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Report No: 73526-KG

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 5.9 MILLION
(US$9.07 MILLION EQUIVALENT)

AND
PROPOSED GRANT

IN THE AMOUNT OF SDR 4.9 MILLION
(US$7.43 MILLION EQUIVALENT)

TO THE

KYRGYZ REPUBLIC

FOR A

SECOND HEALTH AND SOCIAL PROTECTION PROJECT

April 8, 2013

Human Development Sector Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective: January 2013)

Currency Unit	=	Som
47.40 Soms	=	US$1
US$1.54	=	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AMI	Acute Myocardial Infarction
APW	Annual Plan of Works
CAS	Country Assistance Strategy
CDC	Centers for Disease Control
CDF	Comprehensive Development Framework
CHD	Coronary Heart Disease
CME	Continuing Medical Education
CPSR	Country Procurement Status Review
CVD	Cardiovascular Disease
DCS	Disability Certification Service
DHS	Demographic and Household Survey
DPL	Development Policy Loan
DPO	Development Policy Program
DPs	Development Partners
DS	Den Sooluk
EBM	Evidence-Based Medicine
EMF	Environmental Management Framework
EMP	Environmental Management Plan
FGP	Family Group Practice
FM	Financial Management
FMC	Family Medicine Center
GAAC	Governance and Anti-Corruption Action Plan
GDP	Gross Domestic Product
GMI	Guaranteed Minimum Income
GOK	Government of the Kyrgyz Republic
HIV	Human Immunodeficiency Virus
HPAP	Health Policy Analysis Center
ICC	Inter-sectoral Coordination Committee
ICT	Information and Communication Technology
IDA	International Development Association
IDUs	Injection Drug Users
IFA	Integrated Fiduciary Assessment
IM	Infant Mortality
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
ISN	Interim Strategy Note
ISR	Implementation Supervision Report
JAF	Joint Assessment Framework
JAR	Joint Annual Review

JFs	Joint Financiers
KfW	Kreditanstalt für Wiederaufbau
KIHS	Kyrgyz Integrated Household Survey
KISSP	Corporate Social Protection Information System
MCH	Maternal and Child Health
MBPF	Monthly Benefit for Poor Families with Children
MDG	Millennium Development Goals
MDRTB	Multi Drug Resistant Tuberculosis
MHIF	Mandatory Health Insurance Fund
MMR	Maternal Mortality Rate
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTBF	Medium-term Budget Framework
MSB	Monthly Social Benefits
MSD	Ministry of Social Development
NGOs	Non-governmental Organizations
PFM	Public Finance Management
PP	Procurement Plan
PPL	Public Procurement Law
PPMD	Public Procurement Methodology Department
PRS	National Poverty Reduction Strategy
PHC	Primary Health Care
OSCE	Organization for Security and Co-Operation
PIU	Project Implementation Unit
POW	Program of Work
PPL	Public Procurement Law
RHIC	Republic Health Information Center
SGBP	State Guaranteed Benefit Package
SDC	Swiss Agency for Development and Cooperation
SES	Sanitary Epidemiological Services
SWAp	Sector-Wide Approach
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Vice President:	Philippe Le Houérou
Country Director:	Saroj Kumar Jha
Country Manager:	Alexander Kremer
Sector Director:	Ana Revenga
Sector Manager:	Daniel Dulitzky
Task Team Leader:	Nedim Jaganjac

KYRGYZ REPUBLIC
Second Health and Social Protection Project

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PAD DATA SHEET

Kyrgyz Republic

Second Health and Social Protection Project (P126278)

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

ECSH1

Basic Information			
Project ID	Lending Instrument	EA Category	Team Leader
P126278	Investment Project Financing	B - Partial Assessment	Nedim Jaganjac
Project Implementation Start Date		Project Implementation End Date	
04-May-2013		31-Dec-2018	
Expected Effectiveness Date		Expected Closing Date	
30-Oct-2013		31-Dec-2018	
Joint IFC			
No			
Sector Manager	Sector Director	Country Director	Regional Vice President
Daniel Dulitzky	Ana L. Revenga	Saroj Kumar Jha	Philippe H. Le Houerou

Borrower: Kyrgyz Republic	
Responsible Agency: Ministry of Health	
Contact: Health Policy Analysis	Title:
Telephone No.: 996-663707	Email: ch_abdrahmanova@mz.med.kg

Project Financing Data(US$M)		
[ ] Loan	[X] Grant	[ ] Other
[X] Credit	[ ] Guarantee	

For Loans/Credits/Others	
Total Project Cost (US$M):	1369.70
Total Bank Financing (US$M):	16.50

Financing Source	Amount(US$M)
BORROWER/RECIPIENT	1327.10
International Development Association (IDA)	9.07
IDA Grant	7.43
Bilateral Agencies (unidentified)	26.10
Financing Gap	0.00
Total	1369.70

Expected Disbursements (in USD Million)

Fiscal Year	2014	2015	2016	2017	2018	2019			
Annual	2.00	3.50	4.50	4.30	2.00	0.20			
Cumulative	2.00	5.50	10.00	14.30	16.30	16.50			

Project Development Objective(s)

Proposed Development Objective(s)

The proposed PDO is to: (i) improve health outcomes in four health priority areas in support of the "Den Sooluk" National Health Reform Program 2012-2016; and (ii) enable the Government's efforts to enhance effectiveness and targeting performance of social assistance and services.

Components

Component Name	Cost (USD Millions)
Component 1 – Support for implementation of Den Sooluk program of reforms	13.50
Component 2 – Strengthening the Policy and Administrative Capacity of the MSD	3.00
Component 3: Contingency Emergency Response (no funds allocated)	0.00

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	X	
Natural Habitats OP/BP 4.04		X
Forests OP/BP 4.36		X

Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10		**X**
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Annual Program of Works (APW) and Procurement Plan	**X**		Yearly

Description of Covenant

The Recipient shall not later than November 15 of each year during implementation, or such later date as may be agreed by the Association, submit to the Association an APW and associated Procurement Plan, satisfactory to the Association, prepared in accordance with the format included in the POM and which shall include agreed amounts of transfers for APWs for the following fiscal year.

Name	**Recurrent**	**Due Date**	**Frequency**
Health Policy Council	**X**		Yearly

Description of Covenant

The Recipient, through MOH, shall maintain the Health Policy Council, consisting of the state secretary, deputy ministers and heads of departments that will be responsible for coordination of Project activities, until completion of the Project.

Name	**Recurrent**	**Due Date**	**Frequency**
Inter-Ministerial Coordination Committee	**X**		Yearly

Description of Covenant

The Recipient, through MOH, shall maintain the Inter-Ministerial Coordination Committee, consisting of representatives of MOH, MOF and MSD, responsible for:- i) coordination of project activities, including harmonization activities; and ii) review of the functioning of a complain mechanism for considering complaints regarding misuse of funds and ensuring follow-up, until completion of the Project.

Name	**Recurrent**	**Due Date**	**Frequency**
Procurement Post-review	**X**		Yearly

Description of Covenant

The Recipient shall have its procurement at health facilities reviewed by an independent consultant as terms of reference agreed with the Association. Each Procurement Post Review Report shall cover the period of one fiscal year of the Recipient. The Procurement Post Review Report for each such period shall be furnished to the Association not later than six months after the end of such period.

Name	**Recurrent**	**Due Date**	**Frequency**
Evaluation Studies	**X**		Yearly

Description of Covenant

The Recipient, through MOH, shall ensure that evaluation studies are conducted at least twice during Project implementation separately for each of the four priority areas of the Program.

Name	Recurrent	Due Date	Frequency
Progress Reports	X		Yearly

Description of Covenant

The Recipient shall not later than September 15 of each year during the implementation of the Project or such later date as may be agreed by the Association, provide to the Association for its review, a report on the progress achieved in the carrying out of the Project during the period preceding the date of the report.

Name	Recurrent	Due Date	Frequency
Joint Annual Review (JAR)	X		Yearly

Description of Covenant

The Recipient shall on an annual basis jointly undertake with the Association and other donors to Den Sooluk, review of the Project activities.

Name	Recurrent	Due Date	Frequency
Technical Meetings	X		Yearly

Description of Covenant

The Recipient shall on an annual basis, participate in technical meetings with the Association and other donors to Den Sooluk.

Name	Recurrent	Due Date	Frequency
Multi-Year Strategy for Procurement System		30-Apr-2014	

Description of Covenant

By no later than six months after the Effective Date, the Recipient, through MOH, shall prepare a multi-year strategy for the improvement of the public procurement system for the health sector, including a capacity building needs analysis.

Name	Recurrent	Due Date	Frequency
Fiduciary Capacity Building Plan		31-Oct-2014	

Description of Covenant

By no later than one year after the Effective Date, the Recipient, through MOH, shall procure technical assistance to develop and implement a comprehensive fiduciary capacity building plan for the health sector, with a focus on all health facilities, with terms of reference satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Internal Audit Function		15-Aug-2015	

Description of Covenant

By no later than August 15, 2015, the Recipient, through MOH, shall procure technical assistance to strengthen the internal audit function within MOH and MHIF, including automation of the audit workflow, with terms of reference satisfactory to the Association.

Conditions	
Name	**Type**
The POM has been updated in a manner satisfactory to IDA.	Effectiveness
Description of Condition	
The Project Operational Manual, satisfactory to IDA, has been updated to reflect activities under Den Sooluk, including Project accounting and reporting (including simplified un-audited IFRs), funds flow, audit arrangements, disbursement procedures, an updated harmonized procurement manual for health facilities, and standard bidding documents that are consistent Proc. and Cons. Guidelines.	
Name	**Type**
External auditors have been contracted in a manner satisfactory to IDA.	Effectiveness
Description of Condition	
External auditors have been contracted to prepare financial and operational audit reports as required by this Agreement.	
Name	**Type**
A status report on issues raised by the 2011 audit has been submitted to IDA.	Effectiveness
Description of Condition	
A status report on the Government's action plan to resolve issues raised by the audit of the 2011 financial statements of the Health and Social Protection Project, IDA Grant No. H197 KG, has been submitted in a manner satisfactory to the Bank.	
Name	**Type**
Contract management and procurement support	Effectiveness
Description of Condition	
The Ministry of Health has retained at least one qualified contract management specialist, procurement consultant and procurement assistant.	
Name	**Type**
Payments against APW (Health)	Disbursement
Description of Condition	
For first quarter of the Fiscal Year unless the Recipient has either (i) provided to the Association a list of signed contracts and contracts intended to be signed as of December 31 for which payments will be due in the first quarter of the next Fiscal Year; or (ii) approved the Republican's budget for the Fiscal Year covered by the respective APW.	

Name	Type
Payments against APW (Health)	Disbursement

Description of Condition

Transfers for APW are made provided that MOH's budget for the fiscal year covered by the respective APW has been approved by the GOK.

Name	Type
GOK informs Bank of Eligible Crisis or Emergency and Bank formally accepts it.	Disbursement

Description of Condition

No withdrawal shall be made until the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in Component 3 in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof.

Name	Type
Provision of satisfactory Emergency Financing Plan in case of emergency response	Disbursement

Description of Condition

No withdrawal shall be made for payments under Component 3 until GOK has adopted an Emergency Financing Plan in form, substance and manner acceptable to the Bank and the provisions of the Emergency Financing Plan remain - or have been updated in accordance with the provisions of the Credit/Grant's Legal Agreement - appropriate for the inclusion and implementation of said activities under Component 3.

Name	Type
Ineligibility of financing salaries or activities that could trigger safeguards.	Disbursement

Description of Condition

The GOK has ensured that no expenditures in the Emergency Financing Plan finances salaries or finances any activities that trigger any of the Bank's safeguard policies.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Johanne Angers	Senior Operations Officer	Operations	ECSH1
Joseph Paul Formoso	Senior Finance Officer	Disbursement	CTRLA
Montserrat Meiro-Lorenzo	Sr Public Health Spec.	TB Control	HDNHE
Anastassia Alexandrova	Sr Social Protection Specialist	Social Protection	ECSH3
Adam Shayne	Lead Counsel	Legal	LEGLE
John Otieno Ogallo	Sr Financial Management Specialist	Financial Management	ECSO3
Nedim Jaganjac	Senior Health Specialist	Task Team Leader	ECSH1
Gabriel C. Francis	Program Assistant	ACS Support	ECSHD
Asel Sargaldakova	Senior Health Specialist	Public Health	ECSH1

Aly Zulficar Rahim	Social Development Specialist	Safeguards	ECSSO
Nagaraju Duthaluri	Lead Procurement Specialist	Procurement	ECSO2
Carine Ter-Akopova	Team Assistant	ACS Support	ECCKG
Iris Semini	Senior HIV/AIDS Specialist	HIV/AIDS	HDNHE
Antonino Giuffrida	Sr Economist (Health)	Economic Analysis	ECSH1
Erkin Mamadaliev	Social Protection Specialist	Social Protection	ECSH3

Non Bank Staff

Name	Title	Office Phone	City
Amy Evans	Environment Safeguard Specialist		Washington
Zlatan Sabic	Information Systems Specialist		

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	75		
Health and other social services	Other social services	25		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this Project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	65
Social protection and risk management	Social safety nets	25
Human development	Child health	10
Total		100

I. STRATEGIC CONTEXT

A. Country Context

1. The Kyrgyz Republic is a landlocked mountainous country in Central Asia with a multi-ethnic population of 5.4 million. With an estimated GDP per capita of US$1070 in 2011, the Kyrgyz Republic is one of the poorest economies in the Europe and Central Asia region. According to the latest available official statistics, an estimated 32 percent of the population lived below the poverty line in 2009, while 3 percent lived in extreme poverty. The incidence of poverty in rural areas (37 percent) was far higher than in urban areas (22 percent). The 2010 crisis events led to a 1.4 percent fall in GDP and initial indications suggest a 2 percent increase in the poverty headcount during 2010.

2. Since independence in 1991, the country has made a strong advance towards the creation of a liberal market economy with the aim of promoting sustained economic growth and fighting poverty, and has sought international integration through trade and investment, and membership of the World Trade Organization (WTO). Economic reforms resulted in an average annual growth of 5.4 percent over the five years prior to 2009, a decline in poverty from 40 percent to 32 percent over 2006-2009 and a drop in extreme poverty from 9 percent to 3 percent over the same period. But improvements in governance have proved elusive: the country was ranked 164 out of 178 in Transparency International's Corruption Perception Index, and Organization for Security and Co-operation in Europe (OSCE) missions characterized elections until 2009 as falling short of international good practice.

3. The Government that took office following the presidential elections of October 2011 was dissolved in August 2012. A new Government was formed in September and its agenda includes a program of security, governance, anticorruption and, where feasible, ethnic reconciliation measures for securing political consolidation.

B. Sectoral and Institutional Context

Health Sector

4. Since 1995, the Kyrgyz Republic has undertaken wide-ranging health financing and organizational reforms. The first health sector strategy was adopted in 1996 – Manas (1996-2006). The Manas program launched comprehensive structural changes of health care delivery, financing and stewardship. It included reforms of the health care delivery system with the aim of strengthening primary health care (PHC), developing family medicine, and restructuring the hospital sector. The Manas program also introduced fundamental changes to health financing. In 1997, mandatory health insurance was introduced with the aim of attracting additional sources of funding to the health sector and improving the equity, access and health financial protection of the population. The State Guaranteed Benefits Package (SGBP) was introduced in 2001 to regulate the rights and obligations of Kyrgyz citizens and of the Government with regard to the provision of health services and the establishment of a more predictable and transparent system. The SGBP provides free basic health services at the primary care level, and specialized outpatient and in-patient care against regulated copayments. It exempts disadvantaged social

categories and specified disease categories from copayments, which are revised annually. The SGBP represents between 60 and 70 percent of total Government health expenditures. The Mandatory Health Insurance Fund (MHIF), established to administer the mandatory health insurance system, is responsible for purchasing health services covered by the SGBP and acts as a single payer of the public health system.

5. Given the economic situation in the country, it is unlikely that there will be much fiscal space to further increase investments in the health sector both in nominal terms and as a percentage of total Government expenditures, unless they are accompanied by efficiency gains. In this context, better pro-poor targeting of the basic benefit package and rationalization of exempted categories are priorities in order to achieve needed efficiency gains in the health and social protection sectors. The current two-thirds of public expenditure on non-contributory social transfers contribute little to poverty reduction. The process of revising the efficiency of the current copayment exemption targeting mechanism is underway.

6. Improving quality of care and accelerating health gains became the priorities of the second phase of health system reforms, which was launched in 2006. The Manas Taalimi program (2006-2011) aimed at solidifying the health financing reforms, increasing the effectiveness of PHC, improving access to specialized care, improving the quality of health services, strengthening public health, and improving the quality of graduate, postgraduate and continuous education. The Manas Taalimi program was supported by a sector-wide approach (SWAp) program, financed by pooled budget funding from Joint Financiers (JFs) including the World Bank under the ongoing Health and Social Protection Project (SWAp1, IDA Grant No.H197-KG), and financing from other development partners (DPs). The SWAp1 was the first large-scale SWAp to be implemented in one of the former Soviet Union countries.

7. The outcome of the implementation of Manas Taalimi has been mixed. On the positive side, financial protection of the population from catastrophic health related expenditures shows significant improvements. Public expenditures for health, including aid funds, increased from 2.8 percent of GDP in 2006 to 3.3 percent in 2010. At the same time, private (out of pocket) expenditures declined from 56 percent of total expenditures for health in 2006 to 49 percent in 2010. The Government has followed an agreement under the SWAp that stipulates that health expenditures as a percentage of total Government expenditure should increase incrementally by 0.6 percent each year starting in 2006, from the 2005 level of 10.3 percent. This trend was maintained during the five years of the SWAp and Government expenditure on health has now reached a level of at least 13 percent. A positive impact of the SWAp arrangements has been overall improvements in public finance management (PFM) for the entire health sector, despite some serious concerns flagged in audit reports. PFM in the health sector is rated much higher than in any other sector in the country. For example, no other sector has implemented the practice of internal and independent auditing of institutions. However challenges still remain in building the capacity of the MOH to manage procurement, financial management, disbursements, planning, and budgeting.

8. There have been notable improvements in some, but not all health outcomes. Under-five mortality rate has declined from 72 per 10,000 live births in 1990 to 38 per 10,000 live births in 2010. However, further attention must be given to this critical area if Kyrgyz Republic is to achieve the MDG target of reducing the under-five mortality rate by two-thirds by 2015. Infant

mortality (IM) analysis showed that the majority of deaths occur within 24 hours after birth, i.e. when a child is under the supervision of a health worker, suggesting a relative deficit in quality of care rather than in access. Despite some improvements in recent years, maternal mortality (MMR) rate is still high. Currently, the mortality structure is represented by postpartum hemorrhage (44.2 percent), hypertensive disorders (23.1 percent), septic complications (3.8 percent), i.e., conditions that depend on the proper care and monitoring of women during pregnancy, childbirth, and postpartum periods.

9. Cardiovascular disease (CVD) claims the lives of people of working age, which creates a great economic and social burden. The Kyrgyz Republic ranks 6th among the countries of the Eurasian region for standardized mortality rate from Coronary Heart Disease (CHD) and ranks 1st for mortality rate from cerebral stroke (WHO, 2009). Hypertension (HTN), high cholesterol and smoking are the main contributing factors (more than 90 percent) of mortality from heart attack and stroke. Over the past years, mortality rate from CVD has increased for the age-group 30 to 39 years old by 31.2 percent and for the age-group 40 to 49 years old by 47.8 percent. Health system effectiveness to detect and manage CVD is well below the desired level.

10. The situation with multi-drug resistant tuberculosis (MDRTB) is not favorable either. The country is the 7th highest in the world for the proportion of the population with MDRTB, with over 26 percent among new cases and 52 percent among retreatment cases (WHO, 2011). As in the case of other Central Asian republics, the structure of the health care delivery system is inadequate in addressing the growing burden of MDRTB. In fact, it contributes to its high rates. Some factors contributing to this situation are the mandatory lengthy hospitalization in deteriorating facilities with inadequate infection control and the lack of second-line drugs to treat cases of drug-resistant TB.

11. The country is also at a concentrated stage of spread of Human Immunodeficiency Virus (HIV) infection. HIV prevalence rate among injection drug users (IDUs) was 13.6 percent in 2011. The number of women living with HIV and children born to HIV infected mothers has increased over the recent years, which indicates that there is a transition of HIV infection from a drug injectors' environment to the general population.

12. In addition to those challenges, the physical infrastructure is decaying and there is a continued funding gap in the SGBP leading to persistent informal payments. These factors have resulted in dissatisfaction among the population and have undermined the positive health system reforms that have occurred over the years.

13. The Den Sooluk (2012-2016) follows the Manas Taalimi program and has as main objective to establish conditions for the protection and improvement of the population's health as a whole and for each individual, irrespective of social status and gender differences. The Den Sooluk (DS), approved by the Government in May 2012, is based on three interrelated pillars: (i) expected health gain; (ii) core services needed to achieve expected health gains; and (iii) removal of health systems barriers that undermine delivery of core services and hence achievement of health gains. Four priority health improvement areas were identified in DS for which expected gains in health outcomes have been set and improvement in delivery of core services is expected:

CVD, Mother and Child Health (MCH)[1], Tuberculosis (TB), and HIV. Removal of health systems barriers for the four priority areas are grouped around the main functions of health systems: service delivery (public health and individual services), financing, resource generation, and governance.

Social Protection Sector

14. After almost a decade of gains in living standards, poverty increased in the aftermath of the 2010 events. Since 2009 the poverty rates increased by five percentage points, reaching 36.8 percent in 2011. The unstable political and economic environment, food price pressures and slow growth in remittances contributed to the recent upward trend in poverty. The incidence of poverty is the highest in the rural areas (40 percent) and the lowest in urban Bishkek (18 percent). An estimated five percent of the population lives in extreme poverty and is unable to meet its basic food needs. Inequality has risen in urban and rural areas as a result of internal and external shocks in 2010. Yet despite this recent reversal in the incomes of the lower income groups, non-income dimensions of poverty compare well to other low income countries due to the wide availability of basic social and infrastructure services.

15. Poverty has a strong rural-urban and regional dimension. About three quarters of all poor and four-fifths of the extreme poor live in rural areas reflecting the higher incidence of poverty and greater proportion of the population residing in the rural sector. Overall poverty increased in all oblasts (provinces) except Bishkek and Issyk-Kul in 2010. Extreme (food) poverty changes exhibited a strong regional dimension: the proportion of the population unable to meets its caloric needs rose significantly in conflict-affected urban areas of Osh oblast and in rural areas of Jalal-Abad oblast, reaching 17.5 and 9.0 percent, respectively – well above the national average of five percent. This has led to a concentration of 45 percent of extremely poor households in these areas.

16. A medium-term Social Protection Development Strategy for 2012-2014 has been developed and approved by the Government in 2011. The goal of the Strategy is to reduce poverty and improve the well-being of vulnerable groups in the population, such as families with children, the disabled, the elderly and other vulnerable groups. The main problems identified in the Strategy are the insufficient financial support for poor families due to low benefit amounts and low coverage (high exclusion error), the misalignment between pensions and social protection benefits and the lack of social services for vulnerable families and children, the disabled and the elderly. The Strategy foresees addressing identified problems and improving the safety net and delivery of services thereby improving the overall social protection of the Kyrgyz population in need. However, insufficient funds have been budgeted by the Government to implement all measures identified in the Strategy.

17. The social safety net in the Kyrgyz Republic is extensive and consists of an array of cash benefits and allowances, both categorical and means-tested. The Government spends more than five percent of GDP on social protection from the National Budget, including close to three percent of GDP on social assistance (including expenditure on energy compensations and early retirement and pension top-ups financed from the Budget). This is relatively high with other

[1] The terms "maternal and child health" and "mother and child care" are being used interchangeably.

countries with a similar income level and therefore the Government recently took steps to improve efficiency and effectiveness of social assistance. A large number of categorical in-kind benefits and price subsidies were monetized and replaced with a monthly cash compensations program. The number of categories entitled to receive the monetized benefits was reduced from 39 to 25 bringing down the number of beneficiaries significantly. A means-tested program to support poor families with children was introduced and underwent a number of improvements. Nevertheless, currently about two thirds of social assistance spending remains poorly targeted while a large share of the poor does not have access to a social safety net.

18. The Monthly Benefit for Poor Families with Children (MBPF) is the last-resort social assistance program targeted to the poorest. It is the only program that uses a means test to provide monthly cash benefits to children living in needy families. It transferred 0.52 percent of GDP in cash benefits and made roughly one sixth of the total social assistance spending in 2011. The MBPF is fairly well targeted in terms of low leakages to the non-poor: 68 percent of benefits are received by poorest two quintiles. However, coverage is low and has fallen from 434,000 to 377,000 beneficiaries in the past five years. The program reaches less than one-third of the poorest 20 percent of the population. The benefit level is also low: it is calculated as a shortfall between assessed income per capita and the Guaranteed Minimum Income (GMI), which was equal to about one-third of the extreme poverty line in 2010 (US$7 and US$23 a month, respectively). The real value of transfers has eroded with time and it comprises about six percent in the total consumption of beneficiaries. The impact of the MBPF on poverty has been limited due to low coverage and low benefit levels. MBPF design and delivery need to be improved in the following key areas: benefit targeting, outreach to remove barriers for the poor to enter the program, measures to counter error and fraud, enhanced enrollment, information management, payment and accounting systems.

19. Other main social assistance programs target certain categories in the population, such as war veterans, the elderly, pensioners, survivors, people with disabilities, and mothers of many children. These programs do not take the recipient's welfare status into account, and as a rule provide more generous benefits compared to the MBPF. The budgets of these programs have grown substantially in recent years and make about five-sixths of the total social assistance spending. Evidence from national household surveys indicates that the population in the richest two quintiles benefited from categorical benefits more often than those in the poorest two quintiles, except for the Monthly Social Benefit, which channels most of its funds to people with disabilities, and had better targeting outcomes than other categorical programs. Furthermore, some beneficiaries receive several different kinds of benefits at the same time, while others do not receive any support. As experience elsewhere has shown, administration of multiple benefit programs is costly and is confusing to beneficiaries.

20. The Kyrgyz Republic lacks a coherent policy towards people with special needs. It has not ratified the UN Convention on the Rights of People with Special Needs and the limited response to special needs includes certification of disability status, payment of social allowances and institutionalization of people with moderate and severe disabilities, including children. The Disability Certification Service (DCS) procedures and processes are outdated. There is anecdotal evidence suggesting the DCS system is prone to error, fraud and corruption. The DSC is plagued with extremely weak capacity, poor governance and non-transparent practices mostly derived from the legacy of the Soviet Union. It certifies people as disabled and thus eligible for social

transfers, but provides no opportunities for meaningful rehabilitation or social integration planning, and there are no systems available that would support an individual in following such a plan. The system also creates perverse incentives for people with special needs to seek monetary assistance rather than rehabilitation, education or employment opportunities.

21. Social care services are almost exclusively limited to residential institutions for children, people with disabilities, and the elderly, making the system costly and non-responsive to needs. The services are scattered, scarce, and delivered in isolation from each other. There is a poorly funded system of fragmented home-based social services for orphans, elderly, and people with disabilities, but no service standards exist. Child protection services are fragmented and duplicated at the local level, lowering the barrier for poor children to end up in residential institutions. As noted in the Government's Social Protection Development Strategy, 88 percent of 20,000 children in residential institutions had parents or other relatives in 2011. The number of working children is on the rise: an estimated fifty percent, or more than 25,000 of them, are out of school. Services for families and children at the community level are still lacking, apart from a few pilot projects supported by external resources and very limited budget at its disposal, the Ministry of Social Development may also outsources services to local Non-Governmental Organizations (NGOs). The legal basis to involve NGOs in service provision has been created. The current approach to social care services misses potential synergies between programs in enhancing the clients' welfare. There are gaps in such services as rehabilitation assistance, linking medical, social and employment assistance, counseling, shelters, outreach and information assistance together.

22. The World Bank (WB) has supported the Ministry of Social Development (MSD) under the First Health and Social Protection Project, focusing on strengthening the capacity of the Ministry to administer social assistance through technical advice and limited procurement of equipment and services. Support included procurement of computer equipment for all social protection departments and institutions in the country and development of information management software for a social assistance beneficiary registry, as well as technical assistance to improve targeting of benefits to reach the most vulnerable and poor. The WB is also currently undertaking a social protection public expenditure review to provide analytical underpinnings to support the safety net reform efforts by the Government.

23. There has been mixed progress in achieving more equitable spending on social assistance. Spending on regressive cash compensations (former privileges) decreased by a quarter in 2012 compared to 2011, thanks to efforts to limit the inflow of beneficiaries in renewable categories and a freeze in benefit levels. The fairly well-targeted Monthly Benefit to Poor Families with children was increased by more than 50% in nominal terms in November 2012, but still remains very low compared to categorical, rights-based benefits. The pattern of social assistance spending still favors certain categories in the population perceived as vulnerable, rather than the needy.

24. The proposed Second Health and Social Protection Project is aligned with the overarching areas of engagement of the Interim Strategy Note (ISN) for the Kyrgyz Republic (Report No. 62777-KG – June 16, 2011). The ISN, which succeeds the Country Assistance Strategy (CAS) approved by the Board in May 2007, covers the period August 2011 to June 2013. The ISN focuses on the country's recovery and stabilization needs, while paving the way

for support for long-term development. The need for an interim strategy approach was underscored by the fragile political, social and economic situation in the country. The ISN was informed by the key insights of the World Development Report (WDR) on Conflict, Security and Development (2011). It was also guided by the need for continuity in the sector reform processes underway since 2010. The proposed Project is consistent with two of the ISN three pillars, which, in turn, closely correspond with the Government's main priorities: improving governance, effective public administration, and reducing corruption; and social stabilization, through social services, community infrastructure, and employment, with emphasis on the South. The ISN notes that "the continuance of the multi-donor SWAp will be essential to maintain the State's credibility as provider of a critical public service."

C. Higher Level Objectives to which the Project Contributes

25. The main thrusts of the Government's reforms in its Medium-term Strategy are to increase the living standards of the population, reduce poverty based on economic growth, improve the business environment, and develop an efficient governance system. These policy objectives are backed by sector strategies developed by each line ministry. In support of the above objectives and priorities, the World Bank's Interim Strategy Note (ISN) has adopted a focus on fiscal stability and improved public sector governance.

26. The proposed Project is consistent with the World Bank's ISN as its higher level objective is to improve public sector governance and capacity of the health system management and improve health outcomes. The social assistance component contributes to the higher level objective of poverty reduction and increased efficiency of public spending.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

27. The Project Development Objective is to: (i) improve health outcomes in four health priority areas in support of the "Den Sooluk" National Health Reform Program 2012-2016; and (ii) enable the Government's efforts to enhance effectiveness and targeting performance of social assistance and services.

1. Project Beneficiaries

28. The health component of the proposed Project would benefit the entire population of the Kyrgyz Republic as it supports the Government's overall health strategy. It would particularly target people with chronic diseases, mothers and children, vulnerable groups and the poor through selected targeted programs for the prevention and control of CVDs, MCH, TB and HIV.

29. Gender. Studies and analytical work on issues pertaining to health care provision to women and men have underpinned the context in which the proposed Project has been developed. The proposed Project is gender sensitive and addresses, by the activities it would support, many gender-related aspects of health care in the four priority areas (CVDs, MCH, TB and HIV). The implementation of interventions specific to any of these four priorities, especially in rural areas, is the focus of Den Sooluk supported by the proposed Project. In addition, key performance indicators will be disaggregated to the extent possible between women and men in

order to track inequalities and disparities. According to national statistics, life expectancy for men is 10 years less than for women due to premature deaths from CVDs and injuries.

30. The primary target groups to benefit from the social assistance component will be the poor and vulnerable households, including those with special needs/disabilities, as well as poor families with children in general. However, there are secondary target groups to benefit from improved social assistance transfers. International evidence shows that investing in children either through direct transfers or the provision of services has positive long-term effects for the society. Children that are healthy and properly nourished learn better in school, which will increase their future income and productivity as adults.

2. PDO Level Results Indicators

31. As the Project is structured as a SWAp with pooling of funds for the health sector at the Treasury level, it is not possible to fully attribute overall health gains to the Project or to unambiguously assess the Project's contribution to improvements in the overall governance and system reforms. There is a broad agreement among DPs on the importance of adopting a single common results and monitoring framework – Joint Assessment Framework (JAF) - that reflects the Government's priorities in the sector and monitors outcomes of the reforms. For these reasons, two types of PDO indicators will be used. The first type will monitor the Government's commitment and evaluate if essential preconditions for achieving the Den Sooluk strategy are in place (for example that enough budget is allocated to the sector), while the second type of indicators will monitor progress towards the achievement of Den Sooluk key objectives such as improvements in access to key services and financial protection of the population. The second type of indicators will be measured through studies that are part of JAF that will be carried out every two years or at least twice during the implementation period.

32. JAF indicators will be used as intermediate indicators. In addition to JAF, there will be several process indicators that will monitor effectiveness of SWAp management and fiduciary controls. These indicators will be monitored during the Joint Annual Review (JARs) of the program and will be summarized in Joint Summary Notes, which are produced after each JAR. All indicators (both PDO and a selected number of intermediate outcome indicators) listed in Annex 1 will be used for ISR reporting, including relevant IDA core indicators.

33. Key results for the Health component are:

(a) Proportion of consolidated Government health expenditures over total consolidated Government expenditures should be no less than 13 percent;
(b) At least two Disease Management Programs are created and have increasing trend in coverage of population;
(c) Improved access of the patients to preventive care measured by percent of detected cases of hypertension (HT) at the primary health care level;
(d) Improved financial protection of population measured by level of out-of-pocket payments as a proportion of total household consumption in the two poorest quintiles;

Key results for the Social Protection component are:

(e) Improved targeting of MBPF transfers by reducing exclusion errors;
(f) Improved share of Social Assistance spending on poverty-targeted program(s).

III. PROJECT DESCRIPTION

A. Project Components

34. The proposed Health and Social Protection Project 2 would be implemented over a period of five years using a Sector Investment and Maintenance (SIM) instrument. Similar to its predecessor, it would adopt a SWAp for the health sector while using traditional investment arrangements for the social protection component. The Development Partners will significantly contribute to effective Project implementation. The roles and responsibilities of the Development Partners are presented in Annex 3.

35. The Project consists of three components. The first component supports the implementation of reforms in the health sector envisaged in the Den Sooluk reform strategy 2012-2016. The second component supports the Government's Social Protection Development Strategy 2012-2014 to improve the efficiency and effectiveness of cash benefits and social care services in combating poverty. The synergy between the two components relates to targeting accuracy, which is needed in health and social services as well as social assistance. A third unfunded component has been included to improve the Government's capacity to respond in the event of an emergency during the Project's lifetime. The Detailed Project Description is presented in Annex 2.

Health Sector

36. **Component 1 – Support for implementation of Den Sooluk (DS) program of reforms** (US$1,366.7 million equivalent, including US$13.5 million total IDA credit/grant financing). This component would support the implementation of the Den Sooluk Program (DS) through a SWAp. The component has been designed to be flexible so that it can adapt to evolving sector and country priorities. Areas of focus are as follows:

37. **Improve the delivery of core services as defined in DS**. The proposed Project would support the delivery of core services in four priority areas (cardiovascular disease, maternal and child health, tuberculosis, and HIV) through: (i) population interventions; (ii) evidence-based individual medical services; and (iii) the appropriate institutional arrangements that are needed to deliver them. Special emphasis will be on change management of service delivery at the facility level. The proposed Project would also support investments in deteriorating infrastructure.

38. **Health System Strengthening.** The proposed Project would also support the strengthening of the capacity within MOH to further develop a detailed implementation plan (blue prints) for each key area of the reform, with details on the sequencing of the reforms. Examples of key reform areas under DS where the preparation of implementation plans would be supported include: (i) hospital autonomy; (ii) strengthening PHC by shifting core services from inpatient to outpatient PHC care (such as management of CVD, treatment of TB); (iii)

prescription practices and rational drug use; (iv) community-based mental health; (v) preventive services; (vi) implementation of information systems of the health care sector; and others. Health system strengthening as envisaged under DS presents a major shift in current organization of health care delivery as it emphasizes prevention and a more effective disease management model. Technical assistance and training would also be provided to comprehensively address providers' autonomy issues.

39. The proposed Project would also place special emphasis on supporting the MOH in its continued transition from implementing agency to steward of reforms, including oversight and stewardship over fiduciary functions in the health sector.

40. The DS Strategy considers the systemic improvement of information systems in health as one of the "necessary resources for effective functioning of the health care system". The Project would support that process in three key areas: (i) Improving the environment for eHealth development (preparing eHealth Strategy/Master Plan), setting up institutional arrangements for eHealth governance, regulation and implementation, ensuring sustainable financing of eHealth usage and development, providing a regulatory and standardization framework, improving capacities of institutions and facilities for eHealth utilization, etc., (ii) Improving technical infrastructure as a precondition for implementation of clinical systems (purchasing computers for facilities, improving communication infrastructure, improving local computer networks in health facilities, adjusting central location(s) for hosting of new systems, etc.), and (iii) Implementing fundamental clinical information systems (the list of systems to be implemented will depend on general eHealth architecture that shall be defined in eHealth Strategy/Master Plan, but the Primary Health Care (PHC)/Electronic Health Record (EHC) for personified record-keeping of health services, hospital, laboratory and pharmacy information systems will be considered as a priority). See Annex 6 for more details.

41. **Support to the State Guaranteed Benefits Package (SGBP)**. The Project would complement Government funds to help finance the SGBP gap. In addition to the benefits resulting from pooling funds with donors and the Government, reducing the financing gap in basic package will contributing directly to improving quality of care.

42. Efforts to reduce the financial gap would be undertaken by: (i) identifying mechanisms for increasing financing options; (ii) conducting a comprehensive review of the co-payment policy, revising exempted categories, and copayment structures; and (iii) reviewing the scope of benefits and services under SGBP. In addition to efforts to reduce the financial gap, support to MHIF would be provided in order to harmonize MHIF's purchasing practices of health services with a new delivery model that emphasizes prevention services.

43. **Strengthening fiduciary capacity in the health sector.** This area would be closely coordinated with ongoing efforts under the multi-donor PFM Trust Fund administered by the World Bank, particularly the strengthening the control environment, accounting and reporting. The proposed Project would continue to address weaknesses in MOH capacity in order to improve fiduciary controls and capacity building implementation by providing technical assistance and training in key areas of fiduciary tasks.

44. Strengthening the fiduciary capacity of providers and fiduciary controls, oversight and support of the MOH will pave the way to pilot a provider autonomy approach. Furthermore, as autonomy of providers moves along, the relationship between providers, MOH and MHIF will change, and will require defining additional support in: (i) improving the regulatory and legal foundation for increasing the autonomy of health care institutions; (ii) strengthening the quality of management and improvement mechanisms; and (iii) strengthening the MOH's role in fiduciary oversight and support for health care institutions through targeted and phased implementation of the fiduciary capacity building action plan developed following an Integrated Fiduciary Assessment (IFA). Strengthening procurement capacity at the facility level, through the proposed Project, will also contribute to providers' autonomy.

Social Protection Sector

45. **Component 2 – Strengthening the Policy and Administrative Capacity of the Ministry of Social Development (MSD)** (US$3.0 million total IDA credit/grant financing). The objective of the component would be to enable the Government's efforts to enhance effectiveness and targeting performance of social assistance and social services aimed at supporting the poor and the vulnerable. This would be achieved through strengthened institutions, enhanced human resource capacity and better design and delivery of programs to support the poor and the vulnerable. The primary target groups to benefit from this component will be poor and vulnerable households, including those with special needs/disabilities, as well as poor families with children in general. The component has the following two sub-components:

46. **Sub-component 2.1**: **Improving the effectiveness of the social safety net.** This sub-component would provide technical assistance and capacity building to the MSD and would focus on: (i) strengthening the social safety net so that it can provide critical support to the needy protecting against dire poverty and loss of human capital in an inclusive manner; and (ii) enhancing the safety net's role in insuring against the impacts of different shocks. An evidence-based approach to design and delivery of safety net interventions would be promoted so that lessons learned in program implementation and from international experience are fed into program design processes. This sub-component would finance advisory services and training in the areas of program design and delivery, including benefit targeting, outreach and communication, enrollment, verification and control, payment, and other elements of benefit administration. Design, piloting and evaluation of selected interventions would be supported, including testing of alternative targeting approaches and different benefit structure that is compatible with families' incentives for self-sufficiency (e.g. income disregard formulae) and promote investment into their human capital. MBPF would be the focus of the above-mentioned efforts. Diagnostics and analytical work would be undertaken to introduce conditionalities that would promote investment into human capital accumulation by beneficiary households under the MBPF. Analytical underpinnings and recommendations to reform the entire safety net, consisting of the five largest cash transfer programs[2], including the MBPF, would be provided under the ongoing non-contributory Social Protection Public Expenditure Review. If there is political will to reform the entire safety net, including consolidation of the different benefits and

[2] These five programs are: (i) Monthly Benefit for Poor Families with Children; (ii) Monthly Social Benefit; (iii) Cash Compensations (former privileges, in-kind benefits and price subsidies); (iv) Energy compensations to pensioners; and (v) Early retirement benefits and pension top-ups paid from general revenues.

integration of delivery systems, the proposed Project would provide necessary support to this end.

47. This sub-component would also continue support to the MSD, initiated under the previous project, to further implement and improve the registry of social assistance beneficiaries (SA registry) and to design a comprehensive information and communication technology (ICT) strategy focusing on improved benefit administration and better outreach to the poor. This sub-component would further support the first elements of the SA registry currently in the rollout phase in terms of (i) staff training for system usage, improving analytical capacity of the MSD staff to use statistical data from the registry, technical enhancement, including supply of critical equipment, of central database location, support to the MSD IT department in system maintenance, etc.; and (ii) functional and architectural improvements to allow fullest use of the opportunities presented by the registry, including further automation of business processes and generation of information for program planning, monitoring and evaluation. Integration of the SA registry with the household social passport (a detailed socio-economic assessment of needy households), supported earlier by GIZ at the municipal level, presents opportunities for strengthening efficiency and targeting social assistance. The proposed Project would support integration of systems and their gradual implementation as the planned computerization of the local level progresses with potential integration into the planned eAyil local governance information system (technical notes on this are provided in Annex 6).

48. **Sub-component 2.2: Support to strengthening the national policy towards vulnerable groups, including people with special needs.** This sub-component would support a diagnostic review of the Disability Certification Service (DCS) with the objective of streamlining disability certification in accordance with modern approaches focusing on abilities and opportunities for rehabilitation rather than on certifying static disability status. Medical criteria for disability certification would be reviewed, information on best practices in this area would be made available, and proposals for the reform of certification and improved support of the clients would be developed. This work would need to be complemented by a coordinated effort of the entire Government to begin creating community-based infrastructure and services that would enable people with special needs to function in the society. While this is a long-term process, the proposed Project would initiate the first steps by producing clear recommendations for changing the way the DCS operates and laying out a roadmap for the development of individual rehabilitation plans and building supportive infrastructure and services nation-wide. The sub-component would also support some initial capacity building such as exposure of the key players to the modern disability certification models, their practical implementation and lessons from international experience.

49. This sub-component would also provide technical assistance to help the MSD design and test an integrated approach to provision of social assistance and social services that could (i) increase the impact of social assistance on the lives of the poor and the vulnerable by addressing multiple causes and dimensions of their vulnerability; and (ii) improve the efficiency of the administration by streamlining duplicative efforts provided, as of now, separately by social assistance and social services units. The sub-component would support design and would pilot the introduction of community-based integrated social service provision and day care centers for all families in need using a one-stop-shop model. The same approach would be promoted by the sub-component activities for other vulnerable categories that face high risks of

institutionalization or isolation from the society. The sub-component would finance the development of standards and methodologies for introducing core services focused on social support, and integration of social services for families and people in need. It would also help to develop sustainable mechanisms to involve non-Governmental agencies in the provision of community-based services for the vulnerable families.

Component 3 - Contingency Emergency Response (no funds allocated)

50. The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 8.00 (Rapid Response to Crisis and Emergencies). The component would support a rapid response to a request for urgent assistance in respect of an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact in the health and social protection sectors associated with natural or man-made crises or disasters. In such a case, the Joint Financiers, upon request from the Government, would re-allocate funds from Den Sooluk to mitigate potential adverse consequences arising from the emergency situation. Funds would be reallocated from other components into this one to finance goods, health and community-based facilities operating costs, and consulting services which would have been previously agreed with the World Bank under an acceptable Emergency Financing Plan. It should be noted that this component cannot be used to finance salaries, nor any expenditures that could trigger any of the World Bank's safeguard policies (as reflected by the Conditions of Disbursement associated to this component).

B. Project Financing

1. Lending Instrument

51. The Project would use an Investment Project Financing instrument. At the same time it would adopt a Sector-wide Approach for the health sector to enhance donors' coordination and increase effectiveness. The Social Protection component uses traditional sector investment procedures.

2. Project Cost and Financing

52. The total IDA financing would be US$16.5 million equivalent over a five-year period, as shown in Table 1 below.

Table 1: Project Cost and Financing by Component

Project Components	Total Program cost (US$ million)					
	GOK own funds	DP non-pooled	DP Pooled (excl. IDA)	IDA Financing	Total Cost	% IDA Financing
1. Support to the health sector (Den Sooluk)	1,327.10	1.10	25.00	13.50	1,366.70	<1%
2. Social Protection:						
a) Improving effectiveness of social safety net				2.00	2.00	100%
b) Strengthening national policy towards vulnerable groups, including people with special needs				1.00	1.00	100%
3. Contingency Emergency Response					0.00	
Total Financing	**1,327.10**	**1.10**	**25.00**	**16.50**	**1,369.70**	**1%**

53. Pooled funds in support of Den Sooluk are expected to total US$38.5 million over the next five years, with US$13.5 million of that coming from IDA. The proportion of IDA funding should allow the World Bank to leverage its investment to maximize the policy impact. The World Bank has played an important role in the development and management of the health basket fund under SWAp1. It is expected that the Project will allow the World Bank to leverage substantial additional funds from other Development Partners and will maximize the policy impact as a result of united position of development partners. The proposed Project would also provide financing to enhance the effectiveness of social assistance and services aimed to support the poor and vulnerable (Component 2). This will be done using traditional sector investment arrangements.

C. Lessons Learned and Reflected in the Project Design

Health Sector

54. The SWAp approach has significantly contributed to the harmonization of donors support and joint policy advice in the sector. This is very important in a fragile situation where there is a constant threat to break up the solidarity principle in the financing of health care by fragmenting fund pooling in health and decrease funding for the health sector. Pooling funds with the Government proved to be an effective means of creating ownership among other ministries including MOF. It has also been effective in achieving sustained increases in public funding for the health sector as well as in removing some of the financial barriers to health care for the poor.

55. Over time, the capacity of MOH to take on a stewardship role rather than an implementation role needs to be emphasized and strengthened. In order to successfully implement disease management programs, the development of fiduciary capacity should be an integral part of strengthening health care delivery management at the facility level, rather than crowding the MOH with fiduciary staff.

56. Almost 50 percent of funds during the SWAp1 were used to support the financial gap in SBGP. As this is not a sustainable situation, changes in the benefits package are needed to reduce the gap in addition to efforts to create efficiencies in the sector. MHIF has a key role to play in purchasing services and supporting change management at the facility level. Therefore, the proposed Project would strengthen effective purchasing by MHIF, which would contribute to changes in the management of the health care delivery system. Over time this will reduce the need to fill funding gaps in the SGBP by increasing efficiency.

57. Given the new parliamentary democracy and shared power among a number of stakeholders, effective internal communication is essential to secure support for very difficult and politically sensitive reforms in both sectors. Health and Social Protection issues can be effectively used as a political platform for different stakeholders. It is therefore essential that the MOH and MSD focus on creating alliances for the reforms, which without successful communication cannot be achieved.

58. Although the SWAp1 assumed that pooling donors funds with Government budget will result in a joint funding platform where money "loses its color", strict rules that apply to spending Government funds limit achievement of this goal. Therefore, more work needs to be done to create preconditions for real pooling with Government budget while ensuring that budget planning and execution within sector is made jointly between MOH, MHIF, and donors.

59. Supervision of this type of SWAp raises high expectations from stakeholders and consequently, this requires a robust communication strategy. In addition, SWAp arrangement requires intense implementation support resulting in higher associated costs.

Social Protection

60. Weak capacity and fragmented policy-making are the main challenges in Social Protection (SP). The Social Protection Development Strategy 2012 – 2014 is a good example of low capacity issues – it does not treat SP and labor issues in a systemic way, but rather focuses on catering to the needs of a few pre-determined categories of seemingly vulnerable populations. Another example is the section on SP in the Government program adopted in October 2012, which picks up a few issues while neglecting many important ones. Building capacity in areas such as policy analysis, M&E, social security program design and delivery, among others, is a priority.

61. The World Bank's assistance in SP has been relatively modest. It was mainly channeled through broader projects such as the DPL series and Health SWAp1 and its Additional Financing. The World Bank's support has been focused on building a social assistance beneficiary registry as well as on limited technical assistance to improve capacity of the MSD to effectively target and reach the most vulnerable and poor. However, even this limited engagement was troubled by the multiple changes within the Government and counterpart ministry and low capacity issues. To address the existing policy issues and capacity constraints, more sustained efforts are needed.

62. Cooperation with other donors in the sector, notably the EU and UNICEF, is vital in order to achieve synergies, provide harmonized policy advice and support, and to reduce

overlaps and duplication. Coordination of planning and activities needs to be further stepped up under the proposed Project, given planned joint efforts to support modernization of social care and services. Under the Safety Nets agenda there is also a scope to harmonize donor actions, which need to be supported by more consistent efforts to use the existing inter-agency coordination mechanism in SP more effectively. Information sharing and joint planning will be promoted by the team under this proposed Project.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

Health Sector

63. ***Program management and implementation.*** Although the goals of Den Sooluk are clearly defined, there will be many policy questions that would need to be agreed upon during its implementation. MOH, supported by its subordinate institutions and development partners, will lead all activities related to technical and policy issues. The MOH will also take the lead in designing and implementing a communication strategy targeting all stakeholders including the Parliament, the Prime Minister and President's office, health care providers and final users of health services to ensure support at all levels.

64. Overall responsibility for program management and implementation for the Den Sooluk Program would lie with the MOH and its adjacent organizations at the national and regional levels. Four implementation levels are planned: (1) Government and Parliament for oversight; (2) MOH, MHIF, and MOF—stewardship and barrier removal; (3) MOH Departments, MHIF, with support from specialized institutions—technical coordination at program level and results reporting; and (4) all implementing institutions are responsible for implementing Annual Program of Work (APW) backstopped by Oblast Health Coordinators (who will also be supported by consultants). MOH would have a stewardship and supervisory role in relation to all health-related organizations regardless of ownership and administrative level in the country. The MHIF is a separate legal entity and is responsible for the purchasing of health services covered by the State Guaranteed Package and the Outpatient Drug Benefit. While implementation arrangements have worked reasonably well under the original Project, implementation of Den Sooluk will bring about additional implementation challenges, which will require institutional strengthening, supported under the area of health system strengthening of the Den Sooluk. MHIF will work alongside with MOH towards achieving health sector reforms envisaged under DS.

65. Functional responsibilities for the components of the Den Sooluk will be assigned within appropriate organizational units of the MOH, as further detailed in Annex 3. Implementation responsibility for procurement, financial management and Project management tasks would be with the Deputy MOH and the Financial Policy Department of the MOH. A large amount of implementation and fiduciary capacity building would be necessary and it is planned that functions would be strengthened and integrated into this department over time. The Project Operational Manual will guide implementation and serve as a road map to all participating health sector institutions.

66. ***Partnerships and support mechanisms***. The MOH will establish and agree on an APW in cooperation with financing and implementing partners, which will follow the policy framework outlined in the Den Sooluk Strategy. In addition, detailed implementation plans (blue prints) will be further developed during the first year of implementation for each key area of the reform, with details on the sequencing of the reforms and detailed guidelines and plans for providers' autonomy, including the design, testing, and evaluation of a pilot. Mechanisms of cooperation among financiers and Government will be documented in a Memorandum of Understanding (MOU), outlining organizational, institutional and coordination arrangements for implementation and roles and responsibilities of each partner. Donor cooperation and supervision will be coordinated on a yearly basis by means of an annual Join Annual Review (JAR) and three technical meetings with the Government and implementing agencies. Furthermore, donor agencies will collaborate through the organization of joint supervision meetings and regular information exchange.

Social Protection Sector

67. ***Component Oversight***. The MSD would have both the policy design and implementation oversight roles; it would also promote the new policies within the broader Government and reach out to the general public to gain support of the population. The newly created Public Coordination Council for the implementation of the Social Protection Development Strategy will play the role of an independent oversight body to review implementation of the component and recommend strategic directions and actions as may be deemed necessary.

68. ***Program management and implementation***. The responsibility for leading implementation of this component remains with the MSD and its subordinated institutions at the regional and local levels. Similar to the Health component, it is envisaged to have different implementation levels: (1) the Public Coordination Council to oversee implementation of the SP Development Strategy for oversight; (2) MSD and MOF—policy design, quality control and budgeting for implementation of the models designed and supported by the proposed Project; and (3) regional, district and local social assistance offices as well as disability certification offices and social care centers for testing of the new models, technical coordination at the implementation level and results reporting. Given the low implementation capacity in MSD, relatively small allocation of resources for the SP component, and in order to avoid duplicating implementing agencies, MOH will continue to act as a Project management agent for the SP component as it does for the ongoing Health and Social Protection SWAp1 Project. An important feature of the implementation scheme is that the MSD will retain a Project Coordinator position to be funded by the component and to function as the liaison officer between the World Bank, Government partners, regional agencies, and the MSD as well as to coordinate activities between various MSD departments and divisions. Similar implementation arrangements have worked reasonably well under the original Project and are expected to help preserve the institutional memory and ensure that operational knowledge gained under the original Project is applied on a continuous basis. Consultants will be recruited to advise and guide the MSD on specific directions and activities.

B. Results Monitoring and Evaluation

Health Sector

69. Proposed M&E Strategy for Den Sooluk. The proposed M&E strategy for Den Sooluk is built on past achievements of the current M&E system while ensuring that it is fully synergized with the new paradigm presented in Den Sooluk. As it is not possible to monitor the specific attribution of the Project to the success in the overall implementation of the strategy, the Project will have two sets of indicators to ensure adequate monitoring of the implementation progress as well as to evaluate impact of the reforms: (i) PDO indicators; and (ii) the Joint Assessment Framework (JAF) indicators. PDO indicators will be used to monitor: (i) Government's commitment and evaluate if essential preconditions for achieving Den Sooluk strategy are in place; and (ii) progress towards achieving the key objectives of Den Sooluk, such as improvements in access to key services and financial protection of the population. The set of PDO indicators that will monitor achievements of Den Sooluk strategy will be measured through studies that are part of the JAF and that will be carried out every two years or at least twice during the implementation period.

70. Joint Assessment Framework (JAF) will be used by all DPs as a set of intermediate indicators. The JAF has two sets of indicators, the first of which is designed to track progress in improving health gains based on priority programs while the second set seeks to track progress in health system strengthening based on the Program components (see below Table). In addition to the JAF indicators, there will be several process indicators that will monitor the effectiveness of SWAp management and fiduciary controls. Specific indicators within each of the categories listed below will be monitored during the JAR and will be summarized in Joint Statements, which are produced after each JAR.

Structure of JAF Indicators

Section 1 Expected health outcomes based on priorities of the Program: • Cardio-vascular diseases (CVDs) • Mother and child health (MCH) • Health of children under 5 (ChH) • Tuberculosis (TB) • HIV infection (HIV)
Section 2 Expected health system strengthening outcomes based on the Program components: • Public Health (PH) • Individual services (IS) • Financing (F) • Resource generation (RG) • Stewardship (S)

71. In order to monitor the package of JAF indicators, two rounds of studies looking at the levels of coverage with core services focusing on CVD, MCH, TB and HIV will be conducted in 2013 and end of 2015. Large scale surveys (on informal payments for discharged patients and a household survey) will also be conducted twice during the implementation period. In addition, specific health system studies will be defined annually during the JAR based on key policy

issues. WHO will play a leadership role in implementing these studies. Whenever possible, indicators will be disaggregated to inform gender specific action plans.

72. In line with the proposed implementation strategy for Den Sooluk, M&E capacity will be strengthened at sub-national and institutional levels. The national level indicator package for Den Sooluk will be complemented with Oblast level indicators, around which oblast coordination would be strengthened. Further monitoring capacity in key tertiary institutions will also be developed so that indicator packages for priority programs can be handled at that level.

