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1. Country and Sector Background
1. Health Status of the Population: As occurred in most countries of the FSU, many health status indicators in the Kyrgyz Republic deteriorated in the early part of the 1990s and then began to improve again in 1994-95. Many health status indicators mirrored this trend of decline followed by improvement. This is the case with the crude death rate and with mortality from diseases related to the circulatory system (the leading cause of death) and specific types of heart and cerebrovascular diseases. Each worsened from 1990 to 1994/5, and then improved, although 1998 mortality rates were still well above 1990 levels. On a more positive note, mortality from all forms of cancer in the under-65 population declined after 1992 and was at its lowest level of the decade in 1998. However, death rates from liver disease and cirrhosis increased over the same period. Overall, mortality rates from non-communicable diseases remain high in the Kyrgyz Republic. Perhaps more worrying are trends in incidence and mortality from several categories of communicable diseases. The Kyrgyz Republic shows the highest levels of respiratory disease mortality of any FSU country (WHO/EURO 2000) and mortality from infectious and parasitic diseases was considerably higher in 1998 than in 1990. The incidence of some diseases has increased rapidly, notably syphilis and tuberculosis (TB). The latter may be explained, at least in part, by the identification of an increased number of TB cases associated with the implementation of the DOTS (Directly Observed Therapy, Short-Course) strategy and its expansion in 1998. A positive feature associated with this is the decline in TB mortality observed in 1998, even as the incidence of TB continued to rise, reflecting the effectiveness of the treatment strategy. Infant and child mortality rates have fluctuated somewhat during this period, but remain largely unchanged. Provisional
evidence from an analysis of data from the 1997 Demographic and Household Survey (DHS) in the Kyrgyz Republic shows that these rates differ considerably across households of different wealth. This analysis indicates that infant mortality was 1.8 times higher in the poorest 20% of households than in the wealthiest 20%, and child mortality was almost twice as high. Nutritional indicators also followed the same pattern with 2.4 times the stunting rate in the poorest quintile as compared to the wealthiest, as did indicators for underweight children. Female children tended to have slightly better health and nutritional status than male children in all wealth groups. The DHS also shows a very strong income gradient for adolescent fertility, with teenagers (age 15-19) in the poorest quintile being more than four times as likely to become pregnant as those in the wealthiest 20%. The Kyrgyz Republic has very few reported cases of HIV infection, but several factors suggest that there may be cause for concern. One is the rising incidence of syphilis, since this reflects an increased frequency of unsafe sex and because this and other sexually transmitted diseases (STDs) facilitate HIV transmission. Second, data from the Republican Narcology Center indicate that the number of "registered drug addicts" per capita has increased steadily during the 1990s. Injecting drug use is a major form of HIV transmission in many FSU countries. Finally, the evidence from DHS of high fertility among poorer teenagers suggests, again, that there is considerable scope for transmission of STDs, and that this may affect poorer persons disproportionately. While there should not be an over-reaction to these trends, they do create cause for vigilance, even though reported HIV incidence remains very low. Many of the causes of the high rates of non-communicable diseases and the rising rates of several communicable diseases are rooted in non-medical factors. Major risk factors for the high levels of non-communicable diseases are aspects of unhealthy lifestyle choices, such as excessive consumption of tobacco, alcohol, and high-fat foods. Similarly, social factors are associated with the rapid increase in some STDs. The disproportionate burden of infant and child mortality and under-nutrition among poorer households seems to be associated with economic factors. Attacking these causes is important, but so is progress on delivering specific, cost-effective clinical interventions. These can make important contributions to reductions in mortality and ill-health from a number of important conditions, such as TB, acute respiratory infections, and STDs. The epidemiological situation in the Kyrgyz Republic suggests that priority needs to be given to improving both the availability and quality of primary curative care (e.g. treatment of respiratory infections, STDs and TB). Preventive interventions designed for healthy lifestyles (e.g. to reduce the future burden of alcohol, tobacco, and diet related diseases) are also important, as are, cross sectoral "social" interventions such as getting information to young people about avoiding STDs. Analysis of the 1997 household survey data suggests that targeted interventions to improve infant and child health and nutrition in poorer households are also important priorities. The health system must respond to these priorities without expecting any significant increases in real resource levels, because rapid economic growth is not anticipated and the Government's fiscal reform package demands continued efforts to bring public expenditures in line with public revenues. Hence, any strategy to improve the quality and availability of health services in a financially sustainable manner will require cost reductions and efficiency gains. 