher 1999). Power and decision making remain highly centralized, and there is a tendency to focus on immediate crises rather than long-term sectoral planning; thus, associations do not have access to decision makers and/or risk being seen as irrelevant unless directly linked to dealing with a crisis. Ethnic divisions are sources of tension and potential conflict, and associations must pay attention to how they are perceived by both government and their members in these terms. Privatization and free market economic principles are still not universally accepted, so associations need to be careful to avoid accusations that they represent venal or possibly corrupt interests, and that they are promoting inequities. The notion that private entities can serve the public good is not well understood (see McPake 1997). Further, there is the possible danger that reforms underway now could be reversed. In sum, it is not surprising that FGPAs are hesitant to move quickly or forcefully in the direction of policy advocacy.

5. Conclusions and Lessons Learned

This case study did not set out to formally assess the status of health care reforms in Kazakhstan and Kyrgyzstan, but in both countries it appears that substantial progress is being made. Interviews conducted for this study and documents reviewed point to commendable advances in transitioning to new service providers for primary health care, new health financing and provider payment mechanisms, and new working relationships between government health agencies and non-governmental entities (see Telyukov 1996, Hauslohner 1997, Abzalova et al. 1998, Horst 1998, Savas 1998/1999, and Purvis and Alymkulova 1999). The implementation partnerships that bring together the public sector with FGPAs and FGPs are working in Kazakhstan and Kyrgyzstan. They are still in their early stages and as recounted above some problems exist, but overall the story is a positive one.

5.1 Lessons Learned

Several lessons can be identified from the experience in Kazakhstan and Kyrgyzstan of setting up FGPAs and partnering them with government for health sector reform. These lessons are for the most part preliminary, however. These two country experiences, and those of the other Central Asian republics undertaking health sector reforms, warrant ongoing monitoring and analysis, both to confirm the validity of the preliminary lessons listed here and to identify and discuss others.

- **An enabling legal framework**. This study reinforces a lesson flagged by other analyses in a variety of sectors. A supportive legal framework is central to supporting the emergence of viable NGOs and a vibrant civil society, and to creating effective partnerships. Complex and excessively bureaucratic registration procedures, tax status issues, and the implications of membership distinctions (e.g., individuals vs. juridical entities) must be confronted in establishing and operating NGOs in Central Asia. The two cases clearly demonstrate how the legal options and constraints for FGPAs shaped what their roles in the reform process could be, and influenced the nature of their linkages with government and their members.

- **Path dependence, or the weight of the past**. Organizations everywhere are highly path dependent, which means that how they function today is strongly influenced by their historical evolution and past behaviors and capacities. In terms of state–NGO relations, as exemplified by the FGPAs and their member FGPs, the weight of the past hangs heavily over how the state interacts with these new entities. Pluralist notions of operational autonomy and independent policy input into the reform process, while subscribed to in principle within the context of donor-supported health sector reform, appear to be little respected and/or ill understood by government officials. Although the external trappings of new organizations and new modes of interaction may be in place, institutionalizing them will take more time and resources than may be anticipated.

- **Champions for change**. The health reforms underway are a substantial shift from the status quo, including the new non-governmental partners in health care that the reforms create. The successful initiation and continuation of the reforms in general and the FGPAs in particular depend upon the actions of key individuals, and groups, who are champions for change. Without such champions, it is difficult for reforms to get off the ground, as the experience with the failed demonstration sites in Kazakhstan showed. This lesson represents health sector-specific confirmation of a lesson that holds for policy reform across a wide range of sectors regarding the importance of policy champions and supportive stakeholders.

- **Top-down NGO creation**. NGOs established by government agencies with donor support will pursue objectives that fit closely with the desires of their creators. Particularly in FSU countries, where civil society is underdeveloped for the most part, NGO actors have limited experience with alternative models of action. Further, the Soviet tradition of state-created and controlled associations for various social purposes reinforces the top-down mentality. It is not surprising that in Kazakhstan and Kyrgyzstan the FGPAs and FGPs act as extensions of the public health system despite their non-governmental and privatized status. Just because the FGPAs are non-governmental does not necessarily make them countervailing sources of influence and limitation on state power. Whether FGPA leaders will want, or be able, to move the associations in that direction is an open question.

