I. Introduction and Context

Country Context

The Kyrgyz Republic is a low-income and landlocked country with a population of around 5.4
million. With an estimated per capita GDP of US$880 in 2010 (Atlas methodology), it is one of the
poorest economies in the Europe and Central Asia (ECA) Region. It is mostly mountainous and
relies heavily on agriculture, including cotton, tobacco, wool, and meat. Gold, agricultural
products, and hydropower comprise most of the country's exports.

Since 1996, the Kyrgyz Republic has moved towards a liberal market economy to promote
sustained economic growth and fight poverty. Under an International Monetary Fund (IMF) led
austerity program, emphasizing fiscal restraint and economic liberalization, signs of economic
recovery began to emerge after 1995. The Government instituted a series of measures to improve
the efficiency of the public sector and to establish itself as a policymaker, rather than as an
implementer of policies, which were defined historically in Moscow. As a proportion of the GDP,
from 1995 to 1997 the budget deficit was halved, and the Government made important progress in
setting up the legal and regulatory foundation for a market economy. The country privatized small
enterprises and revamped its banking and financial systems. Economic growth increased from 7
percent in 1996 to 10 percent in 1997, only to falter during the 1998 Russian crisis. After the crisis,
the economy stabilized and real GDP grew by 5.4 and 5.3 percent in 2000 and 2001, respectively
with growth in the agriculture and mining sectors.
The Kyrgyz Republic faced a number of crises from 2005 to 2010, hindering economic growth and contributing to political instability. The country’s first elected president was forcibly removed from office in 2005 after nearly 15 years in power following a disputed re-election. The country was then impacted by the rise in food and energy prices in 2007-08, the global financial crisis in 2008, the disruption in regional energy cooperation, and the ensuing global economic recession in 2009. The authorities responded rapidly by relaxing fiscal and monetary policies and increasing external borrowing which resulted in modest growth in 2009. The Government’s intention to accelerate spending on infrastructure in 2010 to create the basis for sustained medium-term growth was shattered in April 2010 by political turmoil and civil disorder.

Civil unrest and ethnic violence in June 2010 threatened social cohesion and the country’s peace and stability. Anti-government riots in April 2010 saw the ousting of former President Bakiyev (2005-2010) in June of that year. In the aftermath, a provisional government drafted a new constitution that shifted the balance of executive power from a presidential system to a parliamentary one. The constitution was approved overwhelmingly in a nation-wide referendum in June 2010. Parliamentary elections were held in October 2010 and presidential powers were vested with the interim president until the presidential elections that took place in November 2011. In December 2010, the Parliament approved a coalition government headed by a Prime Minister from the Social Democrat Party. Before the events of 2010, the Kyrgyz economy was recovering from the global economic crisis and GDP was projected to rise by 4.6 percent during the year. However, the 2010 political turmoil had its toll on the economy: GDP growth contracted by 1.4 percent in 2010 and the fiscal deficit jumped to 9.1 percent of GDP.

The events in 2010 put pressure on the budget, widening the budget deficit. Though total revenues remained relatively constant as a share of GDP, public spending outweighed revenues as the Government distributed compensation to the families of victims and allocated money to the rehabilitation of destroyed infrastructure and buildings. These measures were accompanied by an increase in public sector wages, pensions, social allowances, and cash benefits for the poor, which had a countercyclical effect, but widened the deficit in the general government budget to 7 percent of GDP. Previously accumulated savings and external support were critical in sustaining such a high level of expenditures during the most difficult periods of 2010. In 2011, the Kyrgyz Republic’s economy grew by close to 6 percent, supported by robust domestic demand and strong exports and remittances. Headline inflation decelerated sharply, but core inflation remains elevated. Strong revenue collection, coupled with contained expenditures, led to a lower-than-programmed fiscal deficit in 2011. High growth in remittances—resulting from strong growth in the country’s main economic partners, Russia and Kazakhstan—and favorable prices for gold exports contributed to a narrowing of the current account deficit. Financial stability indicators have improved, but vulnerabilities remain. Looking ahead, an expected economic slowdown in the Russia and Kazakhstan is likely to weigh on growth, but the outlook is generally positive. Growth is projected at 5 percent and inflation at 8 percent in 2012. Over the medium term, growth is projected to increase to 5.5 percent in line with a gradual global recovery and helped by strong private-sector credit growth.