2. Health Expenditure Patterns and Priorities The Kyrgyz Republic is unquestionably a regional
leader in the implementation of a coherent package of reforms in the organization of health care delivery and provider payments. However, patterns of Government health expenditure undermine the potential benefits of these reforms to the population. The main problems are in two areas: (i) a substantial proportion of public funds devoted to hospitals, especially specialized facilities; and (ii) extensive geographic inequity, with more than three times the level of per capita funding in Bishkek as compared to the oblasts as is illustrated in the following figure. Distribution of Per Capita Health Spending by Oblast, 1998
A recent re-calculation, using population data from the '99 census, shows a lesser disparity between Bishkek and the rest of the country but it still exists. Even after deducting the spending from the Republican Budget for specialized tertiary care, for education, administration and services outside the influence of MOH, 27% of the 1999 Republican Budget for Bishkek is proposed by the MOH to be redistributed over a period of 10 years. The main cause of the geographic inequity is expenditures from the Republican budget going to the specialized Republic facilities located, primarily, in Bishkek. Unless this is addressed by the Government, there is little chance that the Kyrgyz health system will be able to provide universal access to good quality primary care. Thus, it is absolutely essential that the reform process be matched by a progressive reallocation of resources from tertiary facilities to primary care and from Bishkek to the oblasts. Current spending patterns are also inconsistent with priority needs, such as improvements in the quality and availability of primary curative care, promotion of healthier lifestyles, and targeted measures to improve the health and nutritional status of children in poor households. These spending patterns also put the population at greater risk for incurring high levels of out-of-pocket expenditures, as this contributes to low levels of public finance for priority inputs such as essential drugs. Analyses of household surveys from 1994, 1996 and 1997, in addition to reports (Abel-Smith and Falkingham, "Financing health services in Kyrgyzstan: the extent of private payments" 1995; Dorabawila, "Health status and private health expenditures in the Kyrgyz Republic" 1999) suggest that the need to make payments for health care imposes a substantial financial burden on families unfortunate enough to experience illness or injury, and that these burdens have probably grown worse as the need to pay for health care services has grown. Among the reasons for this increasing burden on families is the pervasive lack of medical supplies provided through the budget as well as the fact that salaries of medical staff are very low and are usually not paid on time or even for long periods of time. As a result, there is an inherent incentive of medical staff to seek informal payments. In 1994, the total cost of an illness episode for one member of a family exceeded the monthly income of the entire household in 20% of households experiencing an illness. Almost 50% of inpatients reported severe difficulties in finding the money to pay for their stay. Many had to borrow money or sell assets, such as farm animals, in order to obtain the needed money. From 1996 to 1997, monthly per capita expenditures for chronic illness rose by about 40% in real terms, reaching about 590 soms in 1997. On average, these expenditures were about 125% of monthly per capita consumption expenditures. However, for chronic illnesses among the poorest 20% of the population, expenditures were more than 3 times per capita consumption levels. Hence, it is fair to conclude that arrangements for financing health care in the Kyrgyz Republic do not protect individuals and families from falling into poverty as a consequence of health care expenditures. In many cases,
people must make a difficult choice between their short-term physical well-being and their financial status, and many forego much needed care because of its expected cost. Overall, the impact of these expected and actual costs falls disproportionately on the poorest families that are least able to cope with them.

3. The Kyrgyz Health Insurance System: Main Issues

A. Health Insurance. In 1997, the MHIF was established as a judicially independent body. In 1999, the MHIF was moved into the Ministry of Health (MOH) as a department, but retained its status as a judicially independent body with a separate source of funds. In late 1999, the government adopted a new health insurance law that extended coverage to children. Officially, as of October 18, 1999, in compliance with the Law of the Kyrgyz Republic "On medical insurance of the citizens of the Kyrgyz Republic," the executive body of the mandatory health insurance system is the Mandatory Health Insurance Fund (MHIF) under the Ministry of Health. Insurance tax collection, to be channeled to the mandatory health insurance system, is executed by the Social Fund, which also collects other payroll taxes for social protection programs. Mandatory health insurance fee rates are annually approved under the Law "On State Social Insurance Rates." Before 2000, the source of funds for the mandatory health insurance system was the mandatory health insurance tax, paid by employers at 2% of the payroll. In addition, the Social Fund, at the expense of the Pension Fund and the Employment Fund, made contributions for pensioners and for officially registered unemployed to the MHIF. However, given gradual stage-by-stage introduction and coverage by MHIF, the Social Fund has been planning MHIF costs of the above mentioned categories of the population in the amount which does not exceed 50% of the actual requirements, thus leaving the MHIF with deficits. Currently, the sources of funding for the MHIF are: 1. Financial resources transferred from the Social Fund: MHIF tax, paid by employers at 2% rate of the payroll; MHIF tax paid by farmers, self-employed; MHIF tax paid by the Social Fund from the Pension Fund resources for pensioners; MHIF tax paid by the Social Fund from the Employment Fund resources for officially registered unemployed. 2. Resources of the Republican Budget transferred to the Ministry of Health. Given the general administrative reform, including the abolition of the Oblast Health Departments, as of January 2000, functions of budget financing of Oblast Health Care Facilities have been transferred to Oblast MHIF Departments. The central MHIF is working on regional finance plans, as well as, on a new arrangement of budget resources transfer, to be incorporated in the provider payments system.

B. Insured Population. Insured members of the population include: employees; pensioners; the unemployed; children under 16; day time students; citizens disabled since childhood and individuals with social allowances. In 1997, the number of the insured was 1.1 million; in 1998 1.45 million; in 1999 1.47 million, of which 59% were employees, 36% were pensioners, and 4% were unemployed citizens registered with the Employment Service. Since 2000, the number of the insured has increased to 3.4 million, due to extended coverage for children and those receiving social allowances. In total, about 70% of the population is currently covered by the MHIF system. In 2001, the issue of students’ contributions to the MHIF has to be addressed.

C. Information System of MHIF and MOH ("jointly used system"). Since the introduction of the MHIF, all data processing is done using a management information system. To identify citizens, data is integrated with an individualized population registration database of the Social Fund. At present, the initial data input is made at health care facilities, except in Osh, Naryn, and Talas
Oblasts, due to lack of computers in these oblasts. Oblast Departments of MHIF process data received from health care facilities on the basis of which health services are paid. Development of an information system which involves software improvement and the creation of a single health information system (integrated with the MOH system) is underway. D. Health Service Payments under the MHIF System. In compliance with the Basic Program of the MHIF, the insured citizens are entitled to in-patient and primary health care services at medical facilities. Upon admission, the insured citizens are provided with the required medicines from the essential Drug List. At the primary health care level the insured can also receive x-ray diagnostics, basic laboratory diagnosis, and drugs in cases when urgent health care/first aid is required. The rate of payment from 1998-2000 per treated in-patient case, depending on the severity of the case, has varied from 240 Som to 1900 Som, whereas per capita rate for primary care has remained 35 Som since 1998. MHIF continuously reviews the quality of the individual medical services provided under the MHIF system, monitors the health care facilities effectiveness and the quality of services. A mechanism to impose financial penalties for poor treatment of patients, useless and irrational MHIF resource utilization, has been developed. In 1998, the amount of collected fines was 60,000 Som or 0.17% of total funding. In 1999, the MHIF’s approach was further strengthened which resulted in total fines of 650,000 Som, or 0.7% of total funding. The review results demonstrate some improvement in the quality of services provided to the insured population, as well as, a more rational use of drugs.

E. Problems of the Mandatory Health Insurance Fund. A major difficulty of the MHIF is untimely and low (less than committed) transfers of the MHIF tax by the Social Fund which makes MHIF indebted to the health facilities. As a result, in 2000, MHIF had to limit the process of entering into contracts with medical providers and to reduce coverage of the population at the primary level. As of January 1, 2000, total arrears of the Social Fund to MHIF totaled 127.7 million Som, and during 2000, this debt continued to increase. Recently, a schedule for debt recovery has been developed by the MHIF, pending approval by the Social Fund.

F. Further development of the MHIF System. During the second half of 2000, the MHIF is testing a new program of drugs supply at the out-patient level, on a limited scale, to be executed through FPs/FMCs. Under this program, a patient has an opportunity to pay only a part of the selling cost, with MHIF compensating the remainder at the expense of the insurance tax. Given that the Oblast MHIF Departments also finance oblast health care facilities from the Budget, the MHIF plans to develop health finance and economic programs for each region and submit them to Local Administrations.

4. Government Strategy

The main framework for the current health policy was established in the context of the three phased Health Care Reform Program (named after a famous Kyrgyz leader Manas) which was adopted by the Government in 1996. The MANAS program was the successor of the earlier health policy for the country defined in the State program "Healthy Nation" (1994-2000). The broad health system goals defined in the MANAS Program (1996-2000) are focused on four goals: health gain, equity, efficiency and effective and high quality care. The program is concerned with (i) improving the health of the population and access to care; (ii) reducing disparities in health; (iii) guaranteeing the population’s access to existing health services; (iv) improving the effectiveness and quality of care provided by the health system; and (v) increasing the responsibility of citizens for their own health, while protecting patients’ rights. The Manas Program also established specific
objectives to be achieved in the first several years of implementation, particularly related to a focus on re-orienting the health system towards primary care, and away from its previously specialized, hospital care. This was to be supported by a reallocation of the Government’s health resources, accompanied by a reduction in the number of hospital beds and the closure of some hospitals. The goal was to improve the quality of care at all levels updating and standardizing clinical practices for examination and treatment, and protocols for referral to inpatient care. In addition, new management models were to be developed for hospitals as a basis for greater managerial autonomy in the future, supported by new management structures and information systems. The MOH has updated the MANAS document late last year, with assistance from WHO, in an analytical report entitled, "Health 21 - the health for all policy framework for Kyrgyzstan." While the MANAS program provides a coherent policy framework for personal health care services (both preventive and curative), the public policy framework for public health services (not delivered to individuals) is not as well developed and little change has been made in the content or organization of these services or in the Sanitary Epidemiological Services (SES) Department of the MOH.

2. Objectives
The project development objective is to improve performance and long term financial viability of the health system by adjusting the delivery system to available means and focusing on important health risks and diseases; improving access through better distribution of services and offering financial protection for the population against potentially impoverishing levels of out-of-pocket health spending; and improving the responsiveness of the health system to the expectations of the population. The Second Health Sector Reform Project (Health II) will build upon the work carried out under First Health Sector Reform Project (HSRP), which has already generated considerable development impact and whose implementation has been rated as highly satisfactory. The main objective of the HSRP was an integrated effort in the: (i) promotion of primary health care and modern treatment protocols for diseases; (ii) restructuring of the delivery systems; (iii) management of the pharmaceutical system; and (iv) introduction of an incentive-based medical provider payment system. The HSRP was designed and implemented in close cooperation with a USAID funded project and it has mainly contributed to the: (a) establishment of family group practices/family medicine centers (FGPs/FMCs) in Chui Oblast and Bishkek through rehabilitation works, purchase of equipment, as well as, training of family physicians and primary care nurses, particularly in reproductive health and diseases such as tuberculosis, acute respiratory infections and diarrheal diseases; (b) improved management of pharmaceuticals by strengthening the registration procedure and quality control of drugs; introducing an essential drugs program; and supporting adequate procurement and distribution of drugs; and (c) introduction of new provider payment systems: capitation-based system for primary care and case-based system for inpatient care. This was implemented by the Mandatory Health Insurance Fund (MHIF), which had completed contracts with the primary care centers, as well as, with a number of the hospitals. The quality of medical services has also improved through the: (i) strengthening of primary care (retraining and the introduction of new treatment procedures for selected diseases and conditions); (ii) establishment of professional and branch organizations (e.g. FGP/FMC Associations and Hospital Associations); and (iii) implementation of an
external evaluation system through the licensing and accreditation of health care provider organizations at all levels. Quality assurance has also been enhanced by establishing and using the health information system of the MHIF, which contains clinical, as well as, financial data. Annex 11 provides more details and a preliminary assessment of the results achieved by the HSRP and the impact of the project on the effectiveness and efficiency of service delivery. The goal of the Health II Project is to deepen reform efforts already underway. Specifically, it will continue its efforts in restructuring the health system, health finance, quality improvements in the sector, improvements in public health strategies for dealing with communicable and non-communicable diseases and promotion of healthy lifestyles. This will be accomplished by supporting the implementation of health reform measures piloted in a few oblasts during the HSRP to the rest of the country.