- **Partnership power differences**. In partnerships where the state holds the vast majority of power, the NGO partners are unlikely to be anything but docile and cooperative. In both countries, the FGPA and FGPs tread warily in the partnership, mindful of the need to build up a positive reputation, and of the dangers of being criticized for negative health outcomes. In both countries, it is clear that a partnership with the state exists, but it is not fully a two-way street; rather, the power relationship is heavily weighted in favor of the state.

- **New incentives**. Despite the fact that FGPAs and FGPs are government and donor creations, and that they are clearly on the weak side of the power equation in the health reform partnership, the people operating within these new entities are behaving differently in response to new incentives than they did formerly as members of the public sector health establishment. Health personnel in FGPAs and FGPs feel emboldened and empowered to take on the challenges of reform. The flexibility, autonomy, and responsiveness that the non-governmental structures offer have made a difference in the speed and effectiveness of primary health care services reform. These preliminary outcomes offer promise that the new partnership model is viable and valuable.

- **Capacity and sustainability**. The cases show that NGO capacity can be created using facilitative technical assistance and external resources. USAID’s Zdrav*Reform* Program has been instrumental in helping the FGPAs to become operational, to function as partners in reform implementation, and to think strategically about the future. However, sustainability is a concern once donor support is terminated. Donor expectations for the ability of FGPAs to become self-supporting are over-optimistic. The assumption that FGPA members will keep the associations going without outside help and infusions of funds after a few more years is a faulty one. The NGO sustainability problem is not

specific to the health sector, but appears in numerous civil society organizations in the FSU, Eastern Europe, and the developing world. Particularly given their top-down creation, FGPAs will need more time to build a reputation among their membership for value-added, such that members will be willing to contribute their own scarce resources to make the associations sustainable.

- **Federated structures**. A very interesting feature of the cases is the evolution of federated NGO structures as a mechanism both to deal with the decentralized nature of health reform implementation, where the partnership exists at both the national and oblast levels, and to facilitate effective NGO governance across levels. In both countries, FGPAs were initially formed at the oblast level as one of the institutional innovations in the health reform demonstration sites. National FGPAs came later, and in the Kyryzstan case the oblast FGPA voluntarily agreed, despite some misgivings, to become an affiliate in a federated association rather than maintain its independence. It appears that a similar path is likely in Kazakhstan. Federated structures on the NGO side of the partnership are likely to provide a better fit with the decentralized public sector structures because they allow for integration of national and oblast activities while at the same time permitting adaptation and autonomy locally. Experience has shown that federated structures can increase efficiency through coordination, enhance quality through accreditation and standardization, decrease the possibilities for hiding corruption, and increase the possibilities for learning. Federated structures are also the most effective means by which the needs and views of local groups and/or organizations can be represented at the national level. The prospects for the FGPAs achieving these potential benefits will depend on how these federations evolve. There is a danger that in keeping with Soviet tradition, the national FGPAs may become a bureaucratic layer of control rather than a clearinghouse for innovation and/or a national hub of support and representation.

5.2 Prognosis for the Future

The FGPA case study provides evidence that the approach to NGO formation and interaction in health reform policy implementation being applied in Kazakhstan and Kyrgyzstan is leading to effective partnerships. This model includes:

- Initial government support and donor financing for the establishment of a non-governmental association of primary health care practices;
- The development of short-term goals to help implement health reforms and support formation of FGPs, paired with the development of long-term goals to provide services to members; and
- The creation of sustainability plans that work to create eventual demand for (and financing of) these services from members of the association themselves.

The FGPAs seem to be moving in the right direction. They should be both commended for their achievements to date, and encouraged and enabled to function more as independent NGOs in the future.