Sectoral and Institutional Context
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 also introduced in 2001 to regulate the rights and obligations of Kyrgyz citizens and the Government with regard to provision of health services and establish 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. The SGBP exempts disadvantaged social categories and disease categories from copayment that are revised annually. The SGBP represents between 60% and 70% 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 the single payer in the public health system.

Improving care quality and accelerating health gain became the priority 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, increase the effectiveness of PHC, improve access to specialized care, improve the quality of health services, strengthen public health, and improve 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 (including the World Bank under the ongoing Health and Social Protection Project IDA Grant No.H197-KG), and parallel financing from other development partners (DPs). The Health and Social Protection Project 1 was the first large-scale SWAp in former Soviet Union countries.

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 has reached a level of over 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. The health sector has been recognized by all Joint Financiers (JF) as far more advanced in public finance management reforms due to ongoing health financing reforms and fiduciary mitigation measures implemented in the context of the SWAp. Though the MOH capacity for implementation of the SWAp has been strengthened over the years through training of staff in procurement, financial management, disbursements, planning, and budgeting, implementation of Manas Taalimi has suffered delays in procurement processes and payments under contracts due to lack of coordination among MOH departments. Further capacity building of MOH technical staff is needed in the development of technical specifications.
On the other hand, although there is some progress, health outcomes did not show dramatic improvements. Under-five year child mortality rate has declined from 72 per 10,000 live birth in 1990 to 38 per 10,000 live birth in 2010. However, the rate is slower than needed to meet MDG target to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. 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. by those conditions that depend on the proper care and monitoring of women during pregnancy, childbirth and postpartum periods. Cardiovascular disease (CVD) claims the lives of young working age people, and thus, 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). Acute myocardial infarction (AMI) and hypertension (HTN) are the main contributing factors (more than 90%) for mortality from cardiovascular diseases. Over the past years, mortality from CVD increased in the age-group 30 to 39 years by 31.2 percent and in the age-group 40 to 49 years by 47.8 percent. Health system effectiveness to detect and manage CVD is well below the desired level.

The situation with multi drug resistant tuberculosis (MDRTB) is not favorable either. The proportion of newly-diagnosed cases of TB with MDRTB is the 7th highest in the world, tied at 14 percent with Kazakhstan and Uzbekistan. As is the case in other Central Asia republics, the structure of the health care delivery system is not adequate to address the growing burden of MDRTB. In fact, it contributes to its high rates. According to sentinel epidemiological surveillance data, the country is at a concentrated stage of Human Immunodeficiency Virus (HIV) infection spread and HIV prevalence rate among injection drug users (IDUs) was 13.6 percent in 2011. On the other hand, in recent years the number of women living with HIV and children born to HIV infected mothers has increased, which indicates the transition of HIV infection from a drug injectors’ environment to the general population. Also, there are examples of nosocomial infections due to inadequate injection safety procedures. In addition to those challenges, 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 during that period.

The past fifteen years of implementation of health reforms has provided a number of important lessons that have informed the design of the third health reform program. The Den Sooluk (2012-2016) objective is to establish conditions for the protection and improvement of population’s health as a whole and for each individual, irrespective of social status and gender differences. Using building blocks from previous reforms, the strategic approach of Den Sooluk (DS), approved by 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 Care (MCH), 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:

Poverty and inequality indicators deteriorated in the Kyrgyz Republic in 2010 relative to 2009. According to Bank estimates, the headcount incidence of absolute poverty was 33.7 percent in 2010, which is 1.9 percent higher than the rate in 2009. This means that over 1.8 million people were unable to meet basic food and nonfood needs. The extreme poverty rate was 5.3 percent in 2010, which represented an increase of 2.3 percent over 2009. This means 292,000 people were unable to meet their basic food needs in 2010. The gap between the observed consumption levels of poor households and the poverty line, as well as the degree of inequality in distribution below the poverty line, also increased in 2010 relative to 2009. Absolute poverty increased in all oblasts (regions) except Bishkek and Issyk-Kul in 2010. The growth of absolute poverty rates was the highest in Naryn, Talas, and Jalalabat oblasts, where poverty incidence grew by 9.4, 9.3, and 7.4 percent, respectively. In terms of extreme poverty, it increased sharply in conflict-affected urban areas of the Osh oblast and in rural areas of the Jalal-Abad oblast, reaching 17.5 and 9.0 percent, respectively. This led to a concentration of 45 percent of all extremely poor households in these areas.

The Kyrgyz Republic spends more than five percent of GDP on social protection, including 2.1 percent of GDP on social assistance. This compares relatively high compared with other countries with similar income level. More than half of households in the country benefit from at least one type of social transfers and about nine percent of the population receive targeted social assistance. Nevertheless, the absolute levels of funding of both social assistance and care remain low. The Government took a number of steps to improve efficiency and effectiveness of social protection. However, there have been both positive and negative trends in the reform process. On the positive side, a flagship program for needy families with children covering 19 percent of child population had been established. However, the real value of transfers targeted to the poorest has eroded while the share of poorly targeted categorical benefits has seen a rapid increase in recent years. The system of social care remains largely unreformed with the bulk of scarce funding being spent on maintenance of residential institutions rather than on provision of quality care to the target groups. The Government’s Medium-term Strategy for Social Protection Development 2012-2014 sets out a vision for further reforms aimed at improving the outcomes in both social assistance and care. The Bank has supported the Ministry of Social Development (MSD) in the past years to strengthen administration of social assistance through technical advice, provision of equipment, and development of information management software.

Social assistance in the Kyrgyz Republic consists of both categorical and means-tested benefits. The Monthly Benefit for Poor Families with Children (MBPF) is the last-resort social assistance program that is targeted to the poorest. It provides cash benefits to needy families with children to bring the household income to the Guaranteed Minimum Income (GMI) level, which is roughly one-tenth of the subsistence minimum set by the Government. While the MBPF is relatively well targeted, the coverage of the poor remains low: two-thirds of the poorest 20 percent of the population are not covered by the program. The impact of the MBPF on poverty has also been lagging due to low benefit levels. Two other main social assistance programs target certain categories in the population, are not means-tested, and provide much more generous benefits compared to the MBPF. The number of beneficiaries and the budgets of these programs have grown substantially in the past few years. The imbalance between the MBPF and the two categorical programs has been a cause of concern both domestically and among DPs.
Social care services are almost exclusively limited to residential institutions for children, people with disabilities, and the elderly, making the system costly and irresponsive to needs. There is also a poorly funded system of fragmented home-based social services for orphans, elderly, and people with disabilities; 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. Services for families and children at the community level are still lacking, apart from a few pilot projects supported by external resources. There are gaps in such services as rehabilitation assistance, linking medical, social and employment assistance, counseling, shelters, outreach and information assistance together.

Relationship to CAS

The proposed Health and Social Protection 2 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 covers the period of August 2011 to June 2013 and succeeds the CAS approved by the Board in May 2007. 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 before 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.”

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The proposed PDO is to: (i) support implementation of the “Den Sooluk” National Health Reform Program 2012-2016 following the principles of a Sector Wide Approach, focusing on improving control and prevention of cardiovascular diseases, mother and child health, tuberculosis and HIV infections, as priority areas; and (ii) enhance effectiveness of social assistance and services aimed to support the poor and the vulnerable.

Key Results (From PCN)

A Joint Assessment Framework (JAF) for SWAP 2 is being developed and will be agreed among all development partners and the Government. The results framework for the Project will draw from the JAF of the sector program, which refers to the entire pooled basket of funds rather than those of IDA exclusively. The following are possible PDO indicators:

a. Percentage of adults and children receiving prevention/treatment for the four health priority areas (CVD, MCH, TB, and HIV),
   i. Increased enrollment and adherence to primary and secondary prevention of chronic disease
   ii. Expansion of harm reduction programs and intra-hospital infection controls for prevention of HIV infections
   iii. Shift towards outpatient treatment from inpatient for TB patients
   iv. Reduce incidence of severe pre-eclampsia and eclampsia
b. The share of total MBPF transfers going to the poorest quintile(s),
c. Pilots of family support mechanisms and community based options for target groups (people with special needs, vulnerable children, homeless) to prevent and reverse institutionalization developed and implemented.

III. Preliminary Description

Concept Description

The proposed Health and Social Protection Project 2 would be implemented over a period of five years using a Specific Investment Loan instrument. Similar to its predecessor, it would adopt a Sector-wide Approach for the health sector while using a traditional Bank-investment arrangement for the social protection component. The Project consists of two 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’ Medium-term Social Protection Strategy to improve the efficiency and effectiveness of cash benefits and social care services in combating poverty.

Health Sector

Component 1 – Support for implementation of Den Sooluk program of reforms (US$13.5 million total IDA credit/grant financing). This component would support implementation of the Den Sooluk Program through a Sector-Wide Approach. 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. While this component will support the implementation of Den Sooluk, as the previous health project supported implementation of Manas Taalimi, the component is being designed to be flexible so that it can adapt to evolving sector and country priorities. Four sub-components are envisaged under this component as follows:

Sub-component 1: 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, (ii) mother and child health, (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 Millennium Development Goals (MDGs 4 and 5).

This sub-component 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. Population interventions will address primary determinants of health outcomes in terms of health behaviors, social, and environmental factors, for example smoking alcohol consumption, road safety etc. Key evidence-based individual medical services will be addressed along with the needed facility level quality improvement efforts to deliver them at scale to the population. It is intended that during the implementation of DS, MOH will ensure that population coverage of evidence-based core services will increase, and that the allocation of limited funding will be driven by the needs of core services This shift would most likely require investments in deteriorating infrastructure. 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.

Sub-component 2: Health System Strengthening. This sub-component would 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. The refined detailed implementation plans would be consistent with macro-economic, multi-sectoral and health policy, and with economic development and poverty-reduction objectives. Further, the implementation plans would include an assessment of political and other risks with their respective mitigation measures. Examples of key reform areas under DS where the preparation of implementation plans would be supported include: (i) hospitals’ autonomy; (ii) strengthening of PHC by shifting core services from inpatient to outpatient care, such as management of CD, treatment of TB; (iii) prescription practices and rational drug use; (iv) community-based mental health; (v) preventive services; and others. Special attention will be paid to enhance the communication capacity of MOH and to develop and implement an effective communication strategy to inform and ensure support from key stakeholders for health reforms. Technical assistance and training would also be provided to address comprehensively providers’ autonomy issues.

The MOH will continue its transition from implementation agency to steward of the reform. Definition of roles and relationships between MOH and MHIF and implementation of institutional reforms will aim at achieving a better stewardship role of the MoH and strengthen the purchasing capacity of MHIF. This division of tasks between MoH and MHIF is following WHO recommendations and presents best practice. The implementation of the DS will bring additional implementation challenges. To reinforce overall implementation and management, there is a need to further strengthen the capacity of MOH for planning, programming, coordination, procurement and financial management, and tracking of expenditures, as part of ongoing strengthening of country systems.

Sub-component 3: Support to the State Guaranteed Benefits Package (SGBP). This sub-component would complement government funds to help finance the SGBP. The funding gap in the SGBP is a major health system barrier undermining several programs and increasing the financing burden of the population. A working group of MOH and MHIF and independent researchers estimate the financing gap between 25 to 37 percent. In addition to benefits resulting from pooling funds with donors and the Government, reducing gap in basic package is directly contributing to improvements of quality of care.

Efforts to reduce the financial gap would be undertaken through: (i) strengthening of current mechanisms for the collection of resources in MHIF; (ii) identifying mechanisms for increasing financing options, (iii) conducting a comprehensive review of the co-payment policy and reviewing and revising exempted categories, revising copayment structures, and (iv) reviewing the scope of benefits and services under SGBP. This would be done through the provision of technical assistance and training.

Sub-Component 4: Strengthening of the fiduciary capacity in the health sector. This sub-component would be closely coordinated with efforts under the multi-donor PFM Trust Fund administered by the Bank. Despite significant achievements in strengthening country systems, the capacity of the MOH’s Procurement Unit remains fragile due to the high turn-over of procurement staff. Interaction among departments in implementation, particularly in preparation of procurement
packages, tendering, contract administration and disbursement requires systematic coordination and continuity of monitoring. In addition, technical expertise for the preparation of technical specifications for medical equipment to be purchased sometimes does not respond to the complexity of packages resulting in delays in the preparation of specifications and subsequent evaluation of bids. Some of these issues are generic which 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 would continue to address weaknesses of the MoH capacity in improving fiduciary controls and implementation by providing technical assistance and training in key areas of fiduciary tasks. Furthermore, if the plan to grant full autonomy to 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 of autonomy of health care organizations, and (ii) strengthening the quality of management and improvement mechanisms. The strengthening of the fiduciary controls of the MoH will pave the way to pilot a providers’ autonomy approach. 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

Component 2 – Strengthening the Policy and Administrative Capacity of the Ministry of Social Development (MSD) (US$1.5 million total IDA credit/grant financing). The objective of the component would be to enhance effectiveness of social assistance and services aimed to support the poor and the vulnerable. This would be achieved through strengthened institutions, enhanced human resource capacity and better design of programs aimed to support the poor and the vulnerable. The primary target groups to benefit from this component will be the poor and vulnerable households, especially those with special needs/disabilities, as well as poor families with children in general. The component would have three sub-components:

Sub-component 1: Improving effectiveness of targeted social assistance. MSD operates a fairly well-targeted safety net program - the Monthly Benefits for Poor Families with Children (MBPF). MBPF is the only means-tested cash transfer program. While this program has been instrumental in supporting the poor during the crisis periods, it suffers from under-funding and low coverage of the poor (high exclusion errors). The sub-component would support strengthening the means-testing, oversight and control, and outreach efforts to improve coverage and to remove barriers for the poor to enter the program. It is expected that these measures would help boost political support to the program, and to help sustain and increase its budget outlays. The Government is considering a pilot program to test feasible means-testing methods, such as a proxy means-test (PMT) and a simplified means-test based on observable demographic characteristics, assets and sources of income. The pilot program would also compare efficiency of different benefit formulae, e.g. a flat benefit versus a gap benefit currently in use and versus a gap benefit that discounts some earned income to remove any adverse incentives for the able-bodied poor. While the analytical work on modeling the feasible options will be provided by the Bank through a trust fund, this sub-component would support MSD to implement the analytical recommendations. It would finance advisory services and training to support design, implementation and evaluation of the pilot program including improvements in targeting mechanism and business processes related to testing eligibility for the MBPF. It would also finance staff training in the pilot localities and develop and introduce an evaluation of the pilot program.
Sub-component 2: Strengthening the national policy towards people with special needs. 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 only response to special needs that the Government has been providing so far is certification of disability status and institutionalization of people with moderate and severe disabilities, including children. The Disability Certification Service (DCS) is totally outdated, of extremely weak capacity, poor governance and non-transparent practices mostly derived from the discriminatory legacy of the Soviet Union. It certifies people as disabled and thus eligible for social transfers, but it does not have any practice of creating meaningful rehabilitation or social integration plans, and there are yet no systems available that would support an individual in following such a plan. The system creates not only limitations, but also adverse incentives for people with special needs to seek monetary assistance rather than education or employment opportunities. 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 will 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 project would initiate the first steps by producing clear recommendations for changing the way the DCS operates and laying out a roadmap for development of individual rehabilitation plans and building supportive infrastructure and services nation-wide.

Sub-component 3: Development of family support and community-based social care services. Currently, the social care services are scattered, scarce, and delivered in isolation from each other. They target the elderly, disabled or children separately and leave uncovered such groups as women and families at risk, social orphans, homeless, internal migrants, etc. The existing approach misses potential synergies between programs in enhancing the clients’ welfare. On the other hand, even with the scarce financing duplications and leakages are inevitable, resulting in inefficient use of limited resources. Integrated approach to services provision, first through introduction of community-based integrated social patronage and day care centers for all families in need could be the first step towards significantly addressing both issues. This would also be in line with the recently adopted Master Plan towards de-institutionalization, which focuses on prevention of further placement of children in institutional care through creation of family support mechanisms and alternative community-based options. The same approach could be used for other vulnerable categories that face high risks of institutionalization or isolation from the society. The sub-component would finance development of standards and methodologies for introducing core services focused on social support, patronage and integration of families and people in need. It would also develop sustainable mechanisms to involve NGOs and other non-governmental agents in the provision of alternative services for the vulnerable.

IV. Safeguard Policies that might apply

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