### I. Project Context

**Country Context**

The Kyrgyz Republic is a low-income country with a population of around 5.4 million people. In 2010, the gross national income (GNI) per capita was US$880 (Atlas method). The country, which is landlocked and mostly mountainous, relies heavily on agriculture, including cotton, tobacco, wool, and meat. Gold, agricultural products and hydro-power comprise most of the country's exports. Broad systemic reforms have created the foundations of a market economy. Despite pro-poor growth, which averaged 5.4 percent annually over the five years to 2009, the Kyrgyz Republic remains one of the poorest countries in the world, with about 32 percent of people living below the poverty line and 3 percent below the extreme poverty line.

### II. Sectoral and Institutional Context

The first health sector strategy adopted in 1996, and known as Manas, improved the efficiency of service delivery, but did not have an impact on population health status (including child and maternal health), or financial protection and equity. These issues became the priority goals of the second phase of health system reform, which was developed in 2005 and is known as Manas Taalimi. This sector-wide approach (SWAp) program, supported by pooled budget funding from Joint Financiers (including the World Bank under the ongoing Health and Social Protection Project), and parallel financing from other development partners, is the first large-scale SWAp in the former Soviet Union countries. The program funds critical inputs for the health sectors and focuses on: (i) improving health outcomes, especially those related to the Millennium Development Goals (MDGs); (ii) strengthening public health; (iii) enhancing the capacity of the institutions involved in policy formulation, planning, budgeting, and M&E; and (vi) improving the quality of care with a specific focus on maternal and child health (MCH), cardiovascular and respiratory diseases, TB and HIV/AIDS.

The May 2008 mid-term review of Manas Taalimi showed that the program has reduced people's financial burden related to health care, improved their access to health services, increased the population's utilization of health services, and enhanced the transparency and efficiency of public expenditures on health. However, progress in health outcomes under Manas Taalimi has been either slow or regressive, especially in maternal and child health. In 2009, the maternal mortality ratio (MMR) was 55 per 100,000 live births # slightly higher than the period prior to the Health SWAp where it stood at 49 per 100,000 live births (2003 est.). Infant and under-five mortality rates, although slightly improved, still remain high. The Infant mortality rate (IMR) has gone down from 43 per 1,000 live births in 2000 to only 27 in 2009, while the under-five mortality rate (U5MR) was reduced during the same period from 50 to 35 per 1,000 live births. Further, the share of peri-natal deaths in child mortality is as high as 70 percent. While these outcomes may not seem high in relation to some countries, they are among the highest in countries of the former Soviet Union and in Central Asia. More importantly, the Kyrgyz Republic is widely off track in meeting its Millennium Development Goal (MDG) targets for MMR (15.7 by 2015), IMR (8.5 by 2015) and U5MR (10.4 by 2015).

### III. Project Development Objectives

The Project Development Objective is to (1) pilot performance-based payments and/or enhanced supervision for quality of maternal and neonatal care in randomly selected rayon hospitals; and (2) strengthen the Government’s and providers’ capacity in performance-based contracting and monitoring and evaluating for results.

### IV. Project Description

**Component Name**

- Component 1: Pilot Performance-Based Payments and Enhanced Supervision for Quality of Care
- Component 2: Strengthen the Government’s and Providers’ Capacity in Performance-Based Contracting and Monitoring and Evaluation for Results
V. Financing (in USD Million)

<table>
<thead>
<tr>
<th>For Loans/Credits/Others</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borrower</td>
<td>0.00</td>
</tr>
<tr>
<td>Health Results-based Financing</td>
<td>11.00</td>
</tr>
<tr>
<td>Total</td>
<td>11.00</td>
</tr>
</tbody>
</table>

VI. Implementation

Institutional and implementation arrangements for the Project will build upon those in place for the ongoing Health and Social Protection Project. These arrangements have been in place for over five years, and the Government has gained substantial experience and built strong capacity for implementation. The MOH will be responsible for overall implementation, with the support of the RBF Secretariat, which will be established and financed under the Project to coordinate the various national and rayon-level instances that are involved in implementation.

At the national level, the MOH will be responsible for overseeing the overall policy decision-making framework and for ensuring overall coordination of the Project through its Department of Strategic Planning. The MOH will also handle the disbursement and accounting functions under Component 2 of the Project. The MHIF will consolidate the reports. The MHIF will be responsible for purchasing health care services from providers through signed contracts, stipulating quarterly disbursement of funds based on performance, as authorized by the Extended RBF Operational Team. The MHIF will also handle the funds flow, accounting, and disbursement functions under Component 1, as well as consolidated reporting with the support of the RBF Secretariat. A National Steering Committee (NSC), a RBF governance body, will be comprised of representatives from the MOH, MHIF, MOF, and will be responsible for the full oversight of the Project. The NSC will be the policy decision-making body on all RBF-related matters, including regulating the size of performance-based payments and establishing the rules required for implementing RBF. An Extended RBF Operational Team will be comprised of an RBF Secretariat, an Implementation Team, and a representative from the Impact Evaluation Team (the Impact Evaluation Coordinator). The Team will be responsible for the overall coordination of the Project. The RBF Secretariat, housed in the MOH and supported with project funding, will be responsible for the day-to-day Project implementation. The Secretariat will have both a technical and a managerial function. The Implementation Team, including representatives from the MOH, the MHIF, professional associations, NGOs, and development partners, will work closely with the RBF Secretariat, meeting monthly to coordinate Project implementation, serving as observers during quarterly peer verifications, and participating directly in the counter-verification team. Finally, the Evaluation Team, led by an Impact Evaluation Coordinator who will participate in the RBF Secretariat and Implementation Team, will coordinate the work for the Impact Evaluation, and will take the lead in generating the RBF evidence base for decision making by the MOH and the MHIF leadership.

At the rayon level, 40 randomly selected service providers, i.e., the rayon level hospitals management and staff structures, will participate in the Project. Twenty service providers will be included in either Group 1 or Group 2 of the pilot by annually signing service agreements based on the BSC. PHC facilities within the Chui rayon will participate through their management and staff structure, under service agreements signed annually starting 18 months after Grant effectiveness. Peer Verification Teams will comprise representatives of rayon hospitals participating in Group 1 or Group 2 of the Project, other than the hospital whose performance is being evaluated. A senior clinician, chief nurse and chief accountant, one of each from two rayon hospitals, will work with technical staff from the regional MHIF quality department and a team member from the Extended RBF Operational Team (who will have observer status) on the Peer Verification Team. A Counter-verification Team will comprise an extended team that includes representatives from the MOH, the MHIF, civil society, NGOs, development partners and professional associations.

VII. Safeguard Policies (including public consultation)

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

VIII. Contact point

World Bank
Contact: Son Nam Nguyen
Title: Senior Health Specialist
Tel: 458-9228
Email: snguyen@worldbank.org
Borrower/Client/Recipient
Name: Ministry of Finance
Contact:
Title:
Tel: (996-312) 661-350
Email:

Implementing Agencies
Name: Ministry of Health
Contact:
Title:
Tel: 996-312662-680
Email:

IX. For more information contact:
The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop