1. Project Data:

<table>
<thead>
<tr>
<th>PROJ ID</th>
<th>P051372</th>
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<tr>
<td>Project Name</td>
<td>Health Sector Reform 2 Project</td>
</tr>
<tr>
<td>Project Costs</td>
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<td>Country</td>
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<tr>
<td>Loan/Credit</td>
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<td>HE</td>
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<td>Cofinancing</td>
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<td>Sector(s)</td>
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<td>Central government administration (17%)</td>
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<tr>
<td></td>
<td>Compulsory health finance (6%)</td>
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<td>Theme(s)</td>
<td>Health system performance (50% - P)</td>
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<td></td>
<td>Other communicable diseases (25% - S)</td>
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<td></td>
<td>Population and reproductive health (25% - S)</td>
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<td>Board Approval Date</td>
<td>05/08/2001</td>
</tr>
<tr>
<td>Closing Date</td>
<td>12/31/2005</td>
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2. Project Objectives and Components:

a. Objectives:

The Development Credit Agreement lists the project’s objectives as: "To continue to improve performance and long term financial viability of the health system in the Borrower’s territory". The Project Appraisal Document (PAD) expands on those objectives: "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."

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

If yes, did the Board approve the revised objectives/key associated outcome targets?

No

c. Components (or Key Conditions in the case of DPLs, as appropriate):

1. Health Services Delivery Restructuring (US$M 7.54 estimated; US$M 6.24 actual). For modernization and improvement in the management of primary and secondary health care services, and for support of ongoing reforms of primary care services. Six subcomponents included: (i) supporting family group practices/family medicine centers (FGPs/FMCs); (ii) modernizing, streamlining, and rationalizing secondary health delivery systems in line with the country’s health needs and sector resources; (iii) restructuring Bishkek territory hospitals; (iv) improving human
resources policy and management; (v) supporting the Ministry of Health (MOH) strategy for mental health services reform (activities to be parallel financed by DFID); (vi) building capacity for sustainability of reforms through estate management, hospital management training, and functional services planning.

2. Health Financing (US$M 2.67 estimated; US$M 1.91 actual). For further development of a countrywide health care financing system that is logical, efficient, equitable, and sustainable, enabling universal access to an affordable package of services including a differentiated co-payment system in order to improve access for the poor. Also, for further development of the existing health information system that provides the Government, the purchaser, providers, and clients with financial, clinical, epidemiological, and quality data necessary for monitoring and improving the performance of the health care system. Three subcomponents included: (i) development of a health financing policy; (ii) strengthening of the purchasing function of the MOH/MHIF; (iii) development of the health information system.

3. Quality Improvement (US$M 3.52 estimated; US$M 3.05 actual). For improvement of the quality of health services by creating sector-wide quality improvement capacity. Three sub-components included: (i) education of health professionals and (re) training interventions, facilitation of curricula revision, development of health management and systems research expertise, and retraining of staff; (ii) professional development supported by professional (FGP) and branch (Hospital) associations, to include licensing and accreditation and the promotion of evidence-based medicine; (iii) improvement of the management of pharmaceutical management (activities to be parallel financed by DFID).

4. Public Health (US$M 2.01 estimated; US$M 2.67 actual). For strengthening, reforming, and reorienting public health activities to tackle effectively the main health burdens of the Kyrgyz population by restructuring the system of disease prevention and health promotion. Three subcomponents were included: (i) establishment of a National Center for Health Promotion; (ii) development of a new and improved pattern of operation for health promotion activities; (iii) reform of the sanitary and epidemiological services (SES) system.

5. Project Administration and Evaluation (US$M 1.74 estimated; US$M 0.71 actual). For supporting and ensuring effective administration of the overall project program, as well as project monitoring and evaluation under the Project Implementation Unit (PIU).

The appraisal estimate also included US$M 1.35 in Physical Contingencies and US$M 0.67 in Price Contingencies, bringing the total estimated costs to US$M 19.50.

d. Comments on Project Cost, Financing, Borrower Contribution, and Dates:

At project appraisal, DFID had made a commitment of US$ 3.0 million to provide parallel financing for parts of Components 1, 3, and 5. After effectiveness, the Government was informed that DFID had approved a smaller sum or the project than originally planned, leaving the mental health sub-component unfunded. Also, during implementation a USAID grant of US$ 22.0 million became available to the Government, part of which (US$ 2.5 million) was used for technical assistance under Component 2. Some of the freed IDA funds were used to compensate for higher-than-anticipated expenses for trainees coming from outside the capital; the remainder of the funds was cancelled.

The ICR does not explain the 6-month delay in the project’s closing date or the difference between estimated and actual costs, other than those described above. A shortage of counterpart financing (which, in the second year, put the project at risk of achieving its development objectives) necessitated the changing of Country Financing Parameters, allowing the ultimate financing of the project entirely from IDA sources.

3. Relevance of Objectives & Design:

The project’s relevance was substantial. Country conditions included a high (though declining) poverty rate, high mortality rates from non-communicable diseases, increasing mortality from infectious and parasitic diseases, and a significant health gap between the rich and the poor. The quality of health care was poor, and the structure of the health care system was inappropriately skewed toward inpatient and specialized care and toward excessive funding to health facilities in the capital city. The Bank-financed First Health Sector Reform Project (HSRP I, 1996-2001) had successfully supported the Government health reform program, with particular achievements in the areas of family medicine, health care finance reform, and drug supply. The Government very strongly supported further development of Bank-financed efforts to continue these reforms. The project contained a highly relevant focus on reducing inequities in geographic and economic access to health care. Given the country’s epidemiological profile, the project’s efforts in health system restructuring and in public health appropriately prioritized improvements in the availability and quality of primary curative care. Given the identified burden of heart and cerebrovascular diseases, liver disease, and other non-communicable diseases, the project might have prioritized public health efforts specifically targeted toward these areas; instead, focus was placed on less prevalent (but rapidly growing)
A single-payer system was put in place, with the number of purchasing pools reduced from 62 to 2. A basic choice of providers under the guaranteed benefits package (with a small co-payment for referral care) were issued through print and broadcast media.

Outputs: A capitation-based family medicine model was widely introduced that gave patients a greater autonomy in managing their budgets. An outpatient drug benefit was introduced as the centerpiece of hospital financing. A case-based payment system was introduced in the hospital sector, with hospital administrations given significantly greater autonomy in managing their budgets. Legally autonomous primary health care (PHC) centers were established, performing a gate-keeping function at the PHC level. A National Center for Health Promotion (NCHP) was established, with over 1,300 people trained. 78,000 informational and educational materials on health promotion were issued through print and broadcast media.

Outcomes: The goal of reallocating scarce resources away from the Soviet-era focus on unnecessary and wasteful inpatient and specialized care, and toward the delivery of more cost-effective primary care on an outpatient basis, was substantially realized. The share of country and local government spending on health care devoted to PHC rose from 10.2% in 2001 to 25.1% in 2005, and the share devoted to public health rose from 5.2% in 2001 to 7.1% in 2005. Fixed costs were reduced in hospitals from 21.3% of total hospital budgets in 2000 to 12.4% in 2005, allowing expenditures for meals and drugs in hospitals to increase from 18% in 2000 to 20% in 2004. Hospital utility expenditures decreased by 10% from 1999 to 2004. Average length of hospital stay decreased by 12% from 2000 to 2005, with hospitalization rates for several important chronic diseases declining significantly from 2000 to 2004 (hypertension from 21.5% to 13.9%; peptic ulcer from 45.4% to 37.3%; bronchial asthma from 54.6% to 22%). Between 1999 and 2004 hospital admissions per staff increased by 50% and per bed by 25%. The share of unnecessary referrals from PHC to hospitals decreased from 2.5% to 0.6%. These outcomes clearly represent a more effective and efficient use of scarce resources. The direct impact of the public health reforms (establishment of the NCHP and health promotion activity) was not measured, with the exception of one study showing that the NCHP’s training activities had a positive impact on the way medical personnel approached their professions. It is therefore unclear how much NCHP studies and activities contributed to prioritizing focus on important health risks and diseases.

2. Improving access through better distribution of services and offering financial protection for the population against potentially impoverishing levels of out-of-pocket health spending: Substantial.

Outputs: A single-payer system was put in place, with the number of purchasing pools reduced from 62 to 2. A basic guaranteed health benefits package was created for the entire employed population. Hospital administrations were given greater autonomy in managing their budgets. An outpatient drug benefit was introduced as the centerpiece of pharmaceuticals financing. A capitation-based family medicine model was widely introduced that gave patients a choice of providers under the guaranteed benefits package (with a small co-payment for referral care).

Undergraduate, postgraduate, and continuous medical education curricula were reformed to support the new model...
Outcomes: The ICR states that 95 or 98% of the population has access to primary health services through the guaranteed benefit package; it is unclear what share of the population had access to these specific benefits at the start of the project. However, the percentage of the population actually enrolled with an accredited family group practice varied from 30.6% in Batken to 100% in Osh City. There was an increase in access to secondary referral services by the poor, from 1.6% in 2000 to 3.5% in 2004. The cost of prescribed drugs that were covered by the Mandatory Health Insurance Fund increased from 54.2% to 61.5% (the denominator is not clear here, but it is probably total drug costs). There was a 30% decrease in the price of the more frequently used drugs for hypertension. Health spending as a percentage of total household and per capita consumption, while a stated project indicator, was not tracked. The percentage of total payments to primary care from pooled resources driven by consumer choice of provider increased in all tracked regions, more than doubling in many cases. The percentage of total health spending that was out-of-pocket increased from 51.7% in 2001 to 59% in 2006, but the ICR speculates that this might be the expected result of an improving economic situation, or of declining funding for public funding for the health system in general (from 13.5% of public spending in 1996 to 7.2% in 2004) that resulted in the necessity for higher private expenditures for health. The extent to which geographic inequities were resolved is mixed, with total per capita public health funding rising in all regions, and per capita distribution of Republic funds allocated to MOH for tertiary institutions rising in some areas, including Bishkek city, Issyk-Kul, and Batken, but falling in other oblasts.

3. Improving the responsiveness of the health system to the expectations of the population: Modest.

Outcomes: The ICR states that data were not collected to measure the impact of these outputs on the quality of health care. However, several of the main project indicators directly address quality of care. Between 2000 and 2003, the share of health expenditures allocated to direct patient care increased from 16.4% to 36.6%. The percentage of inpatients rating the cleanliness of hospitals to be "good" or "very good" rose in some oblasts and fell in others. The percentage of cases of hypertension for which clinical practice was considered to be appropriate and in accord with MOH clinical guidelines, for example, rose from 48.6% in 2001 to 68.4% in 2005; cases of peptic ulcer disease, from 27.7% in 2001 to 57.0% in 2005. (The analogous achievement for asthma was unchanged from 2001 to 2005, and for acute upper respiratory tract infections in children the percentage declined significantly.) The percentage of drug tests at two monitored quality control laboratories that were rejected or faulty fell from 5.24% in 2001 to 1.94% in 2004 in Bishkek, and from 10.55% in 2001 to 2.03% in 2004 in Osh City. The ICR cites a 60% decline in infant mortality from respiratory infections and a modest decline in mortality rates from tuberculosis, but it is unclear that these outcomes can be attributed to project activities. The ICR also cites qualitative research indicating that the user-centeredness of the PHC model is supported by users and health professionals.

5. Efficiency (not applicable to DPLs):

Efficiency is rated as substantial. The ICR claims that insufficient data were collected to quantify cost savings for most of the project’s components. Project activities in the area of quality improvement resulted in annual cost savings due to restructuring of inpatient services of about 4%. It is reasonable to speculate that, in the medium and long terms, current increased costs for public health services will pay off through overall health improvements and consequent declining costs for patient care, and that current restructuring costs are already resulting in significant savings through reallocation of resources to the more cost-effective outpatient/primary care sector. Indeed, the ICR cites already-realized benefits accruing to health facilities re-investing savings from restructuring. It is unclear, given the wealth of data collected by the project, why a more substantial efficiency analysis was not conducted using the methodology outlined in Annex 4 of the PAD.

### Economic Rate of Return (ERR)/Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

<table>
<thead>
<tr>
<th>Rate Available?</th>
<th>Point Value</th>
<th>Coverage/Scope*</th>
</tr>
</thead>
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<tr>
<td>Appraisal</td>
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<td>%</td>
</tr>
<tr>
<td>ICR estimate</td>
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<td>%</td>
</tr>
</tbody>
</table>

* Refers to percent of total project cost for which ERR/FRR was calculated.
6. Outcome:
Based on substantial relevance, substantial efficacy, and substantial efficiency, the overall project outcome is rated as satisfactory. The project achieved restructuring reforms, and quantified those achievements, to a degree that has been nearly impossible in other ECA countries.

a. Outcome Rating: Satisfactory

7. Rationale for Risk to Development Outcome Rating:
The institutional development achieved by the project is significant, particularly the establishment of family practice medicine, the activity of the NCHP, the purchasing role of the Mandatory Health Insurance Fund, and the transformation of the MOH into a modern institution. It would require significant political and policy reversals to alter the trajectory of these achievements. Government is clearly committed to continuing the momentum established by the project, as evidenced by the move to the Manas Taalimi Health Reform Program (follow-on to the Manas Health Reform Program) and support for the SWAp following project closure. The fact that the project's underlying principles and activities have remained consistent through a change of government and change of health ministers indicates the resilience of the project's perceived legitimacy. The decline in public funding for the health sector is indicative, however, of the need to continue to educate leaders outside the sector on the macroeconomic and multisectoral context of health reform.

a. Risk to Development Outcome Rating: Moderate

8. Assessment of Bank Performance:
Quality at-Entry (QAE) was Satisfactory. A July 2001 QAE assessment rated the project Highly Satisfactory. The project was fully aligned with existing Government priorities; it relied in its design on extensive analytical work; it involved the participation of key Kyrgyz specialists; and it took into account lessons from the health sector reform experience in other ECA countries and in the Bank's first Health Sector Reform Project (HSRP I). Consultation and coordination with other donors was particularly strong. The preparation process could have taken into account more explicitly the political economy risk of the project's probable collateral impact on other sectors outside of health.

Quality of Supervision was Satisfactory. A September 2003 Quality of Supervision Assessment rated the project Satisfactory. The supervision team brought consistent and appropriate oversight and expertise to the project, with particularly important support from management in supporting the project, when necessary, through high-level interventions involving operations and instruments in other sectors. At one point in mid-2002, progress toward achievement of development objectives was downgraded to "Unsatisfactory" due to policy changes instituted by a new Minister of Health. The new minister initially resisted new financial mechanisms, such as the establishment of a single-payer system and formal copayments, but intensified dialogue with the Bank team, supported by a cohesive donor environment, put health sector reform back on track. The Bank team used regular supervision and monitoring to proactively dialogue with the Ministry of Finance on budget problems in the health sector and implications for project implementation. The project had three Task Team Leaders, but the supervision of project activities, relationships with other donors, and policy dialogue activity appear to have continued relatively seamlessly. Project supervision documents did not report adequately on the development of the project's M&E framework and, until mid-term, did not provide data on key project indicators. At mid-term, however, these shortcomings in M&E were addressed, and the revised M&E framework was formally adopted by the Government.

Overall Bank Performance was Satisfactory. The Bank's role as coordinator of a complex donor environment and successful efforts to maintain health system reform as a political priority were key to the achievement of the project's development objectives.

a. Ensuring Quality at-Entry: Satisfactory
b. Quality of Supervision: Satisfactory
c. Overall Bank Performance: Satisfactory

9. Assessment of Borrower Performance:
Government Performance was Satisfactory. The Government was willing to embark on politically sensitive reforms, and significant constituencies maintained commitment to the reforms under dynamic political
circumstances. Together with the Bank supervision team, the MOH played a crucial role in successfully coordinating a wide range of donor activity in the sector. A shortage of Government funding and non-transparent cash management were consistent themes throughout implementation, and changes in top political leadership created significant challenges at several points during implementation. The Government did not support the restructuring of Bishkek territory hospitals, and therefore the proportion of health resources going to Bishkek and Osh cities was not reallocated as planned, and the new financial incentives prevailing in the rest of the country were not developed in Bishkek.