3. Rationale for Bank’s Involvement
The Bank is the major development lender engaged in the health sector in the Kyrgyz Republic. Bank staff have been involved in the health sector since 1994, which marked the beginning of the identification phase of the HSRP. Since that time, staff have provided policy advice and assistance to the Government in a variety of sectoral areas, including health finance, development of legislation for health insurance, provider payment systems, pharmaceuticals, and changing clinical protocols for diseases such as TB, STDs, etc. Bank support in the sector has demonstrated its value added in its ability to initiate policy reform on the national level, and to strengthen the main institutions of the system and provide for large scale structural investments. While there are a number of other donors providing assistance to the health sector in the country, only the Bank can act as a catalyst in providing assistance of the magnitude that will be required to impact on the Government’s comprehensive reform program for the sector. In its catalytic capacity, the Bank can further mobilize significant financial and intellectual resources that will be required to assist the Government in focusing on realizing the menu of sectoral reforms that will be necessary in the system. In addition, through the assistance of the Japan Policy and Human Resources Development Grant (PHRD), the MOH is able to focus on critical structural, organizational and sustainability issues, as well as to deepen the analytical underpinnings of the components proposed for the Health II project. The Bank has been closely cooperating with the other donors in the country by organizing coinciding missions, cooperating with contracted implementation institutions (USAID/Abt; UK/DFID; WHO and Swiss Cooperation) and exchanging documents (ADB) during the preparatory stages of the project. Excellent collaboration and synergy has also been achieved with other donors in the design of systems reform, as well as, the integration of vertical disease programs into the evolving project structure.