Social Protection

73. The MSD has developed an M&E framework including a matrix of indicators to track implementation of the Social Protection Development Strategy 2012- 2014. The World Bank has provided technical advice under a Rapid Social Response grant to improve and refine the M&E framework. This work is continuing and efforts will be made to harmonize the M&E of the SP component with that of the medium-term SP Development Strategy as much as possible. The key sources of data for monitoring the SP component would be the administrative records of the MSD, SA Beneficiary Registry, information on public expenditure, and the Kyrgyz Integrated Household Survey (KIHS). In addition, special purpose sample surveys would be developed to support the MSD in the evaluation of pilots in targeted social assistance and new social care models.

C. Sustainability

Health Sector

74. The sustainability of Den Sooluk and the World Bank's and other Development Partners' contribution will be determined by three things: first, the Government's ownership of Den Sooluk and the policy and investment priorities embedded therein; second, evidence of sufficient budget financing for the health sector to levels agreed between MOH, MOF and donors and enshrined in the MTBF; and third, the technical soundness of policy and investment choices embedded in Den Sooluk. These are considered in the form of three questions:

- Is the Den Sooluk Program "owned" by the Government? The answer to this question is "yes". The Den Sooluk Program was developed in a participatory process that involved representatives of health sector institutions and was accompanied by a serious effort to ensure broad stakeholder consultation once the first draft came out. However, the period in which Den Sooluk was developed was characterized by marked political instability. As Den Sooluk implementation will require significant efforts at all levels, including change management at delivery level as well as multi sectoral action at Government level, MOH will need to implement a comprehensive communication strategy targeting a wide-range of stakeholders to ensure support for the Den Sooluk Strategy. Substantial efforts will be required to strengthen the Ministry's ability to champion the reform program within Government and with the parliament and other stakeholders;

- Will budget financing meet the sector's priority needs? As demonstrated over the past several years, the Government has been committed to increasing health spending. As the

level of expenditures reached the level of 13 percent, which is considered adequate for the current fiscal situation, the Government will, at a minimum, maintain this level. This will be monitored as a PDO indicator. Financial needs for the health sector in any country are unlimited but resources are limited. It is acknowledged that the Kyrgyz Republic faces significant macroeconomic constraints. Nonetheless, it is expected that budgets will, to the extent possible, reflect the Government's objective to sustain current level of financing for the health sector to avoid *inter alia* the resurgence of informal payments, departure of health staff for better-paying jobs elsewhere, and creation of a two-tier system. It will, in tandem, be important to address issues concerning fiscal sustainability and prioritization of recurrent and investment expenditures, recognizing that the Kyrgyz Republic's macroeconomic constraints put a ceiling on what realistically can be spent on health. That being said, and given the poor performance of budget allocation and execution in recent years, trends in Government health expenditure vs. agreed targets will be monitored closely under the SWAp as a matter of priority.

- Will MOH make the right policy and investment choices? Two factors provide cause for optimism in this regard: first, the good performance of MOH under the Manas Taalimi Program and the acknowledged efficiency and equity dividends arising from the Ministry's policy and reform choices under that Program; and second, that the Den Sooluk Program itself focuses on the "right" areas, namely, continuing pro-poor financing reforms, reforms to improve efficiency, equity and quality, and critical issues such as *inter alia* public health, priority health interventions and upgrading health infrastructure. Again, the collective scrutiny and consultative processes associated with a SWAp will help MOH and its partners to stay on a path that is consistent with the Den Sooluk Strategy, which is an important factor in determining disbursements under the SWAp.

Social Protection

75. The Government is giving a more prominent role to social assistance programs as promoters and supporters of economic growth. The MSD has recently adopted a medium term Social Protection Development Strategy and has given the following areas priority: (i) developing community-based social care services; (ii) deinstitutionalizing and transforming institutional care into family-based models; (iii) further improvement of targeting and adequacy of social assistance programs; and (iv) introducing new programs to assist people with special needs/disabilities and children in neglect. The Ministry has also been a reliable partner of the international donor community for years, although frequent changes in SP leadership have caused some disruptions. For the period 2012-2014, the MSD has committed to run pilot programs to improve delivery and targeting of social services and programs at the local level. At the same time, the Ministry's administrative capacity is weak and it continues to need outside support. Many business processes are yet to be automated and the Ministry lacks a comprehensive Management Information System (MIS) which would permit evidence-based policy making. Staff needs training, and many methodologies are outdated and need to be modernized. The biggest challenge is implementing the Strategy given the current level of under-funding and capacity gaps. On the other hand, the new Strategy makes the work of the Ministry more focused and allows prioritization. With support from the proposed Project, it is

expected that MSD will be in a better position to take on the challenging tasks of implementing its Strategy over time.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risks	Rating
Stakeholder Risk	High
Implementing Agency Risk	
- Capacity	High
- Governance	High
Project Risk	
- Design	Moderate
- Social and Environmental	Moderate
- Program and Donor	High
- Delivery Monitoring and Sustainability	Moderate
Overall Implementation Risk	High

B. Overall Risk Rating Explanation

76. The Project's overall implementation risk is considered *high* as detailed in the Operational Risk Assessment Framework (Annex 4).

77. At the sector level the overall risk is considered *substantial.* The key risks affecting the health sector involve the risk that any policy redirection or decrease in external support would have a negative impact on the health sector and thereby could jeopardize Project's impact. Changes of leadership in the MOH might result in deviation from the reform path. The existing coordination mechanism with donors and governance of SWAp implementation are not clear and may create difficulties in supervision and in adherence with World Bank procedures due to "collective" management of the implementation process. Furthermore, although health is in a somewhat better position than other sectors in respect to Public Finance Management, key reforms depend on strengthening fiduciary tasks and multi-year budget planning and execution in the context of overall Government reforms. Lastly, MOH, which is the implementing agency, has a relatively weak capacity and high turnover of staff primarily because of low salaries.

78. In Social Protection there are two types of risks: (i) the Government is facing multiple pressures to reverse its policy of targeting more resources to the poor; and (ii) Ministry of Social Development's agenda is also threatened by lack of appropriate funding provision from the Republican Budget. Further changes in leadership and management in the sector could also limit the prospects for successful implementation of the Project.

79. At the Project level the implementation risk is considered *moderate.* The Project approach has been tested with good results in the Kyrgyz Republic and its implementation has been evaluated favorably in various studies, including the IEG's assessment of performance of SWAps (2009). As the ISN states "the continuation of the multi-donor SWAp will be essential to maintain the State's credibility as a provider of a critical public service". Despite these good

results, many challenges remain to be addressed, particularly since the event of 2010. This includes weaker coordination among the DPs, increased fiduciary risks, and an overall slow pace of implementation of key reforms. Lessons learned from Manas and Manas Taalimi's implementation, have been assessed and are informing the design of Den Sooluk and SWAp2. Nonetheless, the implementation of the Den Sooluk Program will bring additional challenges, which will require continuous and systematic efforts to strengthen the institutional capacity of MOH, MHIF, and health providers to improve the overall delivery of services. On the Social Protection front, the World Bank will continue coordinating its policy advice and speaking with one voice with other DPs active in SP, notably the EU and UNICEF. Overall, because the stakeholder, capacity, and governance risks rating are high, the implementation risk has been rated as *high*.

80. Disclosure of Integrity Risks to the Board. A number of risks related to the procurement of medical equipment have been identified particularly in preparation of bids (technical specifications that prevent fair competition), possible collusion in bidding and capacity of post installation service, such risks may be significantly heightened where local competition among experienced bidders is inherently weak and where capacity to monitor quality of deliverables is lacking. To mitigate these risks, procurement risk mitigation plan, procurement capacity building action plan, and a Governance and Accountability Action Plan (GAAP) have been agreed with the MOH (for details refer to Annex 3).

VI. APPRAISAL SUMMARY

A. Economic and Financial Analyses

Health Sector

81. **Economic Analysis.** Den Sooluk aims at improving health outcomes over the next five years in the following four priority areas: cardiovascular diseases (CVD), Mother and Child Care (MCH), Tuberculosis (TB), and Human Immunodeficiency Virus (HIV). Health outcome objectives are achieved through improvements in both population and individual core health services. The cost-effectiveness of key interventions that will be introduced by Den Sooluk is summarized in the table below (see also Annexes 7 and 8).

Condition, type of intervention and setting	Description of the intervention	Cost effectiveness (US$/DALY)
CVD – population intervention	Tobacco addiction, non-price interventions: advertising bans on television, radio, and billboards; health information and advertising in the form of health warning labels on tobacco products; interventions to reduce tobacco supply, such as smuggling control; restrictions on smoking	353
CVD – population intervention	Tobacco addiction, taxation causing price increase: price increase due to tobacco taxes to discourage tobacco use, prevent initiation (and subsequent addiction) among youths, increase the likelihood of cessation among current users	22
CVD – population intervention	Alcohol abuse: advertising ban and reduced access to beverage retail	404
CVD – population	Alcohol abuse: excise tax, advertising ban, with brief advice	631

Condition, type of intervention and setting	Description of the intervention	Cost effectiveness (US$/DALY)
intervention		
CVD – population intervention	Lifestyle intervention: behavioral change for weight reduction by means of a combination of a low-calorie diet and moderate physical activity	100
CVD – individual intervention at primary health care level	Alcohol abuse: brief advice to heavy drinkers by primary health care providers	642
CVD – individual intervention at primary health care level	Diabetes detection and treatment at the level of primary health care as one of the risk factors for cardiovascular diseases	830
CVD - individual intervention at primary health care level	Prescription of Aspirin and beta-blocker for patients with high risk of myocardial infarction	14
CVD - individual intervention at primary health care level	Prescription of ACE inhibitor and beta-blocker, with diuretics for patients with high risk of congestive heart failure	150
CVD - individual intervention at hospital level	Access to thrombolytic therapy for patients with myocardial infarction	14,000
Maternal health – population intervention	Sustained child health and nutrition program: inclusion of prenatal care, women's health and nutrition, breastfeeding promotion and counseling, complementary feeding, growth monitoring and promotion, micronutrient supplementation, micronutrient fortification, supplementary feeding	225
Maternal health – individual intervention at primary health care level	Increased quality of primary care coverage: antenatal care for timely diagnosis of anemia and prescription of iron-containing drugs and folic acid, diagnosis of bacteriuria and prescription of antibiotics, early detection of hypertensive disorders and timely referral to the delivery, proper monitoring of the fetus, detection and treatment of sexually transmitted infections, prevention of HIV transmission from mother to child	132 - 88
Maternal health – individual intervention at primary health care level	Family-planning programs: family planning services through the use of modern methods of contraception and counseling, counseling on preparing women for childbirth and dangerous signs of pregnancy	117
Maternal health – individual maternity facilities	Improved quality of care and coverage to reduce maternal and infant mortality in maternity facilities: enhanced package including availability of doctor and full range of basic and comprehensive emergency obstetric care	152 - 86
Maternal health - emergency medical care	Improve quality of comprehensive emergency obstetric care: upgrade the existing system, equipping with necessary equipment and drugs for emergency conditions in pregnant women (hemorrhage, hypertensive disorders) at the level of emergency medical care	127 – 87
Child health – population	Improve public awareness of the standard package of recommended preventive services for children under 5 years, which includes an assessment of development, immunization, routine micronutrient fortification of food , diagnosis and treatment of anemia, counseling parents on the grounds of dangerous diseases in children	37 – 7
Child health – individual intervention at primary health care level	Improve the quality of services at the level of primary care ensuring the delivery of a standard package of recommended preventive services to all children, including assessment of	39

Condition, type of intervention and setting	Description of the intervention	Cost effectiveness (US$/DALY)
	development using the card of the child's development, immunization according to the National calendar, routine micronutrient fortification of foods (to prevent anemia and other diseases associated with micronutrient deficiency), diagnosis and treatment of anemia, counseling of parents on important preventive measures, provision of necessary services and medical care for diseases in children (oral rehydration therapy and zinc for diarrhea, antibiotics for pneumonia), assessment of the condition, reasonable and timely referral to hospital	
Child health – individual intervention at hospital level	Case management at community, facility, and hospital levels: introduction of a proper division of children admitted to hospital with diarrhea and respiratory diseases (based on an assessment of urgent and priority signs of disease in an outpatient or counseling-diagnostic units), and provision of timely medical care based on proven methods and approaches	398
TB – individual intervention at primary health care level	Directly observed short-course chemotherapy improved approaches to the organization of directly observed treatment of tuberculosis at the primary health care organizations	301 – 102
TB – individual intervention at primary health care level	Introduction of new rapid diagnostic methods (e.g. GeneXpert) with all the necessary conditions for training, maintenance, and quality assurance measures	625 - 170
TB – individual intervention at hospital level	Management of drug resistance: application of standardized schemes of controlled chemotherapy for the treatment of newly diagnosed TB patients; full coverage with second-line drugs treatment of patients with drug-resistant TB	318 – 207
HIV – population intervention	Peer and education programs for high-risk groups: reduce risky behavior among key population, young people; Preventive work with population through the VHCs, schools, work with local keneshes, aiyl okmotu etc.	37
HIV – population intervention	Home care: work with families of people living with HIV, non-profit organizations and communities, provision of assistance to family members on the issues of care and support, prevention of "burning", adherence to treatment, prevention of HIV transmission from mother to child, etc.	673
HIV – individual intervention at primary health care level	Voluntary counseling and testing: full coverage with counseling and referral of key population groups for HIV testing	47
HIV – individual intervention at primary health care level	Antiretroviral therapy: people living with HIV infection receive antiretroviral therapy and are registered in accordance with clinical protocols	922
HIV – individual intervention at primary health care level	Mother-to-child transmission prevention: examination of pregnant women for HIV infection in primary care organizations	192
HIV – individual intervention at primary health care level	Tuberculosis co-infection prevention and treatment	121
HIV – individual intervention at hospital level	Mother-to-child transmission prevention: conduct of a rapid test for pregnant women unexamined for HIV in childbirth, prevention and treatment with antiretroviral drugs in maternity facilities for early detection and prevention of HIV infection	192
HIV – individual intervention at hospital level	Treatment of opportunistic infections in hospitals in the profile of these diseases (infectious units, dermatovenerological, neurological, narcological, somatic, etc.)	156

82. The large majority of the proposed population and individual interventions are highly cost-effective and the cost per DALY adverted is well below the GDP per capita of the Kyrgyz Republic.

83. **Financial analysis**. To ensure the financial sustainability and the achievements under "Manas Taalimi", the Government and Joint Financiers agreed on a set of "rules" governing the allocation and execution of public funds to the health sector. These rules provided increased fiscal space to implement pro-poor and equity oriented health reforms and policies, and improved predictability of revenue flows to the health sector. In continuation of these arrangements under Manas Taalimi, JFs and Government agreed to review the allocation and execution of public funds to the health sector under the period of implementation of Den Sooluk according to the following budget targets:

84. **Target #1** – the proportion of consolidated health expenditures to total consolidated government expenditures should be no less than 13 percent. The target should be met in the initially approved budget as well as in revised budgets.

85. Consolidated health expenditures are defined in accordance with the definition of expenditures provided in the Law of the Kyrgyz Republic on the Main Principles of the Budget Law, plus contributions (payroll tax) for Mandatory Health Insurance (according to the annual Law of the Kyrgyz Republic on the budget of the Social Fund) less external budget support for health and unforeseen expenditures related to a declaration of state of emergency and natural disasters. Consolidated health expenditures include expenditures under the following positions:

- #36 {MHIF}
- #37 {Ministry of Health}
- #12230 {Health Facility under the Presidential Administration}
- Health expenditures of local government administrations
- Contribution on premium payments for MHIF (from Social Fund)

86. Total government's consolidated expenditures are defined according to definition in the Law of the Kyrgyz Republic on the Main Principles of the Budget#78 dated June 11, 1998 (with all amendments), plus contributions (payroll tax) for Mandatory Health Insurance (according to the annual Law of the Kyrgyz Republic on the Budget of the Social Fund") less external budget support for health. Unforeseen expenditures allocated for liquidation of implications of emergency and natural disasters are excluded from the total government's health expenditures.

87. **Target #2** – the negative quarterly deviations of the executed health budget from the revised budgets should be less than 5 percent; and

88. **Monitoring Target #3** – there should be an increase in the proportion of non-salary costs in total government health expenditures, i.e. total government health expenditures as per the definition in Target #1 minus expenditures under the economic classification #21 as defined in the Ministry of Finance Prikaz N 62-п dated March 30, 2012.

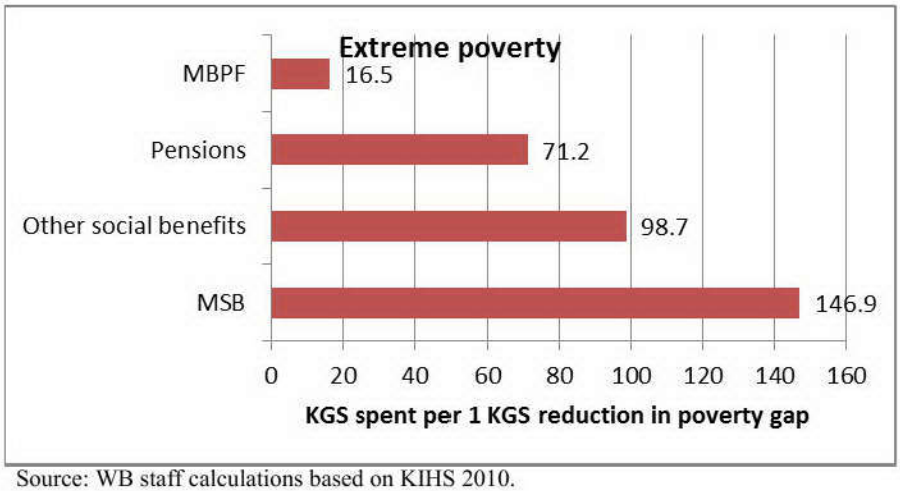
89. JFs will monitor Target #3 expecting to see an increase in the proportion of non-salary costs in total government health expenditure given the low proportion of non-salary expenditures

in both 2011 and 2012 (37.8% and 30.1%, respectively), while the average level recorded over the 2007-2010 period was 46%. It is expected that the proportion of non-salary costs in total government health expenditure would rise to 35 % by 2016.

Social Protection Sector

90. In Social Protection, improvements in the targeting of social assistance are expected to result in fiscal savings and improved cost-efficiency. Currently, more than two-thirds of public expenditure on non-contributory social transfers contributes little to poverty reduction. A gradual shift towards means-testing in social assistance would free resources which could be used to improve coverage of the poorest quintile by the Social Safety Net as well as to improve adequacy of assistance to needs. As experience elsewhere in the region has shown, means-tested benefits perform better in terms of their impact on reducing the poverty gap per unit of public resources spent. This is also the case in the Kyrgyz Republic as demonstrated in the graph below. A more robust and inclusive Social Safety Net would also allow carrying out necessary tariff reform in the energy sector while providing adequate protection to the poorest.

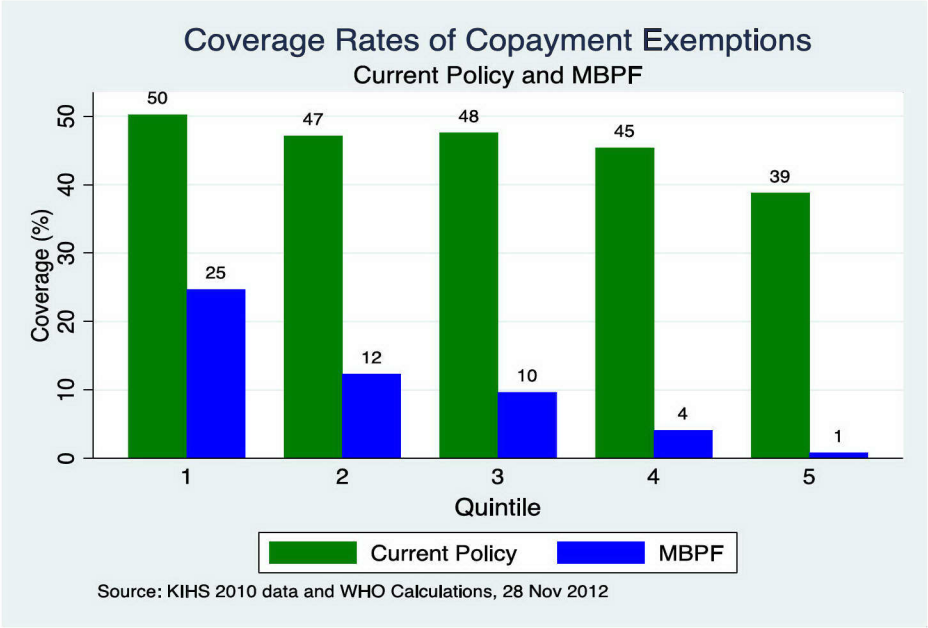
Figure 1: Cost-benefit ratios of social protection benefits, 2010



Source: WB staff calculations based on KIHS 2010.

91. The graph below demonstrates targeting effectiveness of the means-tested MBPF program in comparison to the categorically targeted exemptions from copayments for SGBP services. MBPF program is considerably more pro-poor compared to copayment exemptions. The process of discussing the efficiency of the current copayment exemption targeting mechanism is under way. Efficiency gains could be potentially realized in case a consensus is reached that means-tested targeting in the health sector would be more pro-poor and actions are taken to this end. The proposed Project will contribute to this discussion, including by providing analytical inputs.

Figure 2: Coverage Rates of Copayment Exemptions



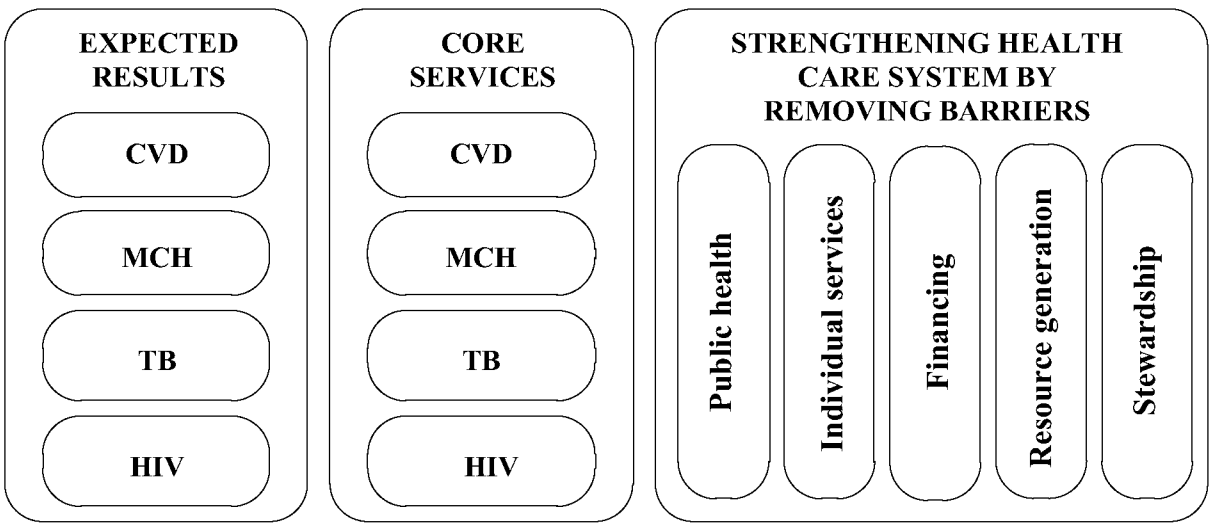
B. Technical

92. Den Sooluk is built on the achievements of the Manas and Manas Taalimi programs and incorporates important lessons learned during the implementation of these previous programs. The strategic approach of Den Sooluk focuses on creating a strong link between program activities and their impact on health outcomes and is based on three basic principles related to each other and based on the foundations laid during the past reforms: (i) expected improvement in health outcomes; (ii) core services needed to achieve the expected improvement in health outcomes; and (iii) identification and removal of barriers in the health care system that prevent coverage of core services, thus hindering the achievement of expected improvement in health outcomes.

93. The starting point of DS is to select the four priority health improvement areas (CVD, MCH, TB and HIV) which are essential to achieve better overall health outcomes. The second step is to identify evidence-based core services for each of the program areas. Core services include services at the population level, individual evidence-based health services and

appropriate institutional arrangements necessary for their implementation. Third, health system strengthening in Den Sooluk is planned through identification and removal of the barriers that have prevented for many years core health services coverage needed to achieve improvement of health outcomes. For each of the four program areas, systemic barriers have been identified and are grouped around the main functions of the health system: public health, individual service delivery, financing, resource generation and stewardship.

Figure 3: Strategic approach of Den Sooluk



C. Financial Management

94. Assessment of the financial management arrangements established by the MOH and the MHIF, and their subordinated institutions[3], was conducted in October 2012, in conjunction with the financial management review of the ongoing Health and Social Protection Project (SWAp1). This was followed by the more comprehensive Integrated Fiduciary Assessment (IFA) in December 2012 aimed at refining capacity building and fiduciary risk mitigation measures to be implemented under the Second Health and Social Protection Project (SWAp2). The IFA included reviewing the budgeting, funds flow, accounting and reporting, internal control, as well as audit and procurement practices in the health sector for implementation of SWAp2. The IFA also reviewed the status of implementation of capacity building and fiduciary risk mitigation measures under SWAp1, including automation of accounting and reporting, which has been largely rolled out throughout the country, establishment and strengthening of internal audit units in the MOH and MHIF to strengthen the internal control environment, annual financial and operational audits conducted by an independent audit firm, taking note of the fiduciary reviews that have been conducted regularly as part of the JAR. The IFA concluded that notable progress has been made in all areas of financial management, disbursement and procurement during the implementation of SWAp1. However, significant weaknesses still exist, particularly in the control environment at the level of individual health organizations. The IFA proposes additional

[3] Included visits to Issyk-kata Rayon Hospital and FMC, Soukuluk Rayon Hospital and FMC, Chui Territorial Department of the MHIF, and the National Hospital in Bishkek

capacity building and risk mitigation measures aimed at further strengthening the fiduciary arrangements.

95. Project funds under SWAp1 have been pooled with the Republican budget, under investment and recurrent categories, and released to the health sector through the Treasury system. There have been delays with transfer of funds, especially for the investment portion, resulting in delayed payments to contractors and consultants. Delays have also been caused by delayed approval of the budget which, over the past 2-3 years has seen the budget approved in April or May, thus delaying disbursements, as these have been based on the existence of an approved budget and APW. A similar pooling arrangement will be followed under the Second Health and Social Protection Project. To ensure more even flow of funds, and uninterrupted implementation of Project activities, the MOF will include Project funds in the $1/12^{th}$ of the annual budget usually released prior to budget approval. During implementation, the MOH will monitor the flow of funds from the MOF to the health sector and maintain a schedule of funds flow that will be submitted to the World Bank together with the quarterly reports.

96. Financial reports required under the ongoing SWAp1 have been submitted regularly but often with some delays and inaccuracies that have had to be corrected before the reports can be accepted as satisfactory. The reports that are consolidated by the MOH using the 1C software are submitted by the health facilities, based on the reporting format designed by the MOF, but with modifications to provide additional information to the World Bank. The reports are submitted by health facilities mainly in hard copies as many of these facilities still prepare them manually. The reports are reconciled with the Budget Execution Reports of the Treasury as additional confirmation of completeness and accuracy. With improved automation throughout the health sector, it is expected that the reports will, in the future, be fully generated by the automated accounting system. Under SWAp2, quarterly reports based on the format to be agreed with the World Bank and included in POM would be submitted within 45 days after the end of each quarter.

97. The internal control environment remains weak, especially at the health facility level, with numerous cases of deficiencies highlighted in the reports of the independent external auditor and the internal auditors of the MOH and MHIF. There is little evidence that management of health care facilities are taking actions to strengthen the internal control systems, while action by MOH and MHIF management has been limited to issuing orders (Prikaz) without effective follow up to ensure that necessary action is taken by the health facility managers. Internal audit of health facilities subordinated to the MOH has also been hampered by a staff shortage (only 3 people in internal audit unit) and lack of an adequate budgetary allocation to enable the internal auditors to travel to the regions. The internal audit unit at the MHIF has recently been strengthened by the hiring of additional staff, but capacity in terms of skills is still limited. Under SWAp2, technical assistance will be provided to strengthen the internal audit functions as part of capacity building plan.

98. External audits of SWAp1 have been performed by a private sector audit firm, but the audit reports have been submitted to the World Bank with considerable delay. Reports of the financial and operational audits for 2011 were submitted in October 2012, which is almost 4 months after the due date. Audit reports for 2010 were delayed even longer, and the delays have been caused mainly by delayed contracting of the auditor. Several weaknesses in operational and

internal control procedures, procurement, accounting and recordkeeping in the health facilities have been highlighted in successive reports of the independent auditor. Implementation of actions recommended to eliminate the weaknesses has been slow due to a number of factors, including frequent management changes at the MOH and MHIF, resulting in ineffective follow up, low skill level and high staff turnover of accounting personnel in the health care facilities. To avoid audit delays under the Project, the contracting of the external auditors, preferably for more than one year, i.e., multi-year contracts, to prepare financial and operational audit reports is a *condition of effectiveness*.

99. Overall the financial management arrangements in the health sector, including budgeting, accounting, internal controls, reporting and staffing, mirror the situation in the general public sector, and are currently ***moderately unsatisfactory***. This is predominantly as a result of the most recent qualified audit opinion that was issued on the 2011 annual financial statements, identifying a number of internal control weaknesses at the individual health facilities. On the other hand, the FM arrangements at the two key implementers of the program, namely MOH and MHIF, have been rated as ***moderately satisfactory.*** A number of capacity building measures designed to strengthen accounting and internal control functions have been implemented, although others not fully. Fiduciary risks remain ***high*** due to country and sector circumstances, but appropriate risk mitigation measures designed to reduce the overall risk continue to be implemented, including strengthened internal audit reviews, automation of accounting systems to improve efficiency of accounting processes and reliability of the underlying financial reports and training. The MOH and the MHIF accounting and reporting systems are expected to be fully automated under the ongoing automation of the accounting systems in health care facilities, while the internal audit function would be further strengthened, including technical assistance as part of the capacity building strategy. Targeted capacity building and fiduciary risk mitigation measures will be implemented throughout the life of the Project as part of Component 1 of the proposed Project. Successful implementation of the proposed capacity building and fiduciary risk mitigation measures will lead to reduction of the overall fiduciary risk, and improved FM risk ratings.

D. Procurement

100. Procurement for the proposed Program would be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Procurement Guidelines); and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Consultant Guidelines) and the provisions stipulated in the Financing Agreement. The Program shall also follow the Guidelines: On Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants dated October 15, 2006 and revised in January, 2011.

101. As part of Project preparation, the World Bank's fiduciary team conducted an Integrated Fiduciary Risk Assessment. Many of the fiduciary weaknesses discussed in this assessment mirror larger problems of the country's Public Finance Management (PFM) system and public procurement. The risk mitigation plan and capacity building action plan (see Annex 3 for details) aims at improving the procurement capacity of the health sector. This will provide

multilateral and bilateral donors the necessary assurances that the funds provided by them for the improvement of the health sector in the Kyrgyz Republic will lead to the intended results. It must, however, be noted here that the issues in the health sector cannot be resolved in isolation from broader country PFM reforms, e.g., treasury modernization, accounting reforms, including development of chart of accounts, salary of civil servants increase, development of institutional and legal framework for internal audit, etc. These reforms, however, can be (and to some extent are being) introduced in a parallel rather than in a sequential manner. The Project procurement risk is "High" and residual risk after implementation of risk mitigation measures is rated "Substantial".

102. Procurement Arrangement: The procurement following ICB procedures and hiring of consultants (more than US$100,000) shall be carried out by MOH. During implementation, if adequate capacity is built in the Republican Hospitals, then this function could be transferred to achieve Project objective to move MOH to a stewardship role and to discharge regulatory and oversight function rather than doing transactions. The procurement of works and goods following NCB procedures and shopping and consulting services (less than US$100,000) shall be procured by the health facilities following updated harmonized procurement manual to be agreed with the World Bank by *effectiveness*.

E. Social (including Safeguards)

103. The design of the proposed Project supports the implementation of the Government's National health Strategy (Den Sooluk) and therefore it would include activities that have national coverage to prevent the perception of favoring some ethnic groups over others, including supporting country-wide policy reforms in social protection and in health.

104. The team is applying the World Bank's post-conflict filter approach to ensure that the Project does not negatively affect social relations in the country and is inclusive of all key groups. The team has identified potential social opportunities within the Project design that could potentially contribute to the mitigation of existing societal stressors. By supporting the strengthening of health systems equitably across regions, the proposed Project can help support efforts on inclusion of all regions of the country in the critical areas of human development and social services targeted by the Project. Encouraging outpatient and preventive treatment should also promote greater and more effective use of existing capacity, helping reduce regional inequalities in access to services. Intended strengthening of the national policy on special needs as well as the development of community-based social care services would also likely contribute to strengthening cohesion and resilience in stressed communities. The Social Protection component explicitly targets improved social assistance and social services for the poor and disadvantaged. The third, unfunded component allows for a rapid response to prevent or rapidly mitigate the potential adverse impacts on vulnerable populations in the event of a new shock.

105. The team also notes the existence of certain potential social risks that the proposed Project will need to remain sensitive to during the course of implementation. Given the sector-wide approach, it is difficult to determine the geographic coverage of potential activities at an early stage. It is not yet possible to reliably estimate distribution of staff, trainings and services that could in turn influence beneficiaries' perception of availability, access and quality of services among different regions. When resources are not equitably distributed, or are not

directed to the localities with the greatest needs, this can contribute to grievances. The rollout of investments, particularly with regard to rehabilitation of health infrastructure, should ensure a broad geographic coverage across the country's Oblasts and Rayons. Ensuring adequate communication across potential beneficiaries and non-beneficiaries is critical to explain limited resources and their distribution. Local Government institutions, public organizations and community consultations should be employed by the counterparts and the World Bank team to ensure robust public engagement. During implementation, the Project team will monitor the geographic coverage of Project benefits as well as the demographic profile of beneficiaries to ensure that the proposed Project is in fact resulting in sector-wide investments across the country's regions and social groups; these measures will be incorporated into the Project results monitoring. Strengthened means testing to better target social assistance to the poor is also an important objective. The Project team, however, will remain sensitive to any reduction in benefits this might imply from currently benefitting groups. In the Kyrgyz context, changes in social assistance benefits can engender strong responses, and the Project team will remain attuned to such responses and risks through ongoing community-level monitoring and consultations.

106. Overall, the supervision plan of the World Bank as well as the counterpart implementation plan will include ongoing Focus Group Discussions and other forms of outreach at the community level in different regions of the country to monitor local-level perceptions of the health reform efforts and social protection investments as the sector-wide initiatives are implemented. This outreach will also include ongoing consultations with civil society at the national, regional and local levels who are active in the health and social sectors. The participation of local communities as well as local authorities in contributing their views on such matters of practice as employment opportunities, cost of services, distributions under scarce resources, grievance mechanisms in cases of poor treatment etc, will strengthen social sensitivity during implementation and supervision. The counterparts and the World Bank team will also coordinate on a communications strategy to ensure that clear and accessible messages are used to explain the scope and benefits of the components supported under the proposed Project.

107. Neither resettlement nor changes in current land use are anticipated under the proposed Project and the Project team will continue to monitor that this remains the case during its implementation.

F. Environment (including Safeguards)

108. The Project is assigned with the World Bank environmental category B, as only moderate negative environmental impacts are anticipated. Minimal to moderate environmental impacts are expected from civil works for rehabilitation or construction of MoH facilities in various locations around the country. Expected negative environmental impacts include dust and noise related to renovation, demolition and construction; disposal of construction waste; and disposal of wastewater, emissions and medical waste during operation of the facilities. It is anticipated that sub-project activities would fall into category B or C. Should any Project activities be determined to have significant safeguards issues such that they would be considered category A, the Project would need to be restructured to reflect the change in category. Positive environmental impacts include improved medical waste management at facilities that are renovated or reconstructed under the proposed Project. The EMP of the first Health & Social

Protection Project and its Additional Financing has been modified by MOH for the current Project as an Environmental Management Framework (EMF), to include a screening tool to identify sub-project activities that would require environmental assessments and management plans (site-specific EMPs), and provide guidance for the preparation of the EMPs. The site-specific EMPs will be provided to the World Bank for review and no objection prior to the start of renovations or reconstruction of medical facilities. The EMF specifies that land acquisition is not eligible for funding under the proposed Project. The new EMF has been disclosed and consultation with stakeholders (including donor partners) took place in country prior to appraisal.

109. The Department of Sanitary Epidemiological Surveillance and United Directorate of Construction Enterprises under the MOH will undertake the safeguards functions for the Project. Overall responsibility for program management and implementation for the Den Sooluk program is with the MOH and its adjunct organizations at the national and regional levels. MOH has a supervisory role in relation to all health-related organizations regardless of ownership and administrative level in the country. The executing agency of the World Bank's support is the MOH through its various administrative divisions and subdivisions. IDA funds flow through the MOH.

110. MOH has successfully implemented three World Bank- financed operations in the health sector, and significant Project management capacity has been built. Specialists have been identified within the Department of Sanitary Epidemiological Surveillance (SES), who - together with the staff of the MOH's United Directorate of Construction Enterprises – are responsible for coordination and supervision of the EMP and risk mitigation measures to be undertaken during implementation. The team works closely with the MOH's Department/Unit responsible for implementation of the Project, staff on the ground, and with national and oblast level environmental officials. The team (a) coordinate relevant training for staff, designers and local contractors; (b) disseminate existing environmental management guidelines and develop guidelines in relation to issues not covered by the existing regulations, for implementation, monitoring and evaluation of mitigation measures; (c) ensure contracting for construction and supply of equipment includes reference to appropriate guidelines and standards; and (d) conduct periodic site visits to inspect and approve plans and monitor compliance. These arrangements have been proven effective for management of environmental safeguards issues in the construction of an annex to the MOH's main building in Bishkek, which was financed under the First Health & Social Protection Project.

Annex 1: Results Framework and Monitoring

Project Name: Second Health and Social Protection Project (P126278)

Results Framework

Project Development Objectives

PDO Statement

The proposed PDO is to: (i) improve health outcomes in four health priority areas in support of the "Den Sooluk" National Health Reform Program 2012-2016; and (ii) enable the Government's efforts to enhance effectiveness and targeting performance of social assistance and services.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
				YR1	YR2	YR3	YR4	End Target			
(a) Percentage of Government consolidated health expenditures over total consolidated Government expenditures	☐	Percentage	12.90	13.00	13.00	13.00	13.00	13.00	Annual	IFRs	MOF
(b) Number of disease management programs created	☐	Number	0.00	0.00	1.00	2.00	2.00	2.00	Annual	MOH report	MOH
Coverage of the population enrolled in disease management programs	☐	Text	TBD	TBD	TBD	TBD	TBD	TBD	Annual	MOH report	MOH
(c) Access of the patients to preventive care measured by %	☐	Percentage	27.00	27.00	30.00	35.00	40.00	50.00	2 times during the Project	Two special Surveys; statistical reports	MOH

of detected cases of hypertension (HT) at the primary health care level											
(d) Financial protection of population measured by level of out-of-pocket payments as a proportion of total household consumption in the two poorest quintiles	☐	Text	Poorest quintiles: 30 2nd poorest quintiles: 22		Poorest quintiles: 28 2nd poorest quintiles: 20			Poorest quintiles: 26 2nd poorest quintiles: 18	2 times during the Project	Two special surveys	MOH
(e) Share targeting of MBPF transfers by reducing exclusion errors	☐	Percentage	71.00	71.00	68.00	65.00	62.00	60.00	Annual	KIHS	MSD/WB
(f) Share of Social Assistance spending on poverty-targeted program(s)	☐	Percentage	15.50	15.50	20.00	25.00	30.00	35.00	Annual	KIHS	MSD/WB

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
				YR1	YR2	YR3	YR4	End Target			
Percentage of negative deviations of the executed health budget from the initially approved budget and quarterly allocations and	☐	Text	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%	Annual	MOF Budget report	MOF

execution of the health budget											
Inter-sectoral determinants of health by conducting at least two comprehensive campaigns	☐	Number	0.00	0.00	1.00	2.00	2.00	2.00	2 x during implementation	MOH Progress reports	MOH
Submission of IFRs satisfactory to IDA within due dates according to Financing Agreement	☐	Yes/No	No	Yes	Yes	Yes	Yes	Yes	Quarterly	IFRs	MOH
Indicators in JAF have baseline and are up to date	☐	Percentage	0.00	50.00	60.00	80.00	90.00	100.00	Annual	JAF	MOH
Indicators in JAF are disaggregated by gender and location where applicable	☐	Yes/No	No	No	Yes	Yes	Yes	Yes	Annual	JAF	MOH
Health personnel receiving training (number)	☒	Number	0.00					TBD	Annual	Progress reports	MOH
Children immunized (number)	☒	Number	0.00					TBD	Annual	Reports	MOH
Children immunized - under 12 months against DTP3 (number)	☒	Number	114000	114000				TBD	Annual	Reports	MOH
Children immunized -	☒	Number	586000					TBD	Annual	Reports	MOH

under 5 years against Polio (number)											
Share of social assistance (MBPF, Monthly Social Benefits (MSB) and Cash compensations) beneficiaries with records in the SA Beneficiary Registry	☐	Text	No	No	No	Piloted	Yes	Yes	Annual	Progress reports	MSD
Turnaround time for processing MBPF applications	☐	Text	8 days	8 days	7 days	7 days	5 days	5 days	Annual	MSD reports and operational data	MSD
Roadmap to reform disability certification service developed and endorsed by the Ministry	☐	Text	No	No	Developed	Developed and tested	Developed, tested and refined	New model implemented	Semi-annual	Progress reports	MSD
Number of beneficiaries of targeted social assistance programs	☐	Number	TBD						Annual	Administrative data	MSD
Monthly Benefit for Poor Families with Children (MBPF)	☐	Number	TBD						Annual	Administrative data	MSD
Monthly Social Benefits (MSB)	☐	Number	TBD						Annual	Administrative data	MSD

Annex 1: Results Framework and Monitoring

Country: Kyrgyz Republic

Project Name: Kyrgyz Second Health and Social Protection Project (P126278)

Results Framework

Project Development Objective Indicators	
Indicator Name	Description (indicator definition etc.)
(a) Percentage of Government consolidated health expenditures over total consolidated Government	Baseline represents average over the last 5 years.
(b) Number of disease management programs created	Two programs for disease management and control (i.e., hypertension, diabetes, etc.) created with incentives for providers and patients to comply.
Coverage of the population enrolled in disease management programs	Enrollment or coverage of the population under disease management and control programs show increasing trends.
(c) Access of the patients to preventive care measured by % of detected cases of hypertension (HT) at the primary health care level	Percent of detected cases compared to estimated number of cases. Denominator will be set by the survey. Last baseline (2009) shows 28% of total population was detected with hypertension.
(d) Financial protection of population measured by level of out-of-pocket payments as a proportion of total household consumption in the two poorest quintiles	Ratio between out-of-pocket and household consumption among two poorest quintiles. This will be monitored from large surveys to be conducted two times during Project implementation.
(e) Share of targeting of MBPF transfers by reducing exclusion errors	60% or less End Target
(f) Share of Social Assistance spending on poverty-targeted program(s)	> 15.5% YR1; >35% End Target
Intermediate Results Indicators	
Indicator Name	Description (indicator definition etc.)
Percentage of negative deviations of the executed health budget from the initially approved budget and quarterly allocations and execution of the health budget	Budget execution rate compared to budget approved.
Inter-sectoral determinants of health by conducting at least two comprehensive campaigns	Campaigns targeting wide range of stakeholders including legislators on tobacco control, road safety and dietary measures

Timely submission of IFRs satisfactory to IDA within due dates according to Financing Agreement	IFRs should be submitted within 45 days upon the end of each reporting period (quarterly).
Indicators in JAF have baseline and are up to date	Each value should be read as: at least x% of indicators in JAF are up to date.
Indicators in JAF are disaggregated by gender and location where applicable	JAF indicators will be disaggregated to reflect gender disparities where possible.
Health personnel receiving training (number)	This indicator measures the cumulative number of health personnel receiving training through a Bank-financed Project.
Children immunized (number)	This indicator measures the cumulative number of children receiving vaccines purchased through a Bank-financed project, as well as the cumulative number of children immunized with vaccines purchased with other resources (i.e. GAVI or government funds) that are delivered through a Bank-supported program. It captures the number of children immunized and not the number of vaccinations.
Children immunized - under 12 months against DTP3 (number)	If Bank financing supports the routine immunization program through health system strengthening activities (e.g. logistics, surveillance, outreach, training of health workers in providing immunization) or the procurement of vaccines, the number of children under one year who have been immunized against DTP3 (i.e. the third dose of DPT) will be recorded. Pro-rating based on proportion of Bank financing is not required.
Children immunized - under 5 years against Polio (number)	If the Bank financing supports the procurement of polio vaccines through the 'buy-down' mechanism, the number of children receiving at least one dose of polio vaccine will be recorded in the ISR.
Share of social assistance (MBPF, Monthly Social Benefits (MSB) and Cash compensations) beneficiaries with records in the SA Beneficiary Registry	Proportion of total number of beneficiaries compared to those registered in the formal (electronic) registry of SA.
Turnaround time for processing MBPF applications	Turnaround processing time to measure efficiency of execution of SA.
Roadmap to reform disability certification service developed and endorsed by the Ministry	Disability criteria for eligibility to SA will be revised.
Number of beneficiaries of targeted social assistance programs	Total number of beneficiaries will be recorded.
Monthly Benefit for Poor Families with Children (MBPF)	Baseline to be determined the first year of implementation; To report total of which number of female receiving benefits.
Monthly Social Benefits (MSB)	Baseline to be determined first year of implementation; To report total of which number of female receiving benefits.

Annex 2: Detailed Project Description

Kyrgyz Republic: Second Health and Social Protection Project

1. The proposed Health and Social Protection Project 2 would be implemented over a period of five years using a Sector Investment and Maintenance (SIM) instrument. Similar to its predecessor, it would adopt a SWAp Approach for the health sector while using a traditional World Bank-investment arrangement for the social protection component. Development Partners will significantly contribute to effective Project implementation. The roles and responsibilities of the development partners are presented in Annex 3.

2. The Project consists of three components. The first component supports implementation of reforms in the health sector envisaged in the Den Sooluk reform strategy 2012-2016. The second component supports the Governments' Social Protection Development Strategy 2012-2014 to improve the efficiency and effectiveness of cash benefits and social care services in combating poverty. The synergy between the two components relates to targeting accuracy, which is needed in health and social services as well as social assistance. A third unfunded component has been included to improve the Government's capacity to respond in the event of an emergency during the Project's lifetime.

Health Sector

3. **Component 1 – Support for implementation of Den Sooluk program of reforms** (US$1,366.7 million equivalent, including US$13.5 million total IDA credit/grant financing). This component would support the implementation of the Den Sooluk Program (DS) through a SWAp. The reforms planned under DS will require a supportive environment of policy development and implementation to enable financial and health efficiency gains. The strategic approach of DS focuses on creating a strong link between program activities and their impact on health outcomes. The component is being designed to be flexible so that it can adapt to evolving sector and country priorities. Areas of focus are as follows:

4. **Improve the delivery of core services as defined in DS**. The DS strategy defines four priority health improvement areas for which expected gains in health outcomes have been set and improvement in delivery of core services is expected: (i) cardiovascular disease (CVD), (ii) mother and child health (MCH), (iii) TB, and (iv) HIV. These areas were selected based on the composition of the disease burden and the commitments of the Kyrgyz Republic to achieve the two of the Millennium Development Goals (MDGs 4 and 5).

5. Component 1 would support the delivery of core services through: (i) population interventions; (ii) evidence-based individual medical services; and (iii) the appropriate institutional arrangements that are needed to deliver them. Special emphasis will be on change management of service delivery at facility level. The proposed Project will also support investments in deteriorating infrastructures. Accordingly, safeguard measures for civil works and waste management will be developed and will build on the existing environmental management plan as was the case for the 2nd Additional Financing of the First Health and Social Protection Project.

6. **Health System Strengthening.** Health systems strengthening in Den Sooluk focuses on the removal of health system barriers that have for years undermined delivery of core services needed to achieve gains. This is in contrast with Manas and Manas Taalimi which pursued a more general approach to health systems strengthening. Health systems barriers have been identified for each of the four priority health improvement areas grouped around the main functions of health systems: service delivery, financing, resource generation and governance. A large share of health systems barriers are the same for each program while a few were program specific. The proposed Project would also support the strengthening of capacity within MOH to further develop a detailed implementation plan (blueprints) for each key area of the reform, with details on the sequencing of the reforms. Examples of key reform areas under DS where the preparation of implementation plans would be supported include: (i) hospital autonomy; (ii) strengthening of PHC by shifting core services from inpatient to outpatient care (such as management of CVD, treatment of TB); (iii) prescription practices and rational drug use; (iv) community-based mental health; (v) preventive services; (vi) implementation of information systems of the health care sector; and others. Health systems strengthening as envisaged under DS present a major shift in current organization of health care delivery as it emphasizes prevention and is a more effective disease management model. Technical assistance and training would also be provided to comprehensively address providers' autonomy issues.

7. The MOH will continue its transition from implementing agency to steward of the reforms. Definition of roles and relationships between MOH and MHIF and implementation of institutional reforms will aim at achieving a better stewardship role for the MOH and at strengthening the capacity of MHIF as the purchasing agency for health services. This division of tasks between the MOH and MHIF follows WHO recommendations and international best practice. The implementation of the DS will bring additional implementation challenges and will require further strengthening of the MOH's capacity for planning, programming, coordination, procurement and financial management, and tracking of expenditures, as part of ongoing strengthening of country systems. Special emphasis will be placed on creating oversight and stewardship role of MOH for fiduciary functions in the sector.

8. The DS Strategy considers the systemic improvement of information systems in health as one of the "necessary resources for effective functioning of the health care system". The Project will support that process in three key areas: (i) Improving the environment for eHealth development (preparing eHealth Strategy/Master Plan), setting up institutional arrangements for the eHealth governance, regulation and implementation, ensuring sustainable financing of eHealth usage and development, providing regulatory and standardization framework, improving capacities of institutions and facilities for eHealth utilization, etc., (ii) Implementing technical infrastructure as a precondition for implementation of clinical systems (purchasing computers for facilities, improving communication infrastructure, improving local computer networks in health facilities, adjusting central location(s) for hosting of new systems, etc.), and (iii) Implementing fundamental clinical information systems (the list of systems to be implemented will depend on general eHealth architecture that shall be defined in eHealth Strategy/Master Plan, but the Primary Health Care (PHC)/Electronic Health Record (EHC) for personified record-keeping of health services, hospital, laboratory and pharmacy information systems will be considered as a priority). The Republican Center for Health Development and Information Systems will be responsible for implementing these tasks (see Annex 6 for more details).

9. **Support to the State Guaranteed Benefits Package (SGBP).** The Project would complement Government funds to help finance the SGBP gap. In addition to the benefits resulting from pooling funds with donors and the Government, reducing gap in basic package is directly contributing to the improvement of quality of care.

10. Efforts to reduce the financial gap would be undertaken by: (i) identifying mechanisms for increasing financing options; (ii) conducting a comprehensive review of the co-payment policy, revising exempted categories, and copayment structures; and (iii) reviewing the scope of benefits and services under SGBP. In addition to efforts to reduce the financial gap, support to MHIF will be provided in order to harmonize its purchasing practices of health services with the new delivery model, which emphasizes prevention services.

11. **Strengthening fiduciary capacity in the health sector.** This area would be closely coordinated with ongoing efforts under the multi-donor PFM Trust Fund administered by the World Bank, particularly the strengthening of the control environment, accounting and reporting. Despite significant achievements in strengthening country systems, the capacity of the health sector's procurement and financial management functions remains fragile due to low skill levels, high turn-over of staff and inadequate managerial accountability. Some of the issues related to procurement and financial management are generic and should be resolved at the country level; others are sector specific which would need collective efforts from all departments and institutions in the sector. The proposed Project builds on existing interventions and would continue to address weaknesses of the MOH capacity in order to improve fiduciary controls and capacity building implementation by providing technical assistance and training in key areas of fiduciary tasks.

12. Furthermore, as autonomy of providers moves along, the relationship between providers, MOH and MHIF will change, and will require defining additional support in: (i) improving the regulatory and legal foundation for increasing the autonomy of health care institutions; (ii) strengthening the quality of management and improvement mechanisms; and (iii) strengthening the role of MOH in fiduciary oversight and support for health care institutions through targeted and phased implementation of the fiduciary capacity building action plan developed following the Integrated Fiduciary Assessment (IFA). The strengthening of the fiduciary capacity of providers and fiduciary controls, oversight and support of the MOH will pave the way to pilot a providers' autonomy approach. Limitations for use and reporting of funds depending on the source present barrier for freedom of management to achieve efficiencies as envisaged with case based payments. Accounting and clinical software will also be closely linked to simplify both requirements under case based payments and accounting. Strengthening procurement capacity at facility level will also contribute to providers' autonomy. A detailed implementation plan will be prepared to define steps required to implement autonomy of providers at the different levels of the system, including the development of a pilot.

Social Protection Sector

13. **Component 2 – Strengthening the Policy and Administrative Capacity of the Ministry of Social Development (MSD)** (US$3.0 million total IDA credit/grant financing). The objective of this component would be to enable the Government's efforts to enhance effectiveness and targeting performance of social assistance and social services aimed at

supporting the poor and the vulnerable. This would be achieved through strengthened institutions, enhanced human resource capacity and better design and delivery of programs to support the poor and the vulnerable. The primary target groups to benefit from this component will be poor and vulnerable households, including those with special needs/disabilities, as well as poor families with children in general. The team will closely monitor implementation progress and, if good progress is achieved, additional funding may be sought for the component, which has the following two sub-components:

14. **Sub-component 2.1**: **Improving the effectiveness of the social safety net.** This sub-component would provide technical assistance and capacity building to the MSD and would focus on: (i) strengthening the social safety net so that it can provide critical support to the needy protecting against dire poverty and loss of human capital in an inclusive manner; and (ii) enhancing the safety net's role in insuring against the impacts of different shocks. An evidence-based approach to design and delivery of safety net interventions would be promoted so that lessons learned in program implementation and from international experience are fed into program design processes. This sub-component would finance advisory services and training in the areas of program design and delivery, including benefit targeting, outreach and communication, enrollment, verification and control, payment, and other elements of benefit administration. Design, piloting and evaluation of selected interventions would be supported, including testing of alternative targeting approaches and different benefit structure that is compatible with families' incentives for self-sufficiency (e.g. income disregard formulae) and promote investment into their human capital. MBPF would be the focus of the above-mentioned efforts. Diagnostics and analytical work would be undertaken to introduce conditionalities that would promote investment into human capital accumulation by beneficiary households under the MBPF. Analytical underpinnings and recommendations to reform the entire safety net, consisting of the five largest cash transfer programs[4], including the MBPF, would be provided under the ongoing non-contributory Social Protection Public Expenditure Review. If there is political will to reform the entire safety net, including consolidation of the different benefits and integration of delivery systems, the proposed Project would provide necessary support to this end.

15. This sub-component would also continue support to the MSD initiated under the previous Project, to further implement and improve the registry of social assistance beneficiaries (SA registry) and to design a comprehensive information and communication technology (ICT) strategy focusing on improved benefit administration and better outreach to the poor. The first elements of the SA registry built under the Health and Social Protection SWAp1 are currently in the rollout phase and the MSD needs further support in terms of (i) staff training for system usage, improving analytical capacity of the MSD staff to use statistical data from the registry, technical enhancement, including supply of critical equipment, of central database location, support to the MSD IT department in system maintenance, etc.; and (ii) functional and architectural improvements to allow fullest use of the opportunities presented by the registry, including further automation of business processes and generation of information for program planning, monitoring and evaluation. Integration of the SA registry with the household social

[4] These five programs are: (i) Monthly Benefit for Poor Families with Children; (ii) Monthly Social Benefit; (iii) Cash Compensations (former privileges, in-kind benefits and price subsidies); (iv) Energy compensations to pensioners; and (v) Early retirement benefits and pension top-ups paid from general revenues.

passport (a detailed socio-economic assessment of needy households), supported earlier by GIZ at the municipal level, presents opportunities for strengthening efficiency and targeting of social assistance. The proposed Project would support integration of systems and their gradual implementation as the planned computerization of the local level progresses (with potential integration into the planned eAyil local governance information system (technical notes on this are provided in Annex 6). The IT Department of MSD will be responsible for the development of the Ministry's ICT strategy and for the implementation of the above tasks jointly with the Department of Monitoring and Analysis, Department of Social Assistance Benefits, Finance Department and other relevant partners within the MSD and district and local (Ayil Okmotu) social assistance offices.