**Implementing Agency Performance was Highly Satisfactory**. The MOH has successfully made the transition from purchaser and service provider to steward and policy maker, and it was one of the project’s significant strengths that the project was implemented by the MOH itself (with the Project Implementation Unit an integral part of the Ministry). This arrangement enhanced ownership of the project at all levels. The Technical Coordination Unit (TCU) and PCU continued timely and effective project implementation despite externally-imposed challenges.

**Overall Borrower Performance was Satisfactory**. The MOH’s institutional transformation is a unique development in the region, demonstrating the Borrower’s commitment to the emergence of a modern system of public health and health care.

<table>
<thead>
<tr>
<th>Government Performance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Implementing Agency Performance</td>
<td>Highly Satisfactory</td>
</tr>
<tr>
<td>Overall Borrower Performance</td>
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</table>

**10. M&E Design, Implementation, & Utilization:**

**M&E Design was substantial**. Given the comprehensive degree to which the project supported the Government’s overall health reform strategy, it was appropriate that the project was designed to support a comprehensive sector monitoring framework rather than a more narrow project monitoring framework. At the time of project approval, baseline data and targets were not fully developed, but they were put in place during the first year of implementation. Project indicators were well aligned with the project’s development objectives and components/subcomponents; an effective plan was put in place to collect the data and monitor project performance; and institutional development was planned to build the capacity to analyze results to inform ongoing project refinement and policy making.

**M&E Implementation was substantial**. There were some shortcomings in the tracking of M&E activities during the first half of the project's implementation. The ICR notes that the indicators were refined and streamlined at mid-term, and that until this point, the Bank’s supervision documents did not report on key project indicators. The September 2003 QSA identified M&E design and use as a weakness of the project. However, those shortcomings were rectified effectively after the mid-term review. It appears that data were being collected across a variety of sources, as documented in the ICR’s table of 40 key performance indicators; data were collected for the vast majority of these indicators at both the country and oblast level. The ICR does not document whether the planned DFID-financed 2001 baseline survey was conducted (as a module of the National Statistical Committee’s monthly Family Budget Survey).

**M&E Utilization was modest**. The ICR is unclear on the extent to which the lack of indicator data in the early Bank supervision documents affected the quality of M&E utilization. The ICR states that the DFID-financed Health Policy Analysis Project (HPAP) has strengthened the evaluation and policy research capacity of the MOH, and that most of its policy recommendations have been approved and implemented.

- M&E Quality Rating: Substantial

**11. Other Issues (Safeguards, Fiduciary, Unintended Positive and Negative Impacts):**

None.

<table>
<thead>
<tr>
<th>Ratings:</th>
<th>ICR</th>
<th>IEG Review</th>
<th>Reason for Disagreement / Comments</th>
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<tbody>
<tr>
<td>Outcome:</td>
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<td>Satisfactory</td>
<td>The Kyrgyz Republic health sector reforms, supported by HRSP II are a unique success in the ECA region.</td>
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<tr>
<td>Risk to Development Outcome:</td>
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<td>Moderate</td>
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**12.1. Risk to Development Outcome:**

None.
**Bank Performance**: Satisfactory  
**Borrower Performance**: Satisfactory  
**Quality of ICR**: Satisfactory

**NOTES:**
- When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
- The "Reason for Disagreement/Comments” column could cross-reference other sections of the ICR Review, as appropriate.

**13. Lessons:**
Effective and consistent M&E, where analytic results can be generated and disseminated rapidly and efficiently, are essential for building support for project activities in a politically contentious environment. Positive data and analysis on intermediate project outcomes can generate political support for further project activities.

- Reform of health care systems is inherently complex, and its impacts reverberate across sectors. In particular, budget and finance institutions must be convinced that the health sector should retain savings accrued through structural realignment.
- Successful institutional development is required for effective health sector reform in a transition country. In order for effective health finance mechanisms to take hold, health ministries must relinquish their payer/provider functions and instead become stewards and policy makers.

**14. Assessment Recommended?** ⬜