4. Description
The key components of this project and indicative costs are as follows:

I. Health Services Delivery Restructuring: The aim of this component is to improve the health of the population through improved management in the delivery of secondary and primary health care services. A modernized hospital system together with primary care will support the numerous changes that are already taking place within the primary care services in the country, and achieve greater effectiveness from available
resources. The component is divided into five sub-components: (i) supporting family group practices/family medicine centers (FGPs/FMCs), continuing the effort of re-focusing care on high quality, cost-effective primary service with emphasis on rural areas, and expanding it nationwide; (ii) creating central rayon and oblast merged hospitals, in order to modernize, streamline and rationalize secondary delivery systems in line with the country’s health needs and sector resources; (iii) restructuring Bishkek territory hospitals within the overall reform of health delivery systems; (iv) improving human resources policy and management, including supporting an extension of the MOH database; (v) supporting the MOH strategy for mental health services reform by promoting rationalization of Republican psychiatric institutions in Bishkek, re-profiling of services in Mental Health Dispensaries, and providing short-stay psychiatric in-patient facilities of 10 beds in each of the three pilot rayon hospitals, in order to reduce patient displacement from their communities. As part of this sub-component, an establishment and provision of support to a Mental Health Resource Center, will be parallel financed by the United Kingdom’s Department for International Development (DFID); and (vi) building capacity for sustainability of reforms through estate management, hospital management training and functional services planning. II. Health Financing: The aim of the Health Financing component is to: further develop a logical, efficient, equitable and sustainable health care financing system for the whole country, enabling universal access to an affordable specified package of services including a differentiated co-payment system in order to improve access to the poor. Moreover, it will further develop the already existing health information system that provides the Government, the purchaser, the providers and the clients with the financial, clinical, epidemiological and quality data needed to monitor and improve the performance of health care. The component is divided into three sub-components: (i) development of a health financing policy; (ii) strengthening of the purchasing function of the MOH/MHIF; and (iii) development of a health information systems. The development of an information system and its potential integration with other main project components was discussed during project preparation. The consensus is to create a common conceptual model for all health information system components aimed at a synchronized information system which builds on the independent small systems (e.g. the Department of Pharmaceuticals), and the current jointly used information system of the MHIF. The goal would be to establish a series of Local Area Networks (LANs), followed by a Wide Area Network (WAN) to enable shared resources and information flow. The first step in this challenge is to conduct a survey (audit) to identify data structures which can be shared (based upon the relevant European standards) and carry out an analysis of data communication costs. From a procurement view, such an approach would enable the development of synchronized procurement planning and shared technical specification criteria which would also result in a unified pricing of the tendered systems across the components. III. Quality Improvement: This component will aim to promote quality improvement of health services through the creation of appropriate structures that would enable sector-wide quality improvement capacity. Actions planned are grouped into three sub-components: (i) education of health professionals and (re)training interventions through reinforcement of the technical basis of educational institutions; facilitation of curricula revision focusing on evidence based medicine, primary care and practical clinical skills; development of health
management and systems research expertise; and retraining of staff to meet
the needs of newly established primary care functions; (ii) professional
development supported by professional (Family Group Practice) and branch
(Hospitals) associations through the strengthening of service evaluations
using licensing and accreditation and through the promotion of
evidence-based medicine. The latter activity will encompass increased
access to health care related information through an improved National
Medical Library, the introduction of modern tools for information
management, systematic review and grading of evidence (literature), as
well as, support for the development of evidence-based practice
guidelines, their implementation and evaluation; and (iii) improvement of
the management of pharmaceutical products in the country through the
strengthening of quality assurance systems (testing, inspection),
reinforcement of pharmaco-information and vigilance functions, and
promotion of rational drug use. This sub-component will be parallel
financed by DFID.

IV. Public Health: The goal of this component is to
strengthen, reform and refocus public health activities to effectively
tackle the main health burdens of the Kyrgyz population. This component
will create a restructured system of disease prevention and health
promotion, which will be aligned with the country’s recent epidemiological
changes and the continuously changing profile of the main health
problems. The project will support activities which have been proven
effective as public health measures in preventing illnesses and promoting
health at the national level. Component activities include: (i) the
establishment of a National Center for Health Promotion; (ii) the
development of a new and improved pattern of operation for health
promotion activities; and (iii) the reform of the present sanitary and
epidemiological services (SES) system.

V. Project Administration and
Evaluation: This component will support and ensure effective
administration of the overall project program, as well as, project
monitoring and evaluation in accordance with sound procurement and
financial practices. For these purposes, a Project Implementation Unit
(PIU), has been set up in January 2001, and will be responsible for the
coordination, management and monitoring of the Health II Project’s
implementation, as well as, the coordination of other donor-funded
activities in the health sector, including parallel financing from DFID.
The PIU will draw on the staff of the current Project Coordination Unit
(PCU) which has been implementing the HSRP. The PIU is headed by a
Director, with support from core staff, including two procurement
officers, a senior accountant, two junior accountants, a disbursement
officer, a secretary and a driver. During the course of the project, the
PIU staff will work closely with the staff of the Technical Coordination
Unit (TCU) to ensure effective project implementation. The TCU, headed by
a Director, has also been established and includes five component
coordinators (Director of TCU handling one of the components), one of
which is charged with all information technology related matters in the
project. Component financing includes staff, office equipment and
operating expenses of the PIU throughout the project implementation
period. The project will be monitored and evaluated in detail.
Arrangements have been made to strengthen the evaluation and policy
research capacity in the MOH and DFID has agreed to fund this part of the
reform strategy. A detailed monitoring and evaluation plan of the project
has been prepared which aims not only to process indicators but also to
monitor the outcome indicators and the impact of the project. The design
and the indicators are carefully related to the project objectives as
Agreement was reached with senior MOH staff concerning the evaluation strategy for the project. To the greatest extent possible, sector and project performance will be assessed by analyzing data generated by the information systems of the MOH. In order to understand the effects of the reforms on the population, however, it will also be necessary to undertake a household survey in 2001, as well as, several years later (e.g. 2003-4). It was also agreed that it is feasible and desirable to implement a baseline survey as soon as possible in mid-2001, as an added ‘module’ of the National Statistical Committee’s monthly Family Budget Survey. DFID has already committed funds to support the design, implementation and analysis of this survey.