16. **Sub-component 2.2: Support to strengthening the national policy towards vulnerable groups, including people with special needs.** This sub-component would support a diagnostic review of the Disability Certification Service (DCS) with the objective of streamlining disability certification in accordance with modern approaches focusing on abilities and opportunities for rehabilitation rather than on certifying static disability status. Medical criteria for disability certification would be reviewed, information on best practices in this area would be made available, and proposals for the reform of certification and improved support of the clients would be developed. Streamlining of the DCS procedures and activities is expected to result in significant fiscal savings as well as in more humane and efficient system of assistance and services addressing people's needs. This work would need to be complemented by a coordinated effort of the entire Government to begin creating community-based infrastructure and services that would enable people with special needs to function in the society. While this is a long-term process, the proposed Project would initiate the first steps by producing clear recommendations for changing the way the DCS operates and laying out a roadmap for the development of individual rehabilitation plans and building supportive infrastructure and services nation-wide. The sub-component would also support some initial capacity building such as exposure of the key players to the modern disability certification models, their practical implementation and lessons from international experience.

17. This sub-component would also provide technical assistance to help the MSD design and test an integrated approach to provision of social assistance and social services that could (i) increase the impact of social assistance on the lives of the poor and the vulnerable by addressing multiple causes and dimensions of their vulnerability, (ii) improve the efficiency of administration by removal of duplicated efforts provided, as of now, separately by social assistance and social services units. The sub-component would support design and would pilot introduction of community-based integrated social service provision and day care centers for all families in need using a one-stop-shop model. This work would be done in partnership with UNICEF and the EU, and in line with the recently adopted Master Plan towards de-institutionalization, which focuses on prevention of further placement of children in institutional care through the creation of family support mechanisms and alternative community-based options. The same approach would be promoted by the sub-component activities for other vulnerable categories that face high risks of institutionalization or isolation from society. The sub-component would finance the development of standards and methodologies for introducing core services focused on social support, and integration of social services for families and people in need. It would also help develop sustainable mechanisms to involve non-governmental agencies in the provision of community-based services for the vulnerable families.

Component 3: Contingent Emergency Response (no funds allocated)

18. The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 8.00 (Rapid Response to Crisis and Emergencies). The component would support a rapid response to a request for urgent assistance in respect of an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact in the health and social protection sectors associated with natural or man-made crises or disasters. In such case, funds would be reallocated from other components into this one to finance goods, health and community-based facilities operating costs, and consulting services which have previously been agreed with the World Bank under an acceptable *Emergency Financing Plan*. It should be noted that this component cannot be used to finance salaries, nor any expenditures that could trigger any of the World Bank's safeguard policies.

19. In the health sector, upon request from the Government, Joint Financiers would re-allocate from Den Sooluk programs funds towards mitigating consequences of the emergency situation. In such case, uncommitted funds would be reallocated from component 1 into this one to finance goods, health facilities operating costs, and consulting services which have been previously agreed with the World Bank under the above-mentioned *Emergency Financing Plan*.

20. The Procurement Plan would be revised on the basis of the agreed *Emergency Financing Plan* and a revised Disbursement Letter would be issued. The scope of the Project's audit would be expanded to cover expenditures incurred under this component, including: (a) the contracting approach, (b) the appropriateness of prices relative to market prices, (c) the adherence to acceptable and agreed commercial practices or emergency procedures, and (d) the appropriate use of funds for intended eligible purposes.

Annex 3: Implementation Arrangements

Kyrgyz Republic: Second Health and Social Protection Project

Project Institutional and Implementation Arrangements

Project administration mechanisms

Component 1: Support to the Den Sooluk Program of Reforms

1. Overall responsibility for program management and implementation for the Den Sooluk Program would lie with the MOH and its adjacent organizations at the national and regional levels. Four implementation levels are planned: (1) Government and Parliament for oversight; (2) MOH, MHIF, and MOF—stewardship and barrier removal; (3) MOH all Departments, National Center for Cardiology and Therapy, National Center for Maternal and Child Care, National TB Center, Republican AIDS Center for technical coordination of the various structures, monitoring and reporting of results of the activities; and (4) with the support of Oblast coordinators, all implementing institutions will be implementing their APWs.

At the central level:

a) Kyrgyzstan Government and Parliament – general management (oversight) of Den Sooluk implementation process. The Government of Kyrgyzstan will use Den Sooluk and its plans of work as the mechanism to improve health policy, plan and implement all health sector reforms and improvements in the health sector through the Supervisory Board on health reform and mandatory health insurance.

b) The MOH, MHIF, MOF – stewardship, monitoring, and responsibility for program outcomes and removal of barriers.

c) Departments of the MOH, MHIF, MOH's National Center for Cardiology and Therapy (NCC&T), National Centre for Mother and Child Health (NCMCH), National TB Center (NTBC), Republican AIDS Center (RAC): Departments of the MOH and the heads of national institutions engaged in managing the implementation of Den Sooluk will be supported by technical coordinators (for the 4 priority programs and cross-cutting sectors), and technical assistance to support day to day implementation activities related to the reform processes, especially related to change management at facility level. MOH will prepare action plans, work on coordination and interaction of processes, and develop aggregate annual work plans with the implementing agencies, as well as monitor and report the results obtained to higher management. All entities will ensure technical coordination of all implementing institutions, monitoring, reporting and responsibility for the implemented programs.

d) MOH will have a supervisory role in relation to all health-related organizations regardless of ownership and administrative level in the country. The MHIF is a separate legal entity that is responsible for receiving and disbursing funds for health services covered by the State Guaranteed Benefit Package and the Outpatient Drug Benefit. While implementation arrangements have worked reasonably well under the original Project, implementation of

Den Sooluk will bring about additional implementation challenges, which will require institutional strengthening, supported under the area of health system strengthening of the Den Sooluk.

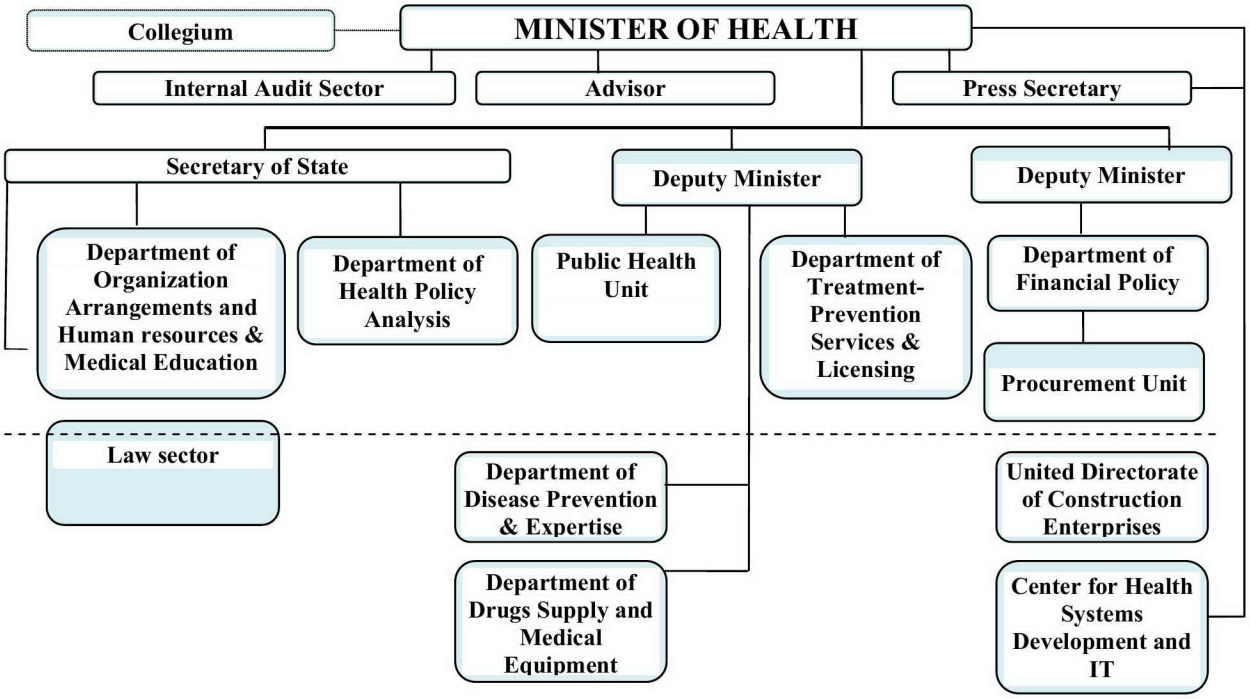
e) Overall responsibility for coordination of program/Project management tasks would be with the Department of Health Policy Analysis (former Department of Strategic Planning and Reform Coordination) Implementation responsibility for procurement and financial management would be with the Deputy MOH on financial issues the Financial Policy Department of the MOH (including Procurement Unit) and the MHIF Deputy Director on financial issues. A large amount of implementation and fiduciary capacity building would be necessary and it is planned that related-functions would be further strengthened. The POM will guide implementation and serve as a road map to all participating health sector institutions.

2. Overall, the MOH is responsible for:

- Implementing Den Sooluk through the respective health institution.
- Collaborating with other health entities in the implementation of parts of the Project within their mandates.
- Coordinating and supervising health organizations involved in the implementation of Den Sooluk.
- Preparing Annual Programs of Work.
- Preparing quarterly and annual Program Management Reports related to Den Sooluk.
- Preparing and approving the TORs for consulting services.
- Monitoring progress of all activities, using agreed monitoring indicators.
- Providing information on the Den Sooluk implementation, package of indicators and execution of the APWs to DPs, both those participating in SWAp and in parallel financing for discussion at JAR and joint missions.
- Coordinating inter-sectoral cooperation of ministries and organizations involved in the Program.
- Promoting investments for health system development and coordinating DP's aid, international projects and programs monitoring.
- Coordinating arrangements for Policy Council, JARs and other missions.
- Coordinating and collaborating with public organizations, mass media within the parameters of Den Sooluk.
- Developing and introducing activities on quality health services management.
- Preparing Program based health budgeting and budget execution.
- Ensuring development of regulatory mechanisms in health services pricing, health financing, sanitary-epidemiologic surveillance, public health services, drugs and healthcare products price adjustment mechanisms.
- Carrying out internal auditing of the adherence to procurement procedures, financial transactions, record keeping in health organizations and subordinate institutions.
- Preparing Project financial reports pursuant to WB requirements.
- Updating and maintaining the Unified Health Information System.

- Organizing procurement in accordance with Financial and Procurement Plans.
- Coordinating Project activities and other activities supported by other DPs.
- Maintaining regular communication of Project activities within relevant MOH departments.
- Ensuring close coordination between planning and procurement functions and procurement and financial management functions to ensure timely availability of data and payments under contracts and ensure proper contract management.
- Ensuring timely appointment of evaluation and negotiations' committees.

MOH Structure



3. Other key functions of the MOH are as follows:

- ***Public Health Services and Population Involvement*** – implementation responsibility will be with the *Head of the Public Health Unit*. The Public Health Unit is responsible for issues pertaining to population-based or public health services. The Head of the Public Health Unit is also responsible for the Public Health Services program area to allow for coordination and integration of program areas.

- ***Health Financing*** –the *Ministry of Health's Department of Financial Policy is responsible for defining health financing policy in the health sector while* implementation of activities in health financing area would be split between the MHIF, which is responsible for financing individual based health services and public health (population-based) services, and the

Financial Policy Department, which is responsible for financing of High-Technology Services, and other services (Education, Science, and Administration).

- ***Individual Health Services and Priority Programs*** – implementation responsibility will be with the *Head of the Treatment-Prevention Services and Licensing Department.* The Head of the Department is also responsible for the program areas of Content of Medical Practice/EBM and Priority Programs to allow for coordination and integration of these closely related program areas.

- ***Human Resources*** – implementation responsibility will be with the *Head of the Organization Arrangements and Human Resources and Medical Education Department.* In addition, the Medical Academy and Post-Graduate Institute will also be closely involved in the development of human resources.

- ***Financial Management*** – the Deputy Minister of Health responsible for financial issues, MOH's Financial Policy Department and the MHIF staff will be responsible for financial management functions. MHIF will be responsible for financial management functions related to expenses for individual health services including the program budget areas of State Guaranteed Benefits Package (SGBP) and Additional Outpatient Drug Package (AODP). The Financial Policy Department of the MOH will be responsible for financial management functions related to expenses for the other three health program budget areas of Public Health Services, High-Technology Services, and other services (Education, Science, and Administration). A large amount of financial capacity building is necessary and it is planned that functions will be strengthened and integrated into this department over time. The POM will further specify financial management functions, responsibilities, policies, and procedures in the Financial Management and Procurement sections

4. **The Mandatory Health Insurance Fund** is a separate legal entity under the Government of Kyrgyz Republic, which is responsible for financing of individual based health services under the SGBP and AODP; population based public health services and TB services. Financial management functions of MHIF are implemented by the Department of Economy and Finance and the Accounting and Reporting Department. The functions are supervised by the Deputy Director for financial matters who has the primary authority to sign all financial and accounting documents.

5. The Head of the Accounting and Reporting Department is also the chief accountant of MHIF with the secondary authority to sign all financial and accounting documents. Powers and duties of each structural unit are specified in the Regulations of the Department, and approved by the Director of MHIF. The MHIF has nine territorial departments (TD MHIF) at the regional level (including the cities of Bishkek and Osh).

At the Oblast Level

6. A distinctive feature of Den Sooluk implementation is the involvement of health care organizations and the role of tertiary institutions in ensuring leadership and coordination in their respective areas. Oblast coordinators' role will play a key part in the implementation of Den Sooluk at the regional level (including the cities of Bishkek and Osh). They will coordinate and

monitor the implementation of activities planned for the coming year at the regional level. They will develop regional plans for implementing Den Sooluk, define the role and place of each organization in the health care system, the ways and mechanisms to achieve the expected results, participate directly in the development of work plans of each organization in the region. Also, the coordinators will submit progress reports for the Health Policy Council's meetings. They will be supported by local consultants in the carrying out of their functions.

7. ***At the health care organizations level.*** The role of health care organizations is to develop and implement annual work plans, submit the budget and procurement plan, participate in the coordination of processes and preparation of reporting against the established indicators. Each region will hold annual general meetings to assess progress in the implementation of Den Sooluk, with the participation of all organizations involved in its implementation, by components and priorities. The principles of management and coordination of the process of implementing Den Sooluk will be reflected in the "Operational Guidelines of Den Sooluk Program".

8. ***Partnerships and support mechanisms***. The MOH will establish and agree on an APW in cooperation with financing and implementing partners, which will follow the policy framework outlined in the Den Sooluk strategy. In addition, detailed implementation plans (blue prints) will be further developed during first year of implementation for each key area of the reform, with details on the sequencing of the reforms and detailed guidelines and plans for providers' autonomy, including the design, testing, and evaluation of a pilot. Mechanisms of cooperation among financiers and the Government of the Kyrgyz Republic is documented in a Memorandum of Understanding, outlining organizational, institutional and coordination arrangements for implementation and roles and responsibilities of each partner. Donor cooperation and supervision will be coordinated by means of regular 'round table' discussions – the annual Joint Annual Review and three technical meetings per year with the Government and implementing agencies. Furthermore, donor agencies will collaborate through the organization of joint supervision meetings and regular information exchange.

Component 2 – Strengthening the Policy and Administrative Capacity of the Ministry of Social Development

9. ***Component Oversight***. The MSD would have both the policy design and implementation oversight roles; it would also promote the new policies within the broader Government and reach out to the general public to gain support of the population. The newly created Public Coordination Council for implementation of the Social Protection Development Strategy will play the role of independent oversight body to review implementation of the Project and recommend strategic directions and actions.

10. ***Program management and implementation***. The responsibility remains with the MSD and its subordinate institutions at the regional and local levels. Similarly to the Health component, it is envisaged to have different implementation levels: (1) the Public Coordination Council to oversee implementation of the SP Development Strategy – for oversight; (2) MSD and MOF—policy design, quality control and budgeting for implementation of the models designed and supported by the Project; and (3) regional, district and local social assistance offices as well as disability certification offices and social care centers—testing of the new models, technical coordination at the implementation level and results reporting. Given low

implementation capacity in MSD, relatively small allocation of resources for the SP component, and in order to avoid duplication of implementing agencies, MOH will continue acting as a Project management agent for SP component in a similar fashion as it does for the ongoing Health and Social Protection SWAp1 Project. An important feature of the implementation scheme is that the MSD will retain a Project Coordinator position to be funded by the component and to function as the liaison officer between the World Bank, Government partners, regional agencies, and the MSD as well as to coordinate activities between various MSD departments and divisions. Similar implementation arrangements have worked reasonably well under the original Project and are expected to help preserve the institutional memory and ensure that operational knowledge gained under the original Project is applied on a continuous basis. The MSD will also hire consultants to provide guidance and advice on specific directions and activities and reinforce its capacity.

Financial Management, Disbursements and Procurement

Financial Management

11. Responsibility for the financial management function, including budgeting, accounting, reporting, internal control, funds flow and audit, would be the responsibility of the MOH, including overall responsibility for consolidated interim and annual Project financial reporting and audit. With input from the MOF (with respect to Designated Account transactions), MSD (for the Social Protection Component) and the MHIF, the MOH would maintain accounting systems capable of generating interim financial reports to be used for monitoring fiduciary aspects of Project implementation.

12. ***Overall, the financial management arrangement*** established for SWAp1 is assessed to have improved significantly following implementation of a series of capacity building and fiduciary risk mitigation measures developed under the original Project. However, the most recent FM supervision has rated the FM arrangement to be **moderately unsatisfactory**, with the overall FM risk rated as *high.* This was predominantly as a result of the most recent qualified audit opinion that was issued on the 2011 annual financial statements report. A number of internal control weaknesses were identified by the auditors at the individual health facility level. Also, there has been little evidence that management of health care facilities are taking actions to strengthen the internal control systems, while action by MOH and MHIF management has been limited to issuing orders (Prikaz) without effective follow up to ensure that necessary action is taken by the health facility managers. It should be noted though, that the FM arrangements of the two key implementers of the program, namely MOH and MHIF (central level), have been rated as **moderately satisfactory.**

13. For purposes of SWAp2 implementation, additional capacity building and fiduciary risk mitigation measures are proposed. Under SWAp2, Technical Assistance will be provided (preferably through a firm contracted under Terms of Reference satisfactory to the World Bank) to develop and implement a comprehensive fiduciary capacity building plan for the health sector, with focus on health facilities. Implementation of the plan would use a targeted and phased approach, taking into account the needs assessment of all health facilities, based on detailed analysis of their capacity gaps. Technical Assistance would also be provided to strengthen the internal audit function, including automation of the audit workflow. At the same time it should

be noted that, in spite of the identified weaknesses in the financial internal control environment, the external and internal audit findings have not identified any misuse of funds. In addition, the purchaser-provider contractual arrangement under the Single Payer System relies on a very effective Monitoring and Evaluation system that monitors the quality of medical services - this in itself serves as an alternative assurance measure that funds are spent for the purposes intended. The MOF also issues guidance on how the funds released under the Single Payer system are to be spent and this is monitored very closely through periodic reports to the Treasury and through financial inspections, thus significantly reducing the risk of misuse of funds.

14. Table 1 below lists the actions required to further strengthen fiduciary arrangements.

Table 1: Action Plan

Suggested Action	Responsibility	Deadline
Update the POM to reflect activities under Den Sooluk, including Project accounting and reporting and simplified un-audited interim financial reports, funds flow, audit arrangements, disbursement procedures, an updated harmonized procurement manual for health facilities, and standard bidding documents that are consistent with the Procurement and Consultant Guidelines. (MOH and MHIF would need to disseminate the POM to enhance its familiarity and use by health facilities through seminars and workshops.)	MOH/MHIF	Effectiveness
Provision of Technical Assistance (preferably through a consultant firm contracted under Terms of Reference satisfactory to the World Bank) to develop and implement a comprehensive fiduciary capacity building plan for the health sector, with focus on all health facilities. Implementation of the plan would use a targeted and phased approach, taking into account the needs assessment of all health facilities, based on detailed analysis of their capacity gaps.	MOH/MHIF	During implementation
Complete rollout of automation of accounting system in the health sector, ensuring adequate operational and technical support on an on-going basis. MOH and MHIF to encourage electronic submission of reports, especially from facilities, which have fully automated their accounting and reporting.	MOH/MHIF	During implementation
Provision of Technical Assistance (preferably through a consulting firm contracted under Terms of Reference satisfactory to the World Bank) to strengthen the internal audit function, including automation of the audit workflow.	MOH/MHIF	During implementation
To avoid delays in submission of annual financial and operational audit reports, MOH to make early arrangements for the contracting of the auditors, preferably under multi-year contracts.	MOH/MHIF	Effectiveness
MOH to closely monitor the flow of funds from the MOF to the health sector and maintain a schedule of funds flow to be submitted together with the quarterly IFRs. It is noted that MOF would be able to release $1/12^{th}$ of the annual budget before annual budget approval. Such releases would cover both protected and non-protected items, thus ensuring even flow of funds throughout the year.	MOH/MHIF	During implementation
As part of staff development, MOH and MHIF will design and implement a comprehensive HR strategy, which would prescribe transparent and clear procedures for staff actions, such as hiring, training, transfer of staff. Such strategy would in the long run address the issue of staff turnover, and thus ensure continuity of the effects of the capacity building strategy described above.	MOH/MHIF	During implementation
Develop and assign satisfactory implementation of a time-based action plan	MOH	Negotiations

Suggested Action	Responsibility	Deadline
to resolve the issues rose in the 2011 audit report and management letter.		
Submit the status of implementation of the action plan, showing how the issues raised in the 2011 audit report and management letter have been resolved, as well as preventive actions taken by the health organizations to ensure the weaknesses will not recur.	MOH	Effectiveness

15. It is expected that upon satisfactory implementation of the actions above, that are identified as effectiveness conditions, the financial management arrangements would meet the minimum requirements of the World Bank and that the overall FM risk would be reduced to *substantial*.

16. **Budgeting & Planning.** The budgeting process follows the country's normal budgetary cycle, and is led by the Planning and Financial Policy Departments of the MOH and the MHIF. The MOH has adopted program budgeting, based on programs under the *Manas Taalimi* Health Reform Program. The program budget is reconciled with the annual budget prepared as part of the Republican budget. Because the budgetary process of the Health Reform Program is intrinsically linked to the Republican budget there are often delays that affect release of funds, including donor funds. It is planned that the investment component of the Health SWAp2 would be budgeted under Special Means to improve the flow of funds for the investment portion, and to ensure timely payment of contracts with suppliers and consultants.

17. **Flow of Funds.** Project funds under SWAp1 have been pooled with the Republican budget, under investment and recurrent categories, and released to the health sector through the Treasury system. There have been delays with the flow of funds to the health sector, especially for the investment activities implemented by the MOH, resulting in delayed payment to contractors and consultants. The delays have been caused by a combination of factors, including delayed approval of the annual budget, especially over the past 2-3 years, which has seen the budget approved in April or May; and delayed implementation of procurement plans. In successive years, funds have been transferred towards the end of the fiscal year causing a spending frenzy, with the risk of ineffective use, or even misuse of funds.

18. Similar pooling arrangement will be followed under the Second Health and Social Protection Project. Flow of funds under SWAp2 will need to be streamlined, with better planning and better linkage between procurement plans and disbursement forecasts. There will also be a need for more even spread of the flow of funds throughout the year, with the release of $1/12^{th}$ of the annual budget every month before approval of the Republican budget. Once the budget is approved, flow of funds would follow the normal monthly budgetary requests from MOH to MOF based on actual expenditure commitments. Funds would be disbursed directly into a designated foreign currency denominated account opened at the National Bank of the Kyrgyz Republic (NBKR) specifically for the purpose of Project funds. The foreign currency would thereafter be promptly sold by the MOF to the NBKR in exchange for Kyrgyz Som and transferred to the health sector through the Treasury system.

19. To ensure more even flow of funds, and uninterrupted implementation of Project activities, the MOF would include Project funds in the 1/12th of the annual budget usually released prior to budget approval. MOH will closely monitor the flow of funds from the MOF to

the health sector and maintain a schedule of funds flow that will be submitted to the World Bank together with the quarterly IFRs.

20. **Accounting and Records**. Accounting at the MOH and the MHIF, and the subordinated institutions, remains largely manual despite efforts towards full automation. Although the MOH and MHIF, and their subordinated facilities in six oblasts, have installed accounting systems based on the 1C accounting software, the actual use of the software is still limited, and accounts continue to be maintained in manual ledgers. A review of the extent of the use of automated processes in a number of facilities [Chui MHIF TD, Issyk-Ata Territorial Hospital and Issyk-Ata Family Medicine Center (FMC)] indicated that not all processes have been automated. For example, in the facilities visited, payroll continues to be processed in a different program that has no compatibility with 1C, while inventories, especially for drugs and foodstuff continue to be maintained in manual records using excel.

21. There has been limited technical support to automate the payroll, while some systems that are unique to health care, such as costing of drugs, have not been factored into the 1C software. The rollout of automation of accounting system in the health sector is expected to be completed early during the implementation of the Second SWAp, which is expected to help improve accounting and reporting in health facilities as well as at the MOH and MHIF. Health care facilities subordinated to MOH and MHIF would be required to maintain adequate records for all expenditures, and keep the full set of records throughout the duration of the Project and until twelve months after receiving the final audit report. All other arrangements, including auditing, would be similar to those under the ongoing Health SWAp.

22. **Information System**. Automation of accounting systems in the health sector facilities has been slow, but progressive, and has now been largely completed in all oblasts (regions). Automation of accounting and reporting in the central MHIF and MOH has been modest, with the quarterly Financial Monitoring Reports (FMRs) under the Health SWAp1 now being consolidated using the automated accounting system (1C). Even though the rollout of automation has been largely completed, utilization of the automated accounting system has been minimal, with majority of health facilities still submitting reports in hard copies produced in excel. Also, some functions, such as payroll and inventories, particularly for drugs in hospitals, have not been automated (with the exception of the National Hospital in Bishkek where almost all functions are now automated). Training on the use of the automated accounting and reporting system has been provided in the pilot oblasts; and full coverage has been undermined by a lack of adequate budgetary allocation to enable the trainers to visit the regions. There has also been a high staff turn-over, with some of the staff in the health facilities covered in the IFA not yet having been trained.

23. Under SWAp2, technical assistance would be provided, as part of the capacity building strategy, to help develop and implement a comprehensive capacity building strategy for the health sector, with a focus on health care providers and health organizations under the MOH. The capacity building strategy would be implemented in a targeted and phased manner, taking into account the needs and gaps assessment of health care institutions. Rollout of automation of the accounting system in the health sector, including training of staff, is expected to be completed early during the implementation of SWAp2, and this is expected to help improve accounting and reporting in health facilities as well as at the MOH and MHIF. Technical and

operational support will be required to ensure the smooth running of the accounting software, and ongoing training, preferably by well trained staff based in the regions. A maintenance and technical support contract with the software vendor will also be needed, at least for the first two years, to ensure that more complicated system and technical glitches can be addressed in a timely manner.

24. **Financial Reporting**. Quarterly Financial Monitoring Reports (FMRs) under the first Health and Social Protection Project were designed to be as close as possible to the reporting formats used by budget organizations. The MOH reports on the use of funds by Programs and Economic Classification, following the Chart of Accounts designed by the MOF, and are consolidated to report on all sources of funds. The main reports submitted to the World Bank include: (i) Summary of Sources of Program Funds in Kyrgyz Som, showing separately: Budget Funds (which will include funds provided by donors and pooled with the Budget funds), MHI funds from the Social Fund, Special Means and Patient Co-payments; (ii) Summary of Program Expenditures in Kyrgyz Som by main program headings, and by main categories of expenditures according to Kyrgyz public sector economic classification for the current fiscal year; and (iii) Summary of Funds received from Donors in both currency of receipt and Kyrgyz Som equivalent.

25. Prior to the reports being submitted to the World Bank, the MOH reconciles them with the Treasury Budget Execution Reports as a way of confirming their completeness and accuracy. Additional forms are submitted, including contract monitoring and disbursement forecasts.