The reasons for exploring partnership models of health sector reform that involve NGOs are both instrumental and value-based. On the instrumental side, NGOs can potentially bring flexibility, responsiveness, adaptability, and efficient and effective performance. Given the operational limitations of the highly bureaucratic, rules-driven, and control-oriented public institutions in both Kazakhstan and Kyrgyzstan, the inheritance of their Soviet past, these instrumental pluses can be very important for making progress with the reforms, as the two FGPA experiences demonstrate. The case study also shows that the nature of the linkages with the state can limit the extent to which these positive features can come into play, however. It suggests the need for further attention to assuring that government officials understand the benefits to be derived from facilitative and supportive linkages with FGPAs and FGPs.

The value-based reason for a model that incorporates NGOs into health sector reform is the contribution to democratization. Creating and strengthening NGOs increases opportunities for citizens to participate in decision making and action relating to policy formation and implementation. Thus NGOs are critical to developing new patterns and practices of governance, particularly in situations such as the Central Asian republics, where historically the state has been the major actor in all aspects of civic life (see, for example, Counterpart Consortium 1999). The empowerment that the FGPAs have created for health care providers, accompanied by the increased confidence among their members to take responsibility and initiative in providing health services, is an important benefit of this model. Another benefit is the increased openness of government to informational input from non-governmental and private entities in the formulation and implementation of health policy. As FGPAs and the state collaborate, over time it can be expected that increased trust and confidence in the relationship will grow, and that government openness to policy advocacy will increase as well. Worldwide experience suggests that sectoral policy reforms can contribute to democratization and improved governance by creating opportunities for participation, accountability, and transparency that advance the larger societal transformation process toward more democratic governance (Brinkerhoff 2000).

Annex A. Defining NGOs

A question that emerged during the data collection for the case study is whether or not FGPAs are "real" NGOs. What defines NGOs is a question has been widely debated among both analysts and practitioners, and has led to elaborate taxonomies and/or convenient labels that attempt to capture gradations of "non-governmental-ness" and "authenticity." Common examples include: BINGOs (big international NGOs), QUANGOs (quasi-NGOs), GRINGOs (government-run and initiated NGOs), and GONGOs (government-owned/organized NGOs), to name a few (see Fowler 1997: 32). Brown and Korten's typology distinguishes between voluntary NGOs and PSCs (public service contractors), which are NGOs that operate as nonprofit service providers with governments and/or donors as clients (1991: 62). Such approaches to definition are illustrative of the diversity of NGOs and highlight the danger of superficial use of the NGO label, but are less than useful for comparative analysis and for drawing lessons across cases.

A structural-functional definition may better describe the FGPAs as NGOs (and even the FGPs as private sector entitities), and may be more helpful operationally than a definition based on legal terminology or some other criteria. The legal frameworks for the nonprofit sector in the FSU countries are in an ongoing state of development, and elaborate legal and regulatory distinctions among types of organizations and categories of activities/functions that make it difficult to classify FGPAs and FGPs along the lines of NGOs or private sector entities as understood in Western legal frameworks. This suggests that for purposes of classification and comparative analysis, the legal definition should be complemented by a structural-functional definition that incorporates how the entities are organized and what they do. One structural-operational approach to definition, used by the Johns Hopkins University Comparative Nonprofit Sector Project, identifies five key features of non-governmental entities (see Salamon and Anheier 1997). These entities are:

- Organized, that is, institutionalized in some formal sense. This can mean legal incorporation under various statutes, or at a minimum having a structure, a mission/charter, officers, staff, and procedures.
- Private, meaning institutionally separate from government as identifiably distinct entities.
- Non-profit distributing, that is, not returning profits to owners, directors, or members for private gain. Non-governmental entities can accumulate profits, but their missions mandate that these proceeds be used to further their programs and purposes.
- Self-governing, that is, possessing governance structures and procedures that allow them to control their own activities.
- Voluntary, meaning that members demonstrate some degree of voluntary participation in the activities or management of the entity.

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