1. Health Services Delivery
   Restructuring
2. Health Financing
3. Quality Improvement
4. Public Health
5. Project Administration and Evaluation

5. Financing
   Total (US$m)
Total Project Cost 19.5

6. Implementation
The project would be implemented over a four and a half year period in accordance with the Project Implementation Plan. The timetable of activities draws from the valuable information and experience gained in the planning and implementation of the HSRP. All implementation arrangements under Health II will be governed by the guidelines and procedures set out in the Project Operational Manual (POM). The completion and Bank’s approval of the POM was a condition of project negotiations and was met prior to negotiations. Any subsequent changes to the POM will need prior Bank review and approval. The overall responsibility for the implementation of Health II will reside with the MOH. It is critically important that the project receives strong policy, technical, operational and logistical support from the Ministry. To ensure this support within the MOH, a Deputy Minister of Reform Policy, Planning and Coordination will have the responsibility of overseeing the project’s overall implementation and will report on the project’s progress directly to the Minister of Health. Two divisions will report to the Deputy Minister for Reform Policy on project progress: one is a newly created Coordination and Evaluation Division and the other is the External Relations and International Projects Division, which will be strengthened under the project. In addition, the MOH will establish a Health Project Implementation Department, under the Deputy Minister of Health. This Department will oversee the Project Implementation Unit (PIU) and the Technical Coordination Unit (TCU), the operation of which will be partly supported by Credit funds. This new Department within the MOH will also contribute to strengthening long-term sustainability and the implementation capacity within the Ministry. The PIU has been established and is headed by a Director and includes a team of procurement specialists, accountants and disbursement officers. The PIU will share a secretary/translator with the TCU. The TCU has also been established and includes a Director, who will also serve as a component coordinator for one of the project components, and technical component coordinators for
each of the respective components of the project. In addition, the TCU includes an additional coordinator for all information technology matters. Whereas the PIU will have the overall responsibility for overseeing all project management activities, including procurement, disbursement and general administrative issues, the TCU will coordinate all technical aspects of the project’s implementation. This structure has worked well under HSRP and provides for a check and balance approach to project management since technically appropriate recommendations by the TCU may not always be appropriate as far as fiduciary and procurement requirements are concerned. Close coordination will be maintained with DFID which is providing substantial resources to the project as parallel financing. It is expected that several other donors and agencies will also play an important role in the successful implementation of the project. Regular donor consultations and meetings will be held, and donor representatives will be invited to participate on supervision missions. In addition, aide-memoires will be shared with the primary donor agencies.

7. Sustainability
The project is designed in a way that major structural changes required for specific components must be made or well advanced either before the project’s effectiveness or prior to the utilization of project funds, and conditionalities have been designed to ensure this. The economic and financial analysis evaluates the sustainability of the project by estimating the recurrent cost implications and ensuring that the sector’s budgetary flows will include adequate financing. In terms of risks, it should be noted that any serious disturbance in the financial markets (as experienced during the after effect of the Russian financial crisis two years ago) or in the security situation in the country would have serious implications on the project. If savings had to be achieved, activities related to quality improvement, training, education and health promotion, could be hampered, since these activities are often easier targets than activities related to the delivery of care.