26. FMRs are being submitted regularly, but often after the deadline of 60 days after the end of the reporting period. This is mainly due to manual summarization of the reports, which often results in differences that have to be revised several times, causing delays and report inaccuracies. The utility of the 1C software for reporting is still very limited, and the reports from the health facilities are submitted to MOH/MHIF in hard copies. These reports are then entered into the accounting system for consolidation and preparation of reports, a process that is time consuming. In order to improve the reliability and timeliness of the reports, the process of full automation of accounting and reporting would need to be accelerated to ensure adequate inbuilt controls to guard against clerical errors which occur frequently when reports are compiled manually. The MOH and the MHIF would need to encourage electronic submission of reports, especially by health facilities that have automated most of their accounting and reporting processes, such as the National Hospital. Full automation of accounting and reporting would improve reliability, timeliness and integrity of reports submitted to the World Bank. Reporting under the Second SWAp would continue to be on a quarterly basis, but within 45 days after the end of each reporting quarter, and based on the sample simplified formats agreed with the World Bank and included in the updated Program Operational Manual (POM).

27. **Internal Control & Internal Audit**. Internal control procedures in the health sector are guided by the POM developed under the Manas Taalimi Health Reform Program, and by instructions issued by the MOF. Although the POM has been updated, as required under the 2nd Additional Financing, it has not been fully disseminated to various health institutions, familiarity with its provisions is limited, and many health institutions are still not following the provisions in the POM. Prior to Project effectiveness, the POM would need to be updated to reflect activities under Den Sooluk, including Project accounting and reporting, funds flow, audit arrangements,

disbursement procedures, etc. MOH and MHIF would need to take steps to enhance the familiarity and use of the POM by health facilities through its dissemination in seminars and workshops.

28. Audit reports for successive years, under the Health Reform Program Manas Taalimi have continued to highlight significant weaknesses in operational and internal control procedures, including procurement, which is an indication of a weak fiduciary environment. This is exacerbated by the apparent lack of concerted effort by the management of MOH, MHIF and health facilities to address the internal control weaknesses in a sustainable way. Various orders (Prikaz) issued to health facilities on control weaknesses have not been followed up in a continuous way. Under the Second SWAp, technical assistance (preferably by a firm hired under TORs satisfactory to the World Bank) would be provided to develop and implement a comprehensive capacity building strategy for the financial management staff of the MOH and MHIF and their subordinated health facilities. The capacity building strategy would use a targeted and phased approach, taking into account the needs assessment of the health care utilities, based on detailed analysis of their capacity gaps.

29. Both the MOH and the MHIF have established internal audit units, with three and ten staff respectively. The internal audit units have previously benefitted from technical assistance provided by a firm as part of a capacity building effort. As a result of that internal audit technical assistance, internal audit skills in the MOH and the MHIF have improved and there has been streamlining of the internal audit function in the health sector. The internal audit units in the MOH and the MHIF continue to perform the function in line with well-developed audit plans prepared with the support of the firm. The MOH has also established a commission that reviews the findings and recommendations of the internal audit unit, and makes necessary decisions on implementation and follow up actions. However, the number of internal audit staff is still small, considering the many health facilities that need to be covered. The MOH internal audit unit has also faced difficulties executing their audit plan due to budgetary constraint that has limited their ability to travel to the regions.

30. Under the SWAp2, technical assistance would also be provided, preferably by a firm hired under TORs satisfactory to the World Bank, to strengthen the internal audit function in order to cope with the needs of the sector, including through joint audits and training. As part of a strategy to improve the internal control environment, the internal audit units would need to scale up their activities to address the many weaknesses in systems and procedures that continue to appear in external audit and operational review reports. Whereas the internal audit methodology has been developed and adopted by the internal audits of MOH and MHIF, further automation of the audit workflow would be needed, and this would be included in the proposed technical assistance as part of a capacity building action plan.

31. **External Audits**. A private sector audit firm contracted by the MOH has audited the Health Reform Program Manas Taalimi for the past four years. This follows failed attempt to have the audit performed by the Chamber of Accounts (the Kyrgyz SAI) jointly with another Supreme Audit Institution under a twinning arrangement. The audit reports have been submitted to the World Bank after considerable delay. Report of the 2010 financial audit was submitted to the World Bank in December 2011, six months after the due date, while the audit reports for 2011 were submitted in October 2012, which is four months after the due date. The delays in the

past were attributable to the late signing of the contract. This will now be addressed by early start of the procurement process and signing of a multi-year contract.

32. Although the 2009 and 2010 audit reports contained unqualified opinion, the management letters listed weaknesses in accounting, internal control, procurement and operational procedures in the health care facilities, many of which being of a recurring nature. The 2011 audit report contained a qualified opinion due to scope limitation; and several weaknesses in operational and internal control procedures, procurement, accounting and recordkeeping, mainly in the health facilities, similar to those highlighted in successive reports of the independent auditor. It should be noted that the 2011 audit covered more health care facilities in all regions, some of which had not been covered in previous audits. The weaknesses reflect lack of management attention at the health facility level to establishing and maintaining effective internal control procedures.

33. Implementation of actions recommended to eliminate the weaknesses has been slow due to a number of factors. Successive ministers of health have routinely issued orders (Prikaz) to address the weaknesses and implement the recommendations made by the auditor, mainly following request from the World Bank after the review of the audit reports. However, follow up of implementation of the actions has been hampered by frequent management changes at the MOH and MHIF as well as high staff turn-over in the health sector. Low skill level and high staff turnover of accounting personnel in the health care facilities also undermines efforts to address the weaknesses in a sustainable way.

34. There will continue to be annual financial and operational audits that may be performed separately or jointly under Terms of Reference agreed with the World Bank. Audit reports by independent auditor acceptable to the World Bank would be submitted to IDA within six months of the end of each fiscal year and also at Project closing. Where joint financial and operation audit is conducted, the auditor would be required to assess and report on the internal control and operational procedures, including procurement, and prepare a separate report in the form of an ISA 260 report. The audited financial statements, including audit opinion, shall be made publicly available in accordance with the World Bank's Access to Information Policy. Upon receipt of the audited financial management statements, the World Bank would also make them publicly available. The following table identifies the audit reports that would be required to be submitted by the Project together with the due date for submission:

Table 2: Audit Requirements

Audit Report	Due Date
Consolidated Financial Statements, incorporating SGBP and SP Components, including Statement of Sources and Uses of Funds, Use of Project Funds by Activities, Statement of Designated Account, and Notes to the Financial Statements	Within six months of the end of each fiscal year and also at Project closing
Report of the Operational Audit (in-depth review of internal control and operational procedures, including procurement) report in the form of ISA 260	Within six months of the end of each fiscal year and also at Project closing
To avoid delayed submission of audit reports, the MOH will need to make early arrangements for the contracting of the audit firm, including using multi-year audit contracts.	

Disbursements

35. Like with SWAp1 Report-based disbursement is planned for SWAp2, but using simplified reports. The World Bank and other Joint Financiers will disburse funds to the Designated Accounts based on Withdrawal Applications submitted by the MOH. Withdrawals from the Credit and Grant accounts would be requested in accordance with the guidance to be given in the Disbursement Letter. The MOH will be responsible for the preparation of withdrawal applications that will be submitted to the World Bank, through the MOF, together with the relevant supporting documentation, as necessary. Accordingly, reporting under the SWAp2 would continue to be on a quarterly basis, but within 45 days after the end of each reporting quarter, and based on the sample simplified formats of IFRs, including forecast of expenditures for the next semester, agreed with the World Bank and included in the updated POM. Share of Bank financing of APW for eligible Program expenditures will be agreed between the Government and the Bank on an annual basis as part of the JAR. The MOH/MHIF would be responsible for the custody of documentation, and making them available to World Bank implementation support missions as well as to the auditors.

36. Designated Accounts. To facilitate timely disbursements for eligible expenditures on goods and services, the Borrower will open and operate, under terms and conditions acceptable to the World Bank, a designated US dollar accounts in the National Bank of the Kyrgyz Republic (NBRK). The NBKR, through the MOF, would provide statements showing balances in the Designated Account to the MOH for purposes of consolidated interim and annual Project financial reporting.

Procurement

37. Procurement for the proposed Program would be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Procurement Guidelines); and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Consultant Guidelines) and the provisions stipulated in the Financing Agreement. The Program shall also follow Guidelines: On Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants dated October 15, 2006 and revised in January, 2011.

38. The procurement at facility level (works and goods following NCB procedures and shopping and consulting services (less than US$100,000)) will be carried out using updated Harmonized Procurement Manual. The Manual was developed as part of Health SWAp1 and this Manual will be updated to be in line with Procurement and Consultant Guidelines, January 2011, NCB provisions stipulated in the Financing Agreement and broadly in line with the revised (or new) Public Procurement Law which is under preparation.

39. The MOH will be the lead implementing entity under the Health SWAp2. Procurement will be carried out on the basis of a rolling procurement plan updated at least annually, reviewed by the participating donors and the Government and approved by the World Bank prior to any procurement being initiated. The initial procurement plan together with the subsequent updates will be published on the World Bank's external web site in line with the requirements of World Bank Guidelines. As this is a SWAp operation, annual procurement plan (PP) and General Procurement Notice (GPN) covering the Project will be published annually upon clearance of the PP. Specific Procurement Notices will be published for all ICB and NCB procurement, as well as, all consulting services contracts as required under the respective Guidelines. The Procurement Unit should be reorganized and strengthened to improve the capacity of its staff to manage procurement effectively through oversight, health sector procurement policy development, the provision of support to health care facilities at all levels of the health sector, and the training of health public officials involved in procurement throughout the country.

40. **Procurement of Works.** Works of above US$1.0 million equivalent per contract will follow ICB procedures. Contracts below US$1.0 million equivalent will be procured using *tender with unlimited participation* (an equivalent to the National Competitive Bidding procedures of the World Bank's guidelines) as defined by the Public Procurement Law subject to the conditions included in the Financing Agreement are complied with. All bidding documents and contracts will include measures to minimize or mitigate environmental impact and will take into account recommendations in the EMPs. The World Bank Standard Bidding Documents (SBD) shall be used for all ICB packages. In case of *tender with unlimited participation*, the harmonized bidding documents will be subject to prior review and no objection by the World Bank before launching the bidding process.

41. **Procurement of Goods.** Goods above US$200,000 equivalent per contract will be procured under ICB procedures using the World Bank Standard Bidding Documents (SBD) for procurement of goods. The *tender with unlimited participation* method will be applicable for procurement of goods with an estimated budget of less than US$200,000 equivalent per contract. The harmonized bidding documents shall be prepared taking into account the NCB conditions set forth in the Financing Agreement. In case of *tender with unlimited participation*, the sample bidding documents will be subject to prior review and no objection by the World Bank before launching the bidding process. Goods with an estimated budget of less than US$100,000 equivalent per contract may be procured using Shopping procedures (which is similar to the *request for quotations* method under the Public Procurement Law) on the basis of at least three written price quotations obtained from qualified suppliers. The list of suppliers to be invited to submit quotations should be defined by a tender committee.

42. **Selection of Consultants.** The methods for selection of consultants will include Quality and Cost Based Selections (QCBS), Quality Based Selection (QBS), Fixed Budget Selection

(FBS), Least Cost Selection (LCS), Selection based on Consultants Qualifications (up to US$100,000), Single Source Selection in compliance with Paragraph 3.8 of the Consultant Guidelines, and Individual Consultants (IC). Contracts estimated to cost above US$100,000 equivalent per contract will be advertised through UNDB, on the World Bank External website and in local media (one newspaper of national circulation or the official gazette, and/or the website of the MOH and Procurement portal to be launched by the Public Procurement Methodology Department (PPMD) of the MOF). Shortlists of consultants for services estimated to cost less than US$100,000 equivalent per contract may be composed entirely of national consultants under the provisions of paragraph 2.7 of the Consultant Guidelines.

43. **Operating cost.** The expenses would include communication cost, translations, bank charges, office supplies, costs of advertisements, mail, training costs, per diem and business trip expenses. Such cost will be financed by the Project based on the annual budget prior reviewed and no objected by the World Bank. Operating cost will not include salaries of civil servants. The procedures laid down in the PPL shall be followed.

44. **Training and study tours.** Training and study tours will be carried out based on the annual training/study tours plan to be prepared by the MOH, prior reviewed and agreed by the World Bank. Consultants required for preparation, facilitation or conducting training activities shall be selected under appropriate procedures for selection of Consultants as described above. Selection of such consultants shall be included in the Procurement Plan. The institutions for training/study tours would be selected considering the availability of such services, duration of training/study tour and reasonableness of cost.

45. **Procurement Arrangement and staffing.** The procurement following ICB procedures and hiring of consultants (more than US$100,000) shall be carried out by MOH. During implementation, if adequate capacity is built in the Republican Hospitals, then this function could be transferred to achieve the Project objective to move the MOH to play a stewardship role with discharge regulatory and oversight functions rather than doing transactions. The procurement of works and goods following NCB and Shopping procedures as well as consulting services (less than US$100,000) shall be procured by the health facilities following harmonized procurement manual.

46. It has been agreed that if a particular invitation for bid comprises several packages, lots or slices, then the aggregate value of the whole package determines the applicable threshold amount for procurement and also for World Bank review. The NCB conditions are part of the Financing Agreement. Domestic preference shall apply for procurement of Goods and Works. The capacity building measures as agreed in the POM shall be implemented during the Project life.

47. **Procurement Plan**. As this is a SWAp operation, the MOH will prepare annual procurement plan to be agreed upon by the World Bank and JFs by December for the next FY. The agreed procurement plan shall be published in the World Bank's external website, PPMD Procurement Portal (to be launched) and MOH website.

48. Procurement under component 2 – Social Protection Sector. The procurement under this component will follow traditional specific investment lending approach. The Procurement under this component will follow the World Bank Guidelines, January 2011 on procurement and

selection of consultants. Each contract to be financed by the Project, including the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame will be included in a Procurement Plan to be agreed between the Borrower and the Bank. The Procurement Plan will be updated at least annually or as required to reflect the actual Project implementation needs and improvements in institutional capacity. The MSD does not have adequate procurement capacity to procure following World Bank Guidelines and therefore this function will be carried out by the MOH on behalf of MSD.

49. **Action Plan for procurement capacity building.** The Project will hire an International Procurement Consultant either using Project funds or Donor resources to update (a) Harmonized Procurement Manual; (ii) Update SBDs; (iii) Prepare Procurement Training Module; and (iv) Deliver procurement training for MOH staff and at a few health facilities.

Summary of Procurement Risk Assessment

Risk	Rating Before	Mitigation	Rating After
The MOH staff lack capacity to undertake the proposed procurement work under the Project, particularly regarding international procurement or World Bank procurement guidelines.	High	A qualified international procurement consultant shall be hired and will provide on-the-job training to the MOH staff and to tender/evaluation committee members. Consultant will provide assistance in the preparation of bidding documents, bid evaluation reports and contract management.	Substantial
The staff at health facility level lack capacity to undertake the proposed procurement work under the Project.	High	Adequate training program for health sector facilities shall be developed. The procurement unit with help of international procurement specialist will deliver such training on a regular basis. Establish an effective procurement "help desk" at the MOH. The procurement unit of the MOH should act more as a capacity building unit rather than transaction unit.	Substantial
Conflict of Interest in procuring pharmaceuticals by MHIF for all health facilities.	High	As per agreed procurement arrangement, MHIF does not have any role in program procurement. This will be monitored during implementation.	High
Poor quality of bidding documents, unclear and unrealistic requirements, such as delivery, completion time, which bidders would be unable to meet, and frequently no qualifications and experience.	High	Prepare and make widely available clear, easy to understand harmonized standard bidding documents containing all bidding requirements in accordance with the international best practice and the national law.	Substantial
Poor quality of technical specifications for health sector goods, in most of cases ambiguous technical specifications. Narrow technical specifications for medical equipment due to lack of relevant expertise within the MOH.	High	Train MOH technical staff in preparing unambiguous technical specifications and set up mechanisms for obtaining technical experts in relevant areas for the preparation of specifications. MOH should compare specifications of number of manufacturers to make sure that the specifications developed are sufficiently generic to allow a wider competition. Create and maintain a database of sample specifications and prepare sample of technical specifications for health goods (items) procured frequently. The relevant technical experts will review detailed technical specifications while	Substantial

Risk	Rating Before	Mitigation	Rating After
		preparing the bidding documents.	
Lack of mechanism for proper acceptance of health sector goods upon delivery.	High	The MOH should establish the technical expert panel for acceptance of health sector goods. Administrative procedures for medical goods contracts shall be developed as part of Contract Administration Manual. The acceptance of health sector goods upon delivery should be done by the staff with relevant technical knowledge/skills.	Substantial
Lack of contract management mechanism in the health sector (at all levels).	High	A qualified contract management consultant shall be hired. A consultant will prepare the contract management manual to be used at all health sector levels and will provide on-the-job training on its application. The manual shall include the requirements for contract monitoring tables. If there are any substantial medical equipment to be purchased in any year, then a pre-shipment inspection agent will be hired by the MOH.	Substantial
Lack of complaint review mechanism.	High	The procurement unit of the MOH should develop the complaint review mechanism for the health sector facilities. Such mechanism should operate with greater transparency, such as through publications of decisions, which might enhance perceptions relating to the fairness of the review system.	Substantial
Lack of awareness of procurement opportunities available in the Project for civil works, goods and services.	High	Carry out public awareness programs using various media, such as newspapers, brochures, radio, TV, Project website, etc.	Substantial

50. The Project procurement risk is "High" and residual risk after implementation of risk mitigation measures will be "Substantial".

51. Many of the fiduciary weaknesses discussed in this assessment mirror larger problems of the country's Public Finance Management (PFM) system and public procurement. The short-term action plans discussed below aims at improving the procurement capacity of the health sector. This will provide multilateral and bilateral donors the necessary assurances that the funds provided by them for the improvement of the health sector in the Kyrgyz Republic will lead to the intended results. It must, however, be noted that the issues in the health sector cannot be resolved in isolation from broader country PFM reforms, e.g., treasury modernization, accounting reforms, including development of chart of accounts, increasing the salary of civil servants, development of institutional and legal framework for internal audit, etc. These reforms, however, can be (and to some extent are being) introduced in a parallel rather than sequential manner.

52. The World Bank maintains dialogue with the Government on public procurement reform. The World Bank along with the Asian Development Bank (ADB) and other DPs has conducted a Country Procurement Status Review (CPSR) in February 2012. A procurement capacity

assessment has also been carried out during Project preparation in September 2012. As part of the ongoing DPO, the Government is committed to reform public procurement in the following areas: (i) revise PPL to be in line with good international practices; (ii) publish Public Procurement Report (iii) establish independent Public Procurement Regulatory body; and (iv) establish independent complaint review board. The World Bank team has also carried out an Integrated Fiduciary Assessment (IFA).

53. As a number of risks related to procurement of medical equipment have been identified, particularly in preparation of bids (specifications that prevent fair competition), possible collusion in bidding and capacity of post installation service, such risks may be significantly heightened where local competition among experienced bidders is inherently weak and where capacity to monitor quality of deliverables is lacking. To mitigate against these risks a following action plan is identified:

Action Plan for Procurement

Action	Timetable	Responsible Unit
Revise/update the Procurement Manual as part of the POM to ensure that the various legislative instruments are updated, comprehensive and coordinated to address observed gaps during the implementation of the first SWAp. Matters of critical importance, such as a better coordination among the technical departments of the MOH. The Manual should include a more explicit statement that no procurement action shall be initiated without an existing budget appropriation.	By effectiveness	Procurement Unit with the help of procurement consultant with international experience
Ensure at least one qualified procurement consultant, contract management specialist and procurement assistant are hired.	By effectiveness	By MOH
Establish an effective procurement help desk at the MOH	First year of Project implementation	Procurement Unit
A comprehensive set of SBDs for the health sector should be prepared and mandated for use by health facilities at all levels. The existing SBDs should be updated consistent with current public procurement legislation and provision stipulated in the Financing Agreement.	First year of Project implementation	Procurement Unit with the help of procurement consultant with international experience
Design and deliver Training-of-Trainers Program for public procurement and contract management.	First year of Project implementation	Procurement Unit with the help of procurement consultant with international experience
An independent committee should be established for complaints regarding procurement processes and contract awards. To the extent that a complaint review function is retained within the MOH, proper segregation of functions and safeguards should be put in place to ensure independence and to minimize the potential for conflicts of interest. The PPMD also should be given full authority to make decisions on complaints in such cases.	First year of Project implementation	Procurement Unit with the help of procurement consultant with international experience

Action	Timetable	Responsible Unit
Prepare a multi-year strategy for the improvement of public procurement system for the health sector. As part of this strategy, carry out a capacity building needs analysis and, based on the findings, prepare a sector procurement capacity building strategy for the short-, medium- and long-terms, considering all available resources, such as existing public servant training mechanisms; universities; and training centers such as the one in the MOF. Based on the strategy, implement a training program for healthcare facilities at all levels for the Project duration.	Six months of Project implementation	Procurement Unit with the help of procurement consultant with international experience
Design and establish a sustainable mechanism for collecting, maintaining, and disseminating procurement statistics, including steps to increase the capacity of the Procurement Unit in this area. Procurement records should be maintained regardless of procurement value or method.	Six months of Project implementation	Procurement Unit with the help of contract management consultant
Ensure timely Procurement Post Review by an Independent Consulting firm (hired by MOH based on the TOR agreed with the Bank) for monitoring health care facility compliance with Project procurement arrangements. Periodic reports on the performance of procurement should be prepared and made available to the public through the MOH website.	Six months of Project implementation	Procurement Unit with the help of contract management consultant
The Procurement Unit should prepare an annual comprehensive procurement report providing statistical and analytical information about the data collected, including data on procuring entity compliance with Project procurement arrangements.	Eighteen months of Project implementation	Procurement Unit with the help of contract management consultant
A specific code of conduct/ethics explicitly covering participants in public financial management systems, including procurement, and addressing matters specific to such persons, should be implemented.	First year of Project implementation	Procurement Unit with the help of contract management consultant

54. **Procurement Supervision and Ex-post Review:** Routine procurement reviews and supervision will be provided by the procurement specialist based in the region/country office**.** In addition, two implementation support visits are expected to take place per year during which ex-post reviews will be conducted for the contracts that are not subject to World Bank prior review on a sample basis (e.g., 20 percent in terms of number of contracts) at MOH. One ex-post review report will be prepared per fiscal year, including findings of physical inspections for not less than 10 percent of contracts awarded during the review period. The MOH will hire a Procurement Post-review (PPR) consultant as per TOR agreed with the World Bank to carryout PPR at health facilities. The PPR report for the CY will be delivered to the World Bank no later than six months (June 30) of the following year.

55. **Procurement Arrangement under Component 3 - Contingent Emergency Response:** In case of a crisis and/or emergency, after the World Bank approves an *Emergency Financing Plan,* the OP/BP 8.0 would trigger. The *Emergency Financing Plan* shall contain list of positive goods to be financed under the Project. In line with "Rapid Response to Crises and Emergencies: Streamlined Procurement Procedures - Guidance to World Bank Staff – June 2009," the MOH handling this Project will be responsible for procurement under this component and prepare a simplified procurement plan for the World Bank's review and clearance. Each contract to be financed by the World Bank under this component, including estimated costs and time frame, would be agreed between the MOH and the World Bank in a Procurement Plan. The

Procurement Plan shall contain the procurement methods and prior review limits in line with the above referred guidance note. There will be a separate procurement post review by the World Bank for the procurement under this component including asset verification and technical audit. The Borrower will also conduct procurement review (with TOR acceptable to the World Bank) and the review would also cover: (a) the contracting approach; (b) the appropriateness of prices relative to market prices; (c) the adherence to acceptable and agreed commercial practices or emergency procedures; and (d) the appropriate use of funds for intended eligible purposes.

Governance and Anti-Corruption Action Plan (GAAC)

56. The Project will follow the World Bank Group Anti-Corruption policies as set forth in the *Guidelines on Preventing and Combating Fraud and Corruption in Projects financed by IBRD Loans and IDA Credits and Grants* (current edition). The World Bank team intends to maintain close oversight and will carry out prior review of all major contracts according to the thresholds that will be regularly reviewed and adjusted as needed in the Procurement Plan. The following measures will be carried out to mitigate corruption risk:

- *The MOH will update the Harmonized Procurement Manual at Facility level and update the bidding documents for procurement of goods and works following NCB and shopping procedures and selection of Individual Consultants and firms of less than US$100,000.* The update of the Manual will be carried out by Project effectiveness with the support of KfW and Project preparation Grant applied by MOH.
- *Training of procurement staff* starting from the Project launch and periodically thereafter, training will be customized to the procedures and methods applicable for Project. The procurement unit of the MOH will lead this training process and will prepare the annual training program for procuring entities at all health sector levels. The adequate financing shall be allocated to implement the training program and reflected in the procurement plan; the training plan shall cover MOH and all health facilities. The MOH will prepare training modules, train the trainers and roll out training to cover 320 + health facilities during the first year of Project implementation with the support of KfW and the Project preparation Grant.
- *Proposal of Mandatory Insurance Fund to centrally procure pharmaceuticals for all health facilities* is a major risk and there is conflict interact in procuring drugs by insurance company for health facilities. This could lead to lack of accountability for service delivery at facility level. The Project team will continue to maintain dialogue with the MOH to mitigate this risk during implementation.
- *Publication of Advertisements and Contracts:* All publications for advertisements and contract awards, including the results of the awards, will be done in accordance with the Procurement Guidelines and published in the World Bank client connection system and on external websites, i.e., UNDB and World Bank websites; in addition, all procurement notices and contract awards shall be published on the Procurement Portal of the MOF and on MOH's website.
- *Debarred Firms and Individuals*: Appropriate attention will be given to ensure that debarred firms or individuals (to be verified from the World Bank's external website) are not given opportunities to compete for World Bank-financed contracts.

- *Temporary suspended firms*: Appropriate attention will be given to ensure that temporary suspended firms or individuals (to be verified through client connection) are not given opportunities to compete for World Bank-financed contracts.
- *Complaints:* All complaints by bidders will be diligently addressed and monitored in consultation with the World Bank.
- *Evaluation Committee:* If required, the World Bank will review qualifications and experience of proposed members of the Evaluation committee(s) with a view to avoiding nomination of unqualified or biased candidates. All members will be required to sign a confidentiality/impartiality form.
- *Monitoring of contract awards:* All contracts are required to be signed within the validity of the bids/proposals and, in case of prior review contracts, promptly after the no objection is issued. Procurement Plan format shall include information on actual dates (of no objections and award) and will be monitored for cases of delay which will be looked at on a case-by-case basis to identify the reasons. The MOH will maintain up-to-date procurement records available to the World Bank staff and auditors.
- *Contract administration:* A comprehensive Contract Administration Manual shall be prepared for health sector staff to ensure a proper management of signed contracts; the relevant staff should receive the training on application of such Manual. A contract management specialist will be hired by MOH by the Project effectiveness to maintain the Procurement Monitoring table (format to be agreed in the POM).
- *Monitoring of payment:* Monitoring reports prepared for the World Bank will be customized to include a form to monitor physical and financial progress.
- *Timeliness of payments:* Payment to contractors, suppliers and consultants will be monitored through semi-annual interim monitoring reports to ensure timeliness of payments. The MOH shall maintain a system/database to ensure payments to the suppliers and contractors are paid without delay according to the conditions of the contract.
- *Conflict of interest (COI) of persons, who are in a legislative (parliamentarians) or supervisory role (board of MOH), but at the same time could be suppliers to the health care systems:* The updated POM and Harmonized Procurement Manual will have a format to be signed by the evaluation committee members that they have no COI in participating in the evaluation.

Environmental and Social (including safeguards)

57. **The Project is assigned with the World Bank environmental category B, as only moderate negative environmental impacts are anticipated under the Project.** Minimal to moderate environmental impacts are expected from civil works for rehabilitation or construction of MOH facilities in various locations around the country. Expected negative environmental impacts include dust and noise related to renovation, demolition and construction; disposal of construction waste; and disposal of wastewater, emissions and medical waste during operation of the facilities. It is anticipated that sub-project activities would fall into category B or C. Should any project activities be determined to have significant safeguards issues such that they would be

considered category A, the Project would need to be restructured to reflect the change in category. Positive environmental impacts include improved medical waste management at facilities that are renovated or reconstructed under the Project. The EMP of the first Health & Social Protection Project has been modified by MOH for the current Project as an Environmental Management Framework (EMF), to include a screening tool to identify sub-project activities that would require environmental assessments and management plans (site-specific EMPs), and provide guidance for preparation of the EMPs. The site-specific EMPs will be provided to the World Bank for review and no objection prior to the start of renovations or reconstruction of medical facilities. The EMF specifies that land acquisition is not eligible for funding under the Project. The new EMF has been disclosed and consultation with stakeholders (including donor partners) took place in-country prior to appraisal.

58. The Department of Sanitary Epidemiological Surveillance and United Directorate of Construction Enterprises under the Ministry of Health will support implementation of the Project and will undertake the safeguards functions for the Project. Overall responsibility for program management and implementation for the Den Sooluk program is with the MOH and its adjunct organizations at the national and regional levels. MOH has a supervisory role in relation to all health-related organizations regardless of ownership and administrative level in the country. The executing agency of the World Bank's support is MOH through its various administrative divisions and subdivisions.

59. MOH has successfully implemented three World Bank- financed operations in the health sector, and significant Project management capacity has been built. Specialists have been identified within the Department of Sanitary Epidemiological Surveillance (SES), who - together with the staff of the MOH's United Directorate of Construction Enterprises – is responsible for coordination and supervision of the EMP and risk mitigation measures to be undertaken in the Project. The team works closely with the MOH's Department/Unit responsible for implementation of the Project, staff on the ground, and with national and oblast level environmental officials. They: (a) coordinate relevant training for staff, designers and local contractors; (b) disseminate existing environmental management guidelines and develop guidelines in relation to issues not covered by the existing regulations, for implementation, monitoring and evaluation of mitigation measures; (c) ensure contracting for construction and supply of equipment includes reference to appropriate guidelines and standards; and (d) conduct periodic site visits to inspect and approve plans and monitor compliance. These arrangements have proven effective for management of environmental safeguards issues in the construction of an annex to the MOH's main building in Bishkek, which was financed under the first Health and Social Protection Project.

60. The Project design supports the implementation of the Government's National health Strategy (Den Sooluk) and therefore it would include activities that have national coverage to prevent the perception of favoring some ethnic groups over others, including supporting country-wide policy reforms in social protection and in health. Neither resettlement nor changes in current land use are anticipated under the Project.

61. The team is applying the World Bank's post-conflict filter approach to ensure that the Project does not negatively affect social relations in the country and is inclusive of all key groups. The team has identified potential social opportunities within the Project design that could

potentially contribute to the mitigation of existing societal stressors. By supporting the strengthening of health systems equitably across regions, the Project can help support efforts on inclusion of all regions of the country in the critical areas of human development and social services targeted by the Project. Encouraging outpatient and preventive treatment should also promote greater and more effective use of existing capacity, helping reduce regional inequalities in access to services. Intended strengthening of the national policy on special needs as well as the development of community-based social care services would also likely contribute to strengthening cohesion and resilience in stressed communities.

62. The team also notes the existence of certain potential social risks that the Project will need to remain sensitive to during the course of implementation. Given the sector-wide approach, it is difficult to determine the geographic coverage of potential activities at an early stage. It is not yet possible to reliably estimate distribution of staff, trainings and services that could in turn influence beneficiaries' perception of availability, access and quality of services among different regions. When resources are not equitably distributed, or are not directed to the localities with the greatest needs, this can contribute to grievances. The rollout of investments, particularly with regard to rehabilitation of health infrastructure, should ensure a broad geographic coverage across the country's Oblasts and Rayons. Ensuring adequate communication across potential beneficiaries and non-beneficiaries is critical to explain limited resources and their distribution. Local Government institutions, public organizations and community consultations should be employed by the counterparts and the World Bank team to ensure robust public engagement. During supervision, the Project team will monitor the geographic coverage of Project benefits as well as the demographic profile of beneficiaries to ensure that the Project is in fact resulting in sector-wide investments across the country's regions and social groups; these measures will be incorporated into the Project results monitoring. Strengthened means testing to better target social assistance to the poor is also an important objective. The Project team, however, will remain sensitive to any reduction in benefits this might imply from currently benefitting groups. In the Kyrgyz context, changes in social assistance benefits can engender strong responses, and the Project team will remain attuned to such responses and risks through ongoing community-level monitoring and consultations

63. Overall, the supervision plan of the World Bank as well as the counterpart implementation plan will include ongoing Focus Group Discussions and other forms of outreach at the community level in different regions of the country to monitor local-level perceptions of the health reform efforts and social protection investments as the sector-wide initiatives are implemented. This outreach will also include ongoing consultations with civil society at the national, regional and local levels who are active in the health and social sectors. The participation of local communities as well as local authorities in contributing their views on such matters of practice as employment opportunities, cost of services, distributions under scarce resources, grievance mechanisms in cases of poor treatment, etc. will strengthen social sensitivity during implementation and supervision. The counterparts and the World Bank team will also coordinate on a communications strategy to ensure that clear and accessible messages are used to explain the scope and benefits of the components supported under the Project.

64. Neither resettlement nor changes in current land use are anticipated under the Project. The Project team will continue to monitor that this remains the case during Project implementation.

Monitoring & Evaluation

Health Sector

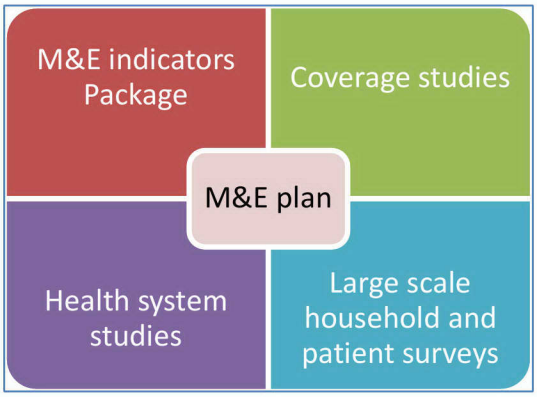
65. Achievement in Monitoring and Evaluation (M&E) during Manas Taalimi. Kyrgyzstan has been a pioneer in strengthening monitoring and evaluation in the health sector. A health system monitoring instrument was first developed in 2002, and continuously revised to match new sector programs. The annual preparation of the instrument has been institutionalized in the Department of Health Policy Analysis of the MOH, which is responsible for its preparation and presentation at the joint annual reviews. In addition, health system studies on various topics are conducted and channeled through the policy process. An annual work plan of studies is developed by the MOH. Six to ten policy research studies are conducted annually. Findings of sector monitoring and policy studies are channeled to the policy development process and to sector dialogue and are coordinated primarily through the Joint Annual Reviews.

66. As the Project is following a SWAp with pooling of funds at the Treasury level, it is not possible to clearly attribute overall health gains to the Project or to assess Project contribution to improvements in the overall governance and system reforms. There is a broad agreement among DPs on the importance of adopting a single common results and monitoring framework - Joint Assessment Framework (JAF) - that reflects Government's priorities in the sector and monitors outcomes of the reforms. For these reasons, two sets of PDO indicators will be used. The first set of indicators will monitor the Government's commitment and evaluate if essential preconditions for achieving Den Sooluk strategy are in place, while the second set of indicators will monitor progress towards achievement of key objectives of Den Sooluk such as improvements in access to key services and financial protection of the population. The second set of indicators will be measured through studies that are part of JAF and will be carried every two years or at least twice during the implementation period.

67. JAF indicators will be used as intermediate indicators. In addition to JAF there will be several process indicators that will monitor effectiveness of SWAp management and fiduciary controls. These indicators will be monitored during the Joint Annual Review (JAR) of the program and will be summarized in Joint Statements, which are produced after each JAR.

68. The proposed M&E strategy for Den Sooluk is built on past achievements of the current M&E system while ensuring that it is fully synergistic with the new paradigm presented in Den Sooluk. Health gain in four priority areas (CVD, MCH, TB, and HIV) is the driving force of Den Sooluk along with corresponding core services and interventions that are to be delivered at scale. However, health system bottlenecks (in public health, individual service delivery, financing, human resources, medicines, and governance) have been identified. Den Sooluk focuses on those health system reforms that remove these bottlenecks in order to scale up core services and achieve expected health gains.

69. The Den Sooluk M&E plan is based on four pillars (basic principles) which jointly will provide a full picture of implementation progress The four pillars include: (i) an M&E indicator package based on routine and annually monitored data; (ii) regular coverage studies assessing progress with expanding core services, (iii) health system studies ordered by the MOH/MHIF/SES looking into progress and obstacles in removing key health system barriers, and (iv) large scale household and patient surveys (Picture 1).



Picture 1

70. Indicator Package Structure. The annual package of indicators is an important part of the M&E strategy for Den Sooluk and developed entirely in line within the structure of the Den Sooluk Program. The indicator package structure consists of two sections, the first of which is designed for tracking progress in improving health gains based on priority programs, and the second one - for tracking progress in health system strengthening based on the Program components (see Table below).

Indicator Package Structure

Section 1 Expected health outcomes based on priorities of the Program: • Cardio-vascular diseases (CVDs) • Mother and child health (MCH) • Health of children under 5 (ChH) • Tuberculosis (TB) • HIV infection (HIV)
Section 2 Expected health system strengthening outcomes based on the Program components: • Public Health (PH) • Individual services (IS) • Financing (F) • Resource generation (RG) • Stewardship (S)

71. In line with the proposed implementation strategy for Den Sooluk, M&E capacity will be strengthened at the sub-national and institutional levels. National level indicator package for Den Sooluk will be complemented with Oblast level indicators, around which oblast coordination could be strengthened. Further monitoring capacity in key tertiary institutions will also be developed so that indicator packages for priority programs can be handled at that level. The rationale for this is that indicator packages for priority programs focus mostly on indicators of clinical and health behaviors and to change these, tertiary institutions will play a key role.

Additionally, the role of the Republic Health Information Center (RHIC) and its oblast structures will be reinforced.

Studies and Surveys

72. Coverage studies will be a new feature in the Den Sooluk M&E strategy inspired by the new structure of the Den Sooluk program. In the program, core services for the population, the second pillar, play an important role to link health system strengthening efforts and health outcome improvement. However, coverage with core services is not known from routine data. To fill this gap, coverage studies will be conducted every two years during the program (2012 for a baseline, 2014 for mid-term evaluation, and 2016 for end-program evaluation) separately for each of the four priority program areas. These studies will document coverage of core population and individual interventions as well as explore barriers at the provider level that stand in the way of further coverage expansion.

73. Health system studies focusing on removal of barriers. The evaluation studies conducted since 2000 on various aspects of the health system remain to be important. The process of commissioning has been developed through years of trial and error and is working well and provides valuable information to the MOH for policy making. During Den Sooluk, health system evaluations will continue with a focus on selected health systems barriers identifies in the program and appearing during implementation. An annual process of developing the topics will be maintained to allow for flexibility and maximum correspondence to MOH policy priorities and concerns.

74. Large scale surveys. Kyrgyzstan is the only country in the CEE and FSU area where household and patient surveys have been conducted at regular intervals. The household survey provides key information on financial protection and access which cannot be obtained from routine data sources. The discharged patient's survey is the main source of information on informal payments which is a key proxy for the size of funding gap in the SGBP. Both surveys will be continued as these issues remain critically important to the success of Den Sooluk. The household survey is proposed for 2013 and 2016. The Discharged Patients survey is proposed for 2012 and 2016.

75. Performers of Den Sooluk M&E Program. M&E strategy implies close cooperation between Government, non-Government and international donor organizations (WHO, DfID, UNICEF, KFW, USUD, WB). Specifically, this cooperation will ensure needed M&E objectivity and efficiency of the National Den Sooluk Program. Public authorities in implementing health sector M&E strategy will include:

- **Ministry of Health of the KR/Department of Health Policy Analysis** – it is a key actor of the Den Sooluk M&E strategy and plays key coordinating role in data collection and analysis, ensuring regular feedback with all stakeholders.

- **Ministry of Health** of the KR prepares and presents M&E indicator Package to discuss outcomes and develop recommendations during Joint Annual Reviews and at meetings of the Public Steering Committee. In addition, since 2007, the MOH annually makes a health policy research plan based on requests from Departments of the MOH and MHIF.

- **MHIF –** is the structure responsible for purchasing health services included into the Single Payer System that implies need in analysis of funding, quality of health services, drug policy etc.

- **Republican Center for Health System Development and Information Technologies** – works in several directions, including evidence-based medicine and development of information technologies for the health sector.

- In addition, it should be mentioned that in health policy research the key partners are such organizations as **RHIC, DSSES, Drugs and Medical Equipment Department, RHPC, tertiary level organizations in line with four priorities (NC&TC, NTBC, RAIDSC and NMCHC), as well as National Statistics Committee and other.**

76. The involvement of Non-Governmental Organizations in implementing M&E Strategy is coordinated by MOH. These organizations provide considerable competence:

- **Public Foundation «Health Policy Analysis Center» (HPAC)** – was established in July 2009 as a result of institutionalized WHO/DFID Health Policy Analysis Project (2000-2010) under agreement with all stakeholders. The organization is represented by researchers trained in applied policy analysis, statistics, survey conduction, questioning and methodology of qualitative studies. The HPAC implements its work according to approved MOH's research plans. Thus, during implementation of Manas Taalimi Program (2006 - 2010), over 30 policy research papers have been prepared (see research list in www.hpac.kg), including large scale studies in partnership with the National Statistics Committee and MHIF (Household survey, Survey of discharged patients).

- **Hospitals Association and FGP Association of the KR –** are organizations with strong potential. Their staff members have multi-year experience of work with different level health organizations that are aware about performance specifics and health reform implementation in all Oblasts/rayons of the country. They have research capacity and have implemented a number of joint research projects (www.hpac.kg). They are long-standing partners of HPAC.

- In addition, to these non-Governmental organizations, **"Socium Consult", "Mental Health", "Avanco", "SocioEconik" and others** take part in health sector monitoring and evaluation**.**

Social Protection

77. The MSD has developed an M&E framework including a matrix of indicators to track implementation of the Social Protection Development Strategy 2012- 2014. The World Bank has provided technical advice under the Rapid Social Response grant to improve and refine the M&E framework. This work is continuing and efforts will be made to harmonize the M&E of the SP Component with that of the medium-term SP Development Strategy as much as possible. The key sources of data for monitoring the SP component would be the administrative records of the MSD, SA Beneficiary Registry, information on public expenditure, and the Kyrgyz Integrated

Household Survey (KIHS). In addition, special purpose sample surveys would be developed to support the MSD in the evaluation of pilots in targeted social assistance and new social care models.

Role of Partners

Indicative Division of labor among Development Partners for Health and Social Protection Project 1 and Proposed Division of Labor for SWAp 2	
Health and Social Protection Project 1	**SWAp 2**
KFW with BMZ: Individual Health Services	**KFW:** Operation and maintenance of equipment, MCH, TB, HIV Emergency Medical Care **Parallel financing:** Blood Safety Institutional strengthening of MOH: (i) Procurement, (ii) Financial Management, (iii) Contract Management, and (iv) Implementation Advisor Further development of detailed implementation plans for four DS priority areas
SDC: Community Involvement Human Resources/Medical Education Component	**SDC:** Providers Autonomy Assessment **Parallel financing:** Implementation support (TF WB)
UNAIDS: Priority Programs – HIV/AIDS	**UNAIDS:** TB/HIV (priority areas of Den Sooluk)
UNICEF: Mother and Child Health	**UNICEF:** Mother and Child Health (priority area of Den Sooluk) Nutrition
USAID: Cardiovascular Diseases Content of Medical Practice Individual Health Services Health Financing	**USAID:** TB/HIV (priority areas of Den Sooluk) Implementation planning for TB/HIV Piloting and scaling up TB/HIV/AIDS activities Support to Association of Family Medicine
WHO: Overall coordination for JARs Technical agency for health policy Guidance for Monitoring and Evaluation Tuberculosis Public Health Health Financing Technical assistance for preparation of Manas Taalimi and Den Sooluk Strategies	**WHO:** Overall coordination for JARs Technical agency for health policy Guidance for Monitoring and Evaluation Public Health Tuberculosis
WORLD BANK: Lead Agency responsible for overall policy dialogue Fiduciary oversight (procurement and financial management) Guidance of all aspects of implementation, including provision of no objection letters Chair of Working Groups on Health Financing/Stewardship Overall coordination for JARs	**WORLD BANK:** Lead Agency responsible for overall policy dialogue Fiduciary oversight (procurement and financial management) Guidance of all aspects of implementation, including provision of no objection letters Health Financing/Stewardship Public Health Piloting of providers autonomy at hospital level, including supporting development of legislation and shifting from budget lines of reporting to higher managerial autonomy (under RBF Project)

Annex 4: Operational Risk Assessment Framework (ORAF)

Kyrgyz Republic: Second Health and Social Protection Project (P126278)

Project Stakeholder Risks						
Stakeholder Risk	**Rating**	**High**				
Description: 1. The risk is that the new government and the parliament may not have commitment to the reform agenda and may attempt to reverse agreed reforms. 2. Although there is a new strategy for health, there is no clear understanding how this strategy will be implemented. 3. Donors may have different view on operational procedures including implementation of reforms, Project management and M&E strategy.	**Risk Management:** 1. The Bank is working closely with the new authorities to bring them up to date on the stage and importance of the reforms. Considerable efforts will continue to be made to gain the same level of commitment from the new government, including members of Parliament. Round tables and briefings on progress made and scope of second generation health reforms under Den Sooluk and to be supported by SWAp 2 will be organized with key stakeholders, including Parliament, Ministry of Finance, Ministry of Health, and NGOs. Better informed policy makers should reduce/prevent reverse of the reforms in the future. Social marketing events would be developed and launched soon after the credit/grant becomes effective to continue to raise awareness and dialogue with stakeholders.					
	Resp: Both	**Status:** In Progress	**Stage:** Both	**Recurrent:** ☑	**Due Date:**	**Frequency:** Yearly
	Risk Management: 2. Clear milestones on how the new strategy will be implemented will be identified and included in communication briefings. The briefings will also be supported by round table discussions with key stakeholders around JARs.					
	Resp: Bank	**Status:** Not Yet Due	**Stage:** Both	**Recurrent:** ☐	**Due Date:** 31-May-2013	**Frequency:**
	Risk Management: 3. New MOU is under preparation by Joint Financiers to help govern relationship with donors and MOH.					
	Resp: Both	**Status:** In Progress	**Stage:** Both	**Recurrent:** ☐	**Due Date:** 31-May-2013	**Frequency:**

Implementing Agency (IA) Risks (including Fiduciary Risks)						
Capacity	**Rating**	**High**				
Description: 1. The risk is that the capacity of MOH to implement reforms may be compromised as a result of high turn-over of staff due to low salaries and inability of the sector to retain qualified staff. 2. Weak FM capacity including weak internal controls in accounting and financial reporting that is mostly manual, especially in the MHIF, may slow down or jeopardize implementation of autonomy of providers. 3. The risk is that MSD has only a few highly qualified staff and a weak methodological basis, which may compromise capacity of the MSD to design, pilot and roll-out the new approaches to social care and better targeting. 4. The risk is that weak monitoring and oversight capacity of MSD (lack of equipment, institutionalized procedures and methodologies) may compromise its ability to ensure that all the rules of the pilot programs are followed and to draw evidence-based lessons from the Project.	**Risk Management:** 1. Salary levels were increased as of May 1, 2011. Efforts have been made by the Government in the past years to provide some non-financial incentives such as development opportunities, including training overseas, public recognition, etc. Efforts will continue to be made by the Bank and DPs to continue to engage technical staff responsible for specific areas of the reform including implementation support, workshops, and other studies.					
	Resp: Bank	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
	Risk Management: 2. SWAp 2 will support further capacity strengthening measures, including use of Planning, FM, and Procurement consultants, to help ameliorate the capacity weaknesses and to continue to build capacities within relevant MOH departments. Further, internal control and operational procedures have been included in the Project Operations Manual updated as a condition of effectiveness of the 2nd Additional Financing. The internal audit of MOH/MHIF units will be strengthened to monitor internal controls. Ongoing efforts for the automation of accounting and reporting in the health sector will be supported and strengthened. Training activities are being supported also for MSD.					
	Resp: Client	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
	Risk Management: 3. The Bank is working closely with other DPs to provide technical assistance with a large capacity building component to mitigate this risk and strengthen the MSD capacity to implement the new approaches as envisaged in the Social Protection Strategy for 2012-2014.					
	Resp: Client	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
	Risk Management: 4. SWAp 2 and the RSR Trust Fund support further capacity strengthening measures, including international technical assistance, seminars and trainings to help develop and institutionalize the business processes leading to a strong monitoring and oversight program as one of the key functions for the MSD. Ongoing efforts (financed by SWAp1 main grant) for the automation of targeted social assistance, creation of beneficiary registries and data exchange with other Government agencies will also contribute to overcoming the current shortages.					

	Resp: Client	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
Governance	**Rating**	**High**				
Description: 1. Weaknesses in transparency and accountability contribute to misuse of funds.	**Risk Management:** 1. The Bank will continue to support improvements in the quality of procurement (CPAR and update) and to strengthen external and internal audit functions. Due to pooling arrangements, the Bank is auditing health facilities and, therefore, the entire sector. More specific actions will be taken by PFM team to enhance internal and external controls and ensure appropriate use of funds.					
	Resp: Both	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
	Risk Management: 1. The SWAp's fiduciary dimensions and efforts have been and will continue to strengthen public budgeting, procurement and financial management. Channeling funds of all DPs through the budget rather than off-budget is helping strengthen Government's oversight and will have externalities beyond health and social protection. This arrangement enables audits and increases transparency and proper use of funds. All partners and joint financiers agree (explicitly) to some degree of risk that is associated with using the country systems as the bank cannot provide full oversight and be responsible for entire fiduciary accountability at all levels of the health system. However, having internal and external audits in place and PFM as a specific component, the risk will be relatively modest. Autonomization of providers may lead to changes in appointment procedures of chief doctors and reduce corruption.					
	Resp: Client	**Status:** Not Yet Due	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
	Risk Management: 2. All social assistance systems contain some level of error and fraud. The Project will aim to minimize these risks by strengthening the beneficiary registry, improving benefit administration, including oversight and control, and, support to disability certification reform.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	31-Dec-2016	
Project Risks						

<table>
<tr><td>Design</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Description:

1. Priority investments included in the five year Program of Work might not be fully aligned with Den Sooluk and sequencing of reforms is not fully defined.</td><td colspan="6">Risk Management:

1. In line with the MOU, DPs will assesses the quality and scope of annual POW and approve them during annual JARs. In addition, as under SWAp 1, the Project is being designed to be flexible to adapt to evolving sector needs. In addition, both during the preparation and first year of implementation, TA will be provided to refine the five-year POW and prepare detailed implementation plans for DS priority areas.</td></tr>
<tr><td>Resp:
Bank</td><td>Status:
Not Yet Due</td><td>Stage:
Both</td><td>Recurrent:
☐</td><td>Due Date:
31-Dec-2016</td><td>Frequency:</td></tr>
<tr><td>Social and Environmental</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="6">Description:

Description:

1. Possible risk that the key beneficiaries might not be reached by Project.
2. Possible risk that rollout of national strategy or specific investments do not reach all geographic areas consistently.
3. Changes in social benefits or other health/social protection program changes are received negatively by existing beneficiaries.
4. Inappropriate disposal of medical waste, limited access to clean water and adequate sanitation facilities; civil works that do not respect EMF.</td><td colspan="6">Risk Management:

1. Project design supports the implementation of the national health strategy – Den Sooluk and therefore would include activities that have national coverage to prevent perception of favoring some ethnic groups, including supporting country wide policy reforms in social protection and health.</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
☑</td><td>Due Date:</td><td>Frequency:
Yearly</td></tr>
<tr><td colspan="6">Risk Management:

2. Revised health care waste management plan and implementation of revised EMP and related practices will be reviewed, monitored, and reinforced where and when necessary during implementation.</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
☑</td><td>Due Date:</td><td>Frequency:
Yearly</td></tr>
<tr><td colspan="6">Risk Management:

3. The World Bank team and counterparts will employ consultations and engagement with civil society across all regions to monitor reactions to policy changes and programs linked to the World Bank financing and ensure appropriate communications and outreach modalities are in place.</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
☑</td><td>Due Date:</td><td>Frequency:
Yearly</td></tr>
<tr><td colspan="6">Risk Management:

4. Revised health care waste management plan and implementation of revised EMF and related practices will be reviewed, monitored, and reinforced where and when necessary during implementation.</td></tr>
</table>

	Resp: Both	**Status:** In Progress	**Stage:** Both	**Recurrent:** ☑	**Due Date:**	**Frequency:** Yearly
Program and Donor	**Rating**	**High**				
Description: As the Bank is the lead agency and agency with fiduciary responsibility and oversight, without additional human and financial resources quality of supervision and support may be low resulting in dysfunctional donor coordination mechanism.	**Risk Management:** 1. A new Bank executed TF is under preparation to support supervision. KfW will also support shared responsibility. New MOU is under advanced stage of preparation and is expected to be signed in the coming months to further clarify shared responsibility. Strong and effective donor coordination is a priority in the design and implementation of this operation as it has been under SWAp 1. Continuous and constructive dialogue with DPs will be pursued in a systematic basis and during the bi-annual Health SWAp review. To better clarify responsibilities, Annex 3, includes a "division of labor" among DPs.					
	Resp: Bank	**Status:** In Progress	**Stage:** Implementation	**Recurrent:** ☐	**Due Date:** 31-Dec-2016	**Frequency:**
Delivery Monitoring and Sustainability	**Rating**	**Moderate**				
Description: 1. A risk is that gained technical and institutional capacity is not maintained with changes in MOH, MHIF and MSD.	**Risk Management:** 1. SWAp 2 will support further capacity strengthening measures, including use of Planning, FM ,and Procurement consultants, to help ameliorate the capacity weaknesses and to continue to build capacities within relevant MOH departments. Further, internal control and operational procedures have been included in the Project Operations Manual updated as a condition of effectiveness of the 2nd Additional Financing. The internal audit of MOH/MHIF units will be strengthened to monitor internal controls. Ongoing efforts focused on the automation of accounting and reporting in the health sector will be supported and strengthened. Training activities for the MSD are also being supported.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**

Overall Risk	
Implementation Risk Rating:	**High**
Comments: The Project's overall implementation risk is considered high. At the health sector level, the key risk is that any policy redirection or decrease in external support would have a negative impact on the health sector and thereby could jeopardize Project's impact. In social protection, there are two types of risks: (i) the Government is facing multiple pressures to reverse its policy of targeting more resources to the poor; and (ii) the Ministry of Social Development's agenda is also threatened by lack of appropriate funding provision from the Republican Budget. At the Project level and for the health sector, the Project approach has been tested with good results in the Kyrgyz Republic and its implementation has been evaluated favorably in various studies. On the social protection front, the World Bank will coordinate its policy advice and position with other development partners active in the sector.	

Annex 5: Implementation Support Plan

Kyrgyz Republic: Second Health and Social Protection Project

Strategy and Approach for Implementation Support

1. The Project will be managed from the field, and virtually all of the Project team members will also be based in the field. This will allow the implementation support to be carried out on an ongoing basis, using a combination of Project-specific meetings as well as the regular policy dialogue processes as noted in Annex 3. Both financial management and procurement support will also be obtained from the country office, which will allow both regular, ongoing support and "just-in-time" assistance as issues come up. The major contracts under this Project will be through the Health Basket Fund, following procedures specified in Annex 3.

2. Because of the nature of the Project, implementation will be dynamic and will be tailored to the specific needs of the evolving policy situation in Kyrgystan. The level of both DP and MOH/MHIF/MSD support will govern the transition to a more performance-oriented and equity-focused health basket fund mechanism. In this respect, there will be a great deal of flexibility in terms of getting toward the desired end result, but the focus will continue to be on this result throughout Project implementation.

3. Fiduciary Support: As part of the implementation support missions, conducted in the framework of the Joint Annual Review (JAR), the World Bank will conduct joint risk-based financial management and procurement reviews after every six months or at appropriate intervals, depending on the level of assessed risk. These will pay particular attention to: (i) accounting and internal control systems at the central and facility levels; (ii) budgeting and financial planning arrangements; (iii) review of un-audited Interim Financial Reports; (iv) review of audit reports, including financial statements, and remedial actions recommended in the auditor's Management Letters; (v) disbursement management and financial flows from the MOF to the MOH and the MHIF, and also transfers to health care providers; (vi) contract management/monitoring and; (vii) review of ongoing risk mitigation and capacity building measures

4. Since the World Bank has had a long-standing relationship with the MOH/MHIF and MSD, it is expected that this relationship will continue through Project implementation and help to move the Project towards its intended goals. In particular, the level of support within the implementing agencies for this approach should help to ensure that there will be an ongoing focus on the Project Development Objectives.