8. Lessons learned from past operations in the country/sector
Lessons of experience need to be considered from several perspectives: (i) lessons learned from working in the Kyrgyz Republic; (ii) lessons from other health projects in the Europe and Central Asia (ECA) region; and (iii) lessons gained from the Bank’s work on the Kyrgyz Republic, including a poverty assessment and the social expenditure review. (i) Limited resources and excess capacity are general features of the health sector in all FSU countries, and the Kyrgyz Republic is no exception. The country has grappled with a number of structural issues which have plagued the health system, including over-capacity and over-employment, inefficient skills mix, inadequate targeting of services to those most in need, uncertainties in funding to providers, and inequitable distribution of health care funding. Traditionally, and particularly in terms of first generation donor supported health projects, the Kyrgyz Republic’s health sector has shared the same characteristics of other FSU countries, including: (a) the dispersion of responsibilities among various levels of Government; (b) lack of coordination among various entities involved in health care; (c) inexperience with Bank procedures; (d) weak implementation capacity; and (e) a resistance to credit-funded external technical assistance. As the Health II project will be the second Bank funded health operation in the country, it will, therefore, benefit from the experience and lessons of the first project which will close in June
2001. As a result of the successful implementation experience gained through the HSRP, and other donor financed projects, the Government and the MOH have improved internal coordination mechanisms for implementing health projects, gained hands-on, and valuable experience and acquired knowledge of Bank procedures, including procurement, disbursement and reporting. As a result, their implementation capacity has been strengthened considerably. Given the country’s tight fiscal situation and desire to maximize limited resources, the Kyrgyz Government still has a strong aversion towards borrowing for foreign technical assistance, preferring to seek foreign technical assistance from bilateral donors, through grants or other means. However, in order to ensure adequate project implementation, limited foreign technical assistance has been integrated in the proposed project. In terms of the technical implementation, the groundwork has been solidly laid through the HSRP and USAID support for the expansion of the provider payment system and FGP/FMCs. A system is now in place for the continued training and re-training of doctors and other health workers, and pharmaceutical management is also now firmly in place and will be strengthened through the second project with support from DFID. Furthermore, the health system, as planned, is in the process of being re-oriented towards primary health care with the restructuring and reconfiguration of facilities that began under the first health project. These efforts will also be expanded and strengthened in the context of Health II. (ii) Due consideration has been given to lessons of other health projects which have been implemented in the region including Bank supported projects in Estonia, Russia, Kazakhstan and Romania, as well as European Union projects in Central and Eastern Europe - TACIS and PHARE. Some of these lessons include: (a) the need to recognize that health sector reform is a lengthy and often a politicized process, therefore, flexibility should be built-in and expectations need to be realistic; (b) institutional aspects of reform are as important as the technical approaches used; (c) attention must be paid to the political economy through marketing reforms to lawmakers, the general public, as well as, the medical community; and (d) projects should be focused key essential elements and not overly complex. In addition to regional lessons, special efforts have been made to incorporate the lessons of other donors working in the sector who have developed some comparative advantage in specific areas including: USAID for health finance and incentive-based payment mechanisms for medical service providers; DFID’s work on facility and staff rationalization in the health sector; and WHO and UNICEF for the implementation of some clinical treatment guidelines in the region. (iii) The project will also incorporate lessons from the findings of the Bank’s work done during the last few years in assessing the depth of poverty in the country, as well as, the Bank’s social expenditure review which was carried out in 1999/2000. As a result of recommendations made from these findings, the Health II project will use a comprehensive approach, with a bias towards those who are impoverished and living in rural areas. It will also emphasize the need to better utilize limited resources by reallocating from the secondary and tertiary levels to the primary care level, thus reinforcing this increased on the poor and rural areas.

9. Program of Targeted Intervention (PTI) N

10. Environment Aspects (including any public consultation)

   Issues : There are no environmental issues in this project.
Some minor civil works will be done to rehabilitate existing buildings, however, no new premises will be sought. The MOH is preparing detailed plans which will need to be reviewed for eventual, unforeseen environmental consequences. During preparation, special attention was made on adequate waste management. Although general waste management of health facilities will not be supported by the project, the MOH is nevertheless working on plans for waste management, including training. The instructions on dealing with potential hazardous waste during civil works will be included in the Project Operational Manual.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

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