The level and type of implementation support (per fiscal year) is shown in the attached table:

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Health system management and overall coordination	8	2	TTL
Health financing	3	2	Health Economist
Operational and Implementation Support	3	2	Sr. Operations Officer
Local Government administration and financing	3	2	PREM and Health Economist
Public service management	3	1	PREM
Public financial management and procurement	3	2	FM Specialist and Procurement Specialist
Monitoring and evaluation	3	2	M&E Specialist
Social Protection	10	4	SP Specialists (2)
Safeguards	1	1	Safeguards Specialist
Information and Communication Technology	3	2	ITC Specialist

Partners

Name	Institution/Country	Key Role
See Annex 3 under Role of Partners	SDC, KfW, WHO, USAID, UNICEF, UNAIDS	Participation in joint reviews

Annex 6: Technical note: Implementation of Information Technology

Kyrgyz Republic: Second Health and Social Protection Project

A. Systemic Improvement of Information Management in Health.

1. The DS Strategy recognizes systemic improvement of information systems in health as one of the "necessary resources for effective functioning of the health care system". The MOH is already making efforts towards strategic planning and consolidation of information management in health. Currently, most of the IT support in health is concentrated on statistics, while some pioneering work on clinical systems and electronic health record is underway (for example, various registries such as registry of newborn, registry of infant mortality and registry of diabetes patients, are actually having many characteristics of clinical systems but are not used in that way).

2. As the computerization is taking many directions and forms, the MOH is recognizing the momentum for strategic planning and consolidation of information management in health. The introduction of clinical systems in addition to improvement of existing, mostly statistically oriented systems is already considered as a strategic direction to follow. However, that is also recognized as long term, complex and challenging endeavor. It seems that the following processes need particular attention and immediate action:

i. **Improving the environment for eHealth development.** The eHealth development in Kyrgyzstan will need an enabling environment to make progress. It will include at least:
   - Adopted eHealth Strategy/Master Plan, defining general strategic directions, regulation and governance structures, overall architecture of the KR eHealth, the systems to implemented, infrastructure requirements, needed standards and interoperability requirements, investment, human resources and financing plans.
   - Setting up institutional arrangements for the eHealth governance, regulation, and implementation. It is important to have these processes separated, while there might be various options for their implementation, for example, they might be set in five layers:
     - *Governance*, ensuring policy making, strategic leadership, master planning and monitoring.
     - *Regulation*, as an expert function of defining regulatory framework, including legal framework, functional compliance standards, data and data exchange standards, referrals, identifiers, etc.
     - *Implementation management*, ensuring investment management, sustainable implementation business models, operational planning, contracting, technical implementation monitoring and tracking, etc.
     - *Health information analytics*, ensuring clinical data quality management, statistical analytics, technical data warehousing, etc.
     - *Implementation support*, providing institutional capacities for sustainable support to systems daily management, maintenance, and coordination with

vendors.

- Developing regulatory and standardization framework.
- Improving capacities of institutions and facilities for eHealth utilization, etc.

ii. **Developing technical infrastructure.** The technical infrastructure is a precondition for implementation of clinical systems. It is hard to expect the facilities (PHC, hospitals, pharmacies, etc.) to develop the infrastructure gradually using their own budget. While the Government needs to ensure sustainable financing of technical infrastructure operations and maintenance, the Project can overcome the problem first investment by:

- providing computers to facilities;
- improving global communication infrastructure;
- improving local computer networks in health facilities;
- adjusting central location(s) for hosting of new systems;
- improving technical capacity of MOH and other institutions to maintain the infrastructure, etc.

iii. **Implementing fundamental clinical information systems.** Currently, most of the implemented information systems are oriented to data collection and statistics. In order to support clinical processes, and provide reliable and timely data source for statistics, finance/payment analytics, and decision making, a set of information systems shall be implemented to support grassroots level of clinical operations. The list of systems to be implemented will depend on general eHealth architecture that shall be defined in eHealth Strategy/Master Plan, but it shall include at least:

- Primary Health Care (PHC)/Electronic Health Record (EHC) for personified record-keeping of health services;
- Hospital information systems;
- Laboratory information systems; and
- Pharmacy/pharmacology information systems.

B. Systemic Improvement of Information Management in Social Protection.

3. Currently, two key information management systems are under implementation in social protection in Kyrgyzstan. The KISSP[5] is web based information system that supports daily business processes in social protection, from rational level to the MSD. The technical development of the system is almost finished and the system is under implementation. One rayon (Pervomaiski Rayon) is fully using it, while the implementation in other rayons and by the MSD is in progress (out of 59 rayons, 20 have installed software, while about 10 is using the system). This process is in a critical phase, and will need further support after the Project.

[5] Корпоративная информационная система социальной помощи (КИССП)

i. **Improving internal resources for KISSP system implementation and maintenance:**

- **Training.** More training for system usage is needed. The rational staff has received the training, but as the full system implementation advances, new training needs emerge.
- **Analytical skills.** System is capable of generating many new reports that were not available earlier, so improvement of the analytical capacity of the MSD staff to use statistical data from the KISSP is needed to utilize fully the system's potential as an analytical tool.
- **Central location.** The servers and other equipment are installed on central location. However, the location needs technical upgrade to be compliant with relevant standards (cabling, fire protection, physical security, communication channels, generator, etc.).
- **Supporting system operations and maintenance.** The IT Department of the MSD is responsible for system implementation, operations and maintenance. However, the MSD has not ensured budget lines for that purpose, while the IT Department is relatively weak in terms of human resources. In such environment, the full utilization of the system is not sustainable. The Government shall ensure the budget lines and employ staff to the IT Department, while the Project can support system operations in the meantime.

ii. Functional and architectural KISSP enhancements:

- **New functions.** Even pilot usage of the system opened the space for its functional improvements. Support to some new business functions crystallized as new requirement, such as accounting reporting, and enhanced data warehousing and analytics. However, cautious approach is advised in the introduction of new functions as the existing functions are still not fully implemented.
- **Architectural improvements.** The system starts supporting workflows at the rayon level. The process of preparing the benefits applications and their entering into the system is not supported on local level (at Ayil Okmotu, where it actually happens – at the social specialist offices). Only after the application is approved (through paper based and manual workflow), it is entered into the system (in rayon office). Actually, the system can support local level, but it is not implemented that way. There are many reasons for that, but the main one is the lack of infrastructure. However, that might significantly change in the near future as the computerization of local governance is one of the Government's priorities. The KISSP needs some small architectural changes and may be gradually introduced to the local level. That will significantly improve its function in information management and speed up the full implementation.
- **Interfaces to external systems.** The social protection information systems are very sensitive to connection to external systems – they use many data on beneficiaries that are already in other databases such as population registry, tax authority databases, cadaster, and unemployment registries, various health related registries, etc. Further improvement of KISSP is possible through implementation of interfaces for automatic data exchange with such system (of course, only those which are computerized) that will improve efficiency and accuracy of data input as well as

reduce the number of documents that need to be provided by beneficiaries.

4. The other important system that is under implementation is Social Passport. The Social Passport is data set on demographic characteristics, assets and sources of income of persons in need. It is used on local level by social specialists as a support for data management and targeting. The system is still under first phases of implementation, but it is already assessed by social specialists as a very useful tool. It is mainly paper based, but some locations have computers and can use its computerized version (stand alone or as a feature of eAyil system). It is also used as part of a cash benefits workflow, which is attached with the application and supporting documents.

5. The Project will support the integration of KISSP and Social Passport systems and their gradual implementation as the planned computerization of the local level progresses.

6. **Integration of KISSP and Social Passport.** The integration of systems is technically possible with minor technical adjustments on both systems. The integration means that the KISSP administrative workflow can automatically use the data of the Social Passport of a person, while the Social Passport may have access to already approved benefits and services from the KISSP database. Two systems have complementary purposes (administrative support and targeting), so in combination, they can significantly improve efficiency and effectiveness (targeting) of the social protection.

7. **Integration to eAyil.** The introduction of an electronic system for local governance opens also the space for integration of both KISSP and Social Passport interfaces into a unified local governance portal.

Annex 7: Technical note: Effective and Efficient HIV Program and Service Delivery Models

Kyrgyz Republic: Second Health and Social Protection Project

1. In Kyrgyzstan, the HIV epidemic is concentrated in key populations at risk, mainly people who inject drugs (PWID), and to a lesser extent men who have sex with men and sex workers. Injecting drug use is the main mode of transmission, and more than 67 percent of reported HIV cases are attributed to sharing of contaminated equipment among injecting drug users. Fifty percent of people living with HIV (PLHIV) are at the age of 20-29 years and it is estimated that approximately 9,800 people are living with HIV (UNAIDS, 2010). Where HIV epidemics are driven by injecting drug users, we know what works. Highly effective interventions exist to address these epidemics. There is compelling evidence that implementation of a combination of harm reduction interventions– particularly in combination with treatment services - are ***cost effective or highly cost effective investment choices*** to reduce HIV transmission and impact among PWID and their sexual partners. The returns on investment – in terms of deaths, morbidity and treatment costs averted – are potentially very substantial. (WB, 2012) In addition to the modeled effect on HIV incidence and related morbidity and mortality among IDU and their sexual partners, there is evidence that these interventions can reduce drug-use related morbidity and mortality, such as from overdose.

2. The effectiveness of any prevention program will largely depend on the extent to which effective interventions reach people at high risk. Thus, sustainable impact on HIV epidemic trajectory will be defined by: a) selecting the optimal mix of evidence-proven effective interventions appropriate to the local HIV epidemic dynamics; b) targeting the optimal mix of interventions to the population(s) at greater risk of infection and the geographical areas where the majority of new infections occur; and c) implementing the combination of interventions at required quality and coverage to cause high impact through locally-adapted service delivery models.

3. *Selecting the Optimal Mix of Effective Interventions:* In Kyrgyzstan, where IDU transmission dominates, WHO, UNODC and UNAIDS and international evidence indicate a ***comprehensive package*** of interventions for the prevention, treatment and care of HIV among IDUs and their sexual partners, which includes:

> *Needle and syringe programs (NSPs); Opioid substitution therapy (OST) and other drug-dependence treatment; HIV testing and counseling (HTC); Antiretroviral therapy (ART); and Prevention and treatment of sexually transmitted infections (STIs); Condom programs for IDUs and their sexual partners; Targeted information, education and communication (IEC) for IDUs and their sexual partners through outreach strategies, as well as Vaccination, diagnosis and treatment of viral hepatitis, and Prevention, diagnosis and treatment of tuberculosis (TB)* (WHO, UNODC et al. 2009; IDU Reference Group 2010).

4. These interventions are included in the comprehensive package because they have the greatest impact on HIV prevention and treatment as determined by scientific evidence supporting their efficacy in preventing the spread of HIV, in addition to reducing other harms associated

with drug use. These interventions are able to contribute the most to preventing and treating HIV when available *in combination*. Empirical studies and extensive modeling have revealed that single interventions alone have only limited impact; to significantly reduce HIV transmission and harm combined interventions with high levels of coverage are required.

5. A combination of NSP, OST (where opioid utilization occur) and commensurate access for PWID and their sexual partners to ART are the cornerstone of the harm reduction programs. In Kyrgyzstan, harm reduction and methadone are available both in prison and outside. However, coverage and quality of implementation is far from optimal to achieve high impact (UNAIDS, 2010).

6. NSPs is a public health measure that aims to prevent the shared use of injecting equipment in order to reduce the risk of acquiring blood-borne infections among IDUs. Equipment provided by NSPs usually includes needle-syringes, swabs, sterile water, and sharps bins for the safe disposal of injecting equipment. The number of needle-syringes distributed per IDU per year is probably a more appropriate measure of NSEP coverage. A nominal target of 'good coverage' is to attain a regular distribution of 200 sterile needle-syringes to each IDU per year. However, the coverage goal should be defined based on the IDU population and their behavioral practices with the objective of minimizing sharing of injecting equipment. Findings from a range of studies indicate that NSPs do not increase the numbers of persons who begin to inject drugs or increase the frequency of drug use. (PEPFAR 2010). A report sponsored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) considered three core reviews which in total report on 43 studies, 39 of them showing that NSPs reduce injecting risk behavior (Rhodes and Hedrich 2010).

7. In 2011, Wilson et al conducted a cost-effective analysis of NSPs in eight countries in the EECA, which indicated that NSPs were estimated to avert approximately10-40 percent of HIV infections across the eight countries. The greatest effect was in Belarus (33-44%), while the lowest was in Estonia (9-13%). Compared to HIV, a lower percentage of HCV infections were averted (~5-25 percent for six countries and ~25 percent and ~35 percent for Tajikistan and Belarus, respectively). In Ukraine, the relationship between NSEP scale-up and sharing levels was documented, with sharing levels at ~35 percent prior to the commencement of NSEPs and then declining steadily as the programs scaled up, decreasing to ~10 percent. In the same study, in Kazakhstan, it is estimated that over the period 2000-2010, NSEPs prevented 2,205-2,720 new HIV cases, 435-934 HIV-related deaths, and 20,941-24,715 cases of hepatitis C. A modeling study estimated that the NSP in Yunnan, China, averted approximately 16 to 20 percent (5,200 to 7,500) of the expected HIV cases and led to gains of 1,300 to 1,900 DALYs. The total of US$1.04 million spent on NSP from 2002-08 yielded a cost-saving of US$1.38-US$1.97 million via the averted costs of prevention, care, and patient management (Lei, Lorraine et al.).

8. Infections averted during the past implementation of programs will also lead to future benefits of further gains in Quality Adjusted Life Years (QALYs) and health costs saved. In Kazakhstan, during 2000-2010, an estimated 78,606 to 85,670 QALYs were gained by averting new HIV and hepatitis C cases as a result of implementation of NSPs. The vast majority of QALYs gained was due to averted cases of hepatitis C. The average cost per QALY gained was calculated to be USD 132-147 (for reference, the standard threshold for cost-effectiveness in Kazakhstan is USD 9,136 per QALY gained). Thus, NSPs in Kazakhstan and the other countries

were extremely cost-effective. When considering the additional health benefits of averted HCV infections, or the lifetime benefits of HIV infections averted, NSPs were very cost-effective to cost-saving in all countries with median return on investment of 1.6-2.7 times original investments (3% discounted). (Wilson D et al., 2012).

9. *OST* has been demonstrated to be effective in reducing opioid dependence, reduce risk behaviors related to injection drug use, prevent HIV transmission, and improve IDU adherence to ART (PEPFAR 2010). The *Lancet* paper on IDU and HIV (2010) documents that OST is associated with a strong consistent negative effect on injecting risk behavior across the studies they reviewed (Degenhardt, Mathers et al. 2010).

10. A longitudinal cohort study in selected MAT sites in Asia (China, Indonesia, Thailand), Eastern Europe (Lithuania, Poland, Ukraine), Iran and Australia were included in the analysis with participants interviewed at treatment entry, three months, and then at six months. Treatment retention at six months averaged 70 percent, and all sites demonstrated significant and marked reductions in reported opioid use. Reduction in HIV-related risk behaviors ($p<0.006$) were reported, and psychological and social well-being improved over the course of the study. (Lawrinson, Ali et al. 2008) In China, two different studies of Methadone Maintenance Treatment showed major declines in the proportion of clients injecting drugs and in the frequency of injection. There were also beneficial results in terms of reduction of unsafe sex practices. (Pang, Hao et al. 2007; Qian, Hao et al. 2008).

11. *These interventions will be more effective if implemented in combination.* In Vietnam, the World Bank and UNAIDS supported an evaluation of the country's harm reduction strategy. At the ecological analysis level, in 12 of the 19 provinces with data, high levels of per capita needle-syringe distribution (i.e., more than 100 needle-syringes per IDU) corresponded with a stable or declining HIV prevalence trend among IDU. From a modeling analysis incorporated in the same report, the results suggest that in seven provinces, harm reduction programs averted between 2 percent to 56 percent of infections in IDU, depending on the level of program coverage (VAHC, UNAIDS et al. 2010). In Ukraine, modeling found that scaling up ART to 80 percent coverage and OST to 25 percent coverage was able to avert 8,300 infections versus no intervention. Comparing the dual ART-OST strategy to an OST-only strategy meant the addition of 105,000 QALYs at US$1,120/QALY gained. An OST-only strategy was the most cost-effective, reducing infections by 4,700 and adding 76,000 QALYs compared with no intervention, at US$530/QALY gained (Alistar, Owens et al. 2011).

12. Yet the political, social, and legal environments in which these epidemics too often occur serve as potent barriers to program initiation, implementation, quality, and scale (Beyrer, Malinowska-Sempruch et al. 2010). Improvements in the policy environments are key to reducing HIV transmission in this group (Jolley E, Rhodes T, et al. 2012), therefore, structural intervention shall be included in the overall comprehensive package.

A) *Targeted combination of HIV prevention and treatment programs for key populations at risk, in particular IDUs and their sexual partners.* The HIV epidemic is concentrated among PWID and their sexual partners in heterogeneous geographic patterns. Thus, there is a need to generate and/or incorporate knowledge of HIV transmission dynamics into prevention strategies appropriate to the profile and risk behaviors of PWID and local context. The

appropriate scale up of resources and HIV programs should be designed and resources allocated to invest on the geographical areas where the majority of new infections occur.

B) *Design, implement, and evaluate locally-adapted service delivery models that focus targeted interventions with very high population coverage, intensity, and quality.* Often, effective HIV prevention strategies are dominated by implementation challenges. Inefficient implementation coupled with limited coverage can undermine reaching health outcomes and return of investments. One of the key challenges of the HIV response is rendering service delivery efficient and effective. This pervasive health challenge in EECA is compounded by the complexities of sustaining and reaching with HIV and other health-related services marginalized populations, i.e. PWID and their sexual partners, which are often at the fringes of the society. Projects of limited scale can be successful, however, many countries, including Kyrgyzstan, are struggling with challenges of scaling up HIV prevention while preserving quality and a continuum of services from community to health services. Against this background, innovative service delivery models need to be designed to ensure efficient and effective delivery of the optimal mix of interventions, delineated above and based on local epidemic appraisal, to PWID and their sexual partners. To ensure sustainability, it will be crucial that service delivery models integrate effective linkages between community-based prevention interventions, to HIV testing and counseling, STI and drug treatments and ART in public health services to maximize resource utilization, and mainstream/integrate services where appropriate. These models shall integrate program management and implementation process that support scale up of programs.

13. There are also economies of scale as programs mature and cover more of the population which should facilitate their growth. The unit cost of needle-syringe distribution declined with increasing coverage. Vickerman et al. previously conducted an evaluation of NSPs in Odessa, Ukraine and determined that the early stage of their implementation was cost-effective at US$97 per infection averted. A study by Marseille et al. reported decreasing costs of risk reduction programs as the number of injecting drug users covered increased, with costs falling from US$100 to US$10 per client per year.

14. Evaluation of efficiency and effectiveness of service delivery and implementation modalities will inform operational adjustments to render services sustainable and flexible to the local epidemic dynamics and diversity of risk population needs.

CE of HIV interventions

Table 1: Cost-effectiveness of HIV interventions in concentrated epidemics

Citation	*Intervention*	*CE*	*Notes*
Vickerman, Kumaranayake et al. 2006; Odessa, Ukraine	NSP (Odessa, Ukraine)	US$ 97 per infection averted	
Alistar, Owens, et al. 2011.	OST (Ukraine)	4,700 new infections averted and 76,000 QALYs added compared to no intervention US$ 530/QALY gained	
	Combination of OST and ART for the coverage levels indicated	105,000 QALYs added at US$1,120/QALYs gained	Scaling up ART to 80% and OST to 25% coverage
"The Global HIV Epidemics among People who inject Drugs" The World Bank, 2012.	Scaling up combination prevention (NSP, MAT, HCT, and ART*) compared to status quo**	Ukraine: US$598 - US$5,105	Incremental cost-effectiveness ratios (ICER) of policies spanning 2012-15, expressed as US dollars per adult HIV infection averted
		Pakistan: US$520 – US$8,299	
		Thailand: US$404 - US$788	
		Kenya: US$1,459 - US$1,600	
Galarraga O, et al. " HIV Prevention cost-effectiveness: a systematic review". BMC Public Health. 2009.	PMTC	US$ 34 per DALY in Africa 310 per DALY in Asia	
	ART India	US$145-280 per DALY averted	With ART if enhanced with any of three prevention strategies considered: improved adherence to therapy; treatment for PMTCT+ (the + indicates that treatment would be available also for eligible husbands); and subsidies for ART for people living below the poverty line.
		Costs per life saved dropped to about US$ 10-30	If antiretroviral treatment could be delivered in a way that also scaled up prevention efforts (mainly through increased condom use)
	ARTs	Cost per life year saved compared with baseline scenario is US$ 146 for ADHERE, US$ 199 for MTCT+, US$ 286 for below poverty line (BPL).	Modeling of 3 ART policy options to predict course of the epidemic in the absence of expanded ART availability: improved adherence to therapy; treatment for PMTCT including husbands; and subsidies for ART for people living below the poverty line.

Table 2: Estimated HIV and HCV related epidemiological and economic outcomes with and without NSPs (2000-2010); all healthcare costs and QALYs have been discounted by 3% [6]

	Armenia		Belarus		Estonia		Georgia		Kazakhstan		Moldova		Tajikistan		Ukraine	
	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *
Summary of HIV-related outcomes																
Prevalence of HIV among IDUs (2010)	9.23%	11.7-12.3%	11.7%	15.9-18.5%	47.2%	47.8-48.4%	2.1%	2.3-2.5%	3.6%	4.8-5.1%	20.3%	25.5-29.0%	17.7%	25.8-31.8%	24.8%	27.8-31.7%
Cumulative incidence of HIV infections	776	1,098-1,158	4,831	7,168-8,657	1,147	1,260-1,322	1,042	1,161-1,240	4,546	6,751-7,266	8,477	10,267-11,527	9,206	11,484-13,277	107,142	116,755-128,865
Infections averted	322-382		2,337-3,826		113-175		119-198		2,205-2,720		1,790-3,049		2,278-4,071		9,613-21,723	
% infections averted	29.3-33.0%		32.6-44.2%		8.97-13.2%		10.2-16.0%		32.7-37.4%		17.4-26.5%		19.8-30.7%		8.23-16.9%	
QALYs gained (2000-2010)	223-251		1,310-1,642		41-53		41-56		2,364-2,518		559-1,026		909-1,283		3,903-7,949	
HIV-related health costs (2000-2010)	$4.69m	$4.89-4.92m	$18.29m	$19.28-19.46m	$48.08m	$48.09-48.09m	$2.87m	$2.93-2.96m	$11.18m	$13.49-13.78m	$5.27m	$5.38-5.49m	$2.21m	$2.29-2.34m	$146.2m	$149.2-152.2m
Health costs saved (2000-2010)	$202,303-228,478		$988,971-1,165,767		$7,688-9,150		$58,074-81,614		$2,304,057-2,595,243		$111,700-215,701		$83,200-132,484		$2,976,865-5,997,783	
Financial investment in NSPs (2000-2010)	$217,365		$3,472,715		$5,435,005		$1,191,034		$17,093,063		$2,147,014		$2,832,156		$12,890,214	
Cost per QALY gained (HIV, 2000-2010)	Return ~ investment (Extremely cost-effective)		$1,405-1,896 (Very cost-effective)		$102,375-132,374 (Not cost-effective)		$19,811-27,633 (Not cost-effective)		$5,758-6,256 (Very cost-effective)		$1,882-3,640 (Cost-effective)		$2,104-3,024 (Borderline CE)		$867-2,540 (Very cost-effective)	
Lifetime benefits (HIV) from 2000-2010 programs																
QALYs gained (HIV, lifetime)	7,022-8,254		40,346-64,566		1,343-2,096		877-1,465		33,323-112,742		26,873-45,251		13,088-23,269		197,910-446,142	

[6] All $ amounts are in the US currency.

	Armenia		Belarus		Estonia		Georgia		Kazakhstan		Moldova		Tajikistan		Ukraine	
	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *	With NSPs	Without NSPs *
Health costs saved (HIV, lifetime)	$13.57-16.03m		$7.91-12.53m		$1.21-1.86m		$1.51-2.57m		$3.82-5.04m		$4.08-6.86m		$1.55-2.99m		$29.68-67.99m	
Cost per QALY gained (HIV, lifetime)	Cost-saving		Cost-saving		$3,148-2,492 (Very cost-effective)		Cost-saving		$107-398 (Very cost-effective)		Cost-saving		Cost-saving – Very cost-effective ($98)		Cost-saving	
Return on investment	62-74 times		2.3-3.6 times		22-34% of investment		1.3-2.2 times		22-29% of investment		190-320% of investment		55-106% of investment		2.3-5.3 times	
Additional benefits associated with HCV																
Prevalence of HCV among IDUs (2010)	39.3%	40.7-41.1%	39.0%	42.3-43.9%	89.4%	90.3-90.8 %	56.6%	57.6-58.2%	63.9%	73.1-75.4%	63.0%	69.0-72.1%	34.8%	37.4-39.5%	48.9%	51.8-55.4%

Source: Wilson D. Et al. *Needle-syringe programs are cost-effective in Eastern Europe and Central Asia: data synthesis, modeling and economics for eight case study countries.* UNAIDS, the World Bank, UNSW. 2012

Annex 8: Technical note: Effective and Efficient Tuberculosis Program and Service Delivery Models

Kyrgyz Republic: Second Health and Social Protection Project

1. Kyrgyz Republic not only has high Tuberculosis (TB) with prevalence and incidence rates of 175 and 128 per 100,000 population, respectively in 2011, it also ranks seventh worldwide in terms of multidrug resistant-TB (MDR). Over one-fourth of new TB patients and over 50 percent of patients who needed retreatment have MRD-TB. TB mortality was estimated at 26/100,000 in 2011. The country has already made an attempt to introduce DOTS, WHO's recommended TB control strategy, but these efforts are not sustained.

Key challenges include:

- Re-introducing DOTS strategy with clear financing mechanism and pay for performance scheme;
- Introducing programs to address TB in prisons;
- High costs and consequent financial gap to treat MDR-TB. Only about 60 percent of the diagnosed MDR cases were enrolled in treatment in 2011. This leads to the spread of MDR-TB;
- Low diagnostic capacity, especially for MDR-TB only 22 percent of patients needing retreatment underwent a drug sensitivity test while over 50 percent have MDR-TB;
- Very high concentration of TB and MDR-TB in vulnerable and marginal groups (prisoners and ex-prisoners and returning immigrants), that often are lost in the middle of their treatment;
- Weak infection control measures for MDR-TB suspects and confirmed cases in hospitals and prisons;
- High but insufficient cure rate from DOTS suggests the need to strengthen the program, particularly at the primary health care level, which can track and follow-patients more readily;
- Insufficient financial resources;
- Insufficiently strong information system and use of the information to shape interventions.

Response to challenges:

2. To confront those challenges a two pronged approach is needed: One for general TB, and a focused one for groups with high risks of MDR-TB. In both cases interventions need to be cost-effective and its implementation and results strictly monitored to provide feedback to regularly adjust interventions.

3. Cost-effectiveness depends on the incidence and prevalence of a condition. Thus in Kyrgyzstan, the Cost-effectiveness of treating MDR-TB is likely to be closer to US$200 than US$800.

4. Given the concentration of TB and MDR-TB in prisons the Government may want to consider analyzing the costs-effectiveness of testing every person currently incarcerated as well as new entries into the penal system and penal system staff as well as using Isoniazid preventive

therapy in those settings. Having smoke free prisons could reduce both TB mortality and transmission. Geographical mapping to find the foci of TB and MDR TB will also be desirable to focus limited resources in those areas. Finally, setting in place a system to track high risk population, ex-convicts and their families, returning immigrants and their families, etc., and targeting quick diagnosis technique to those groups is also likely to pay off.

Cost effectiveness of interventions (Global Tuberculosis Report, WHO 2012)

Summary of the available evidence on cost effectiveness of interventions for TB care and control		
POPULATION	INTERVENTION	COST PER DALYAVERTED (US$)
Patients with smear-positive TB	First-line treatment under DOTS	5-50
Patients with smear-negative or extrapulmonart TB	First-line treatment under DOTS	60-200
Patients with MDR-TB	18-24 months of second-line treatment under WHO guidelines	200-800
People living with HIV, infected with TB	Isoniasid preventive therapy	15-300
People living with HIV, with TB disease	First-line drugs under DOTS plus ART	100-365
People in whom TB is suspected	Diagnosis of TB using *Xpert MTB/RIF* as an add on to smear	40-200

KYRGYZ REPUBLIC

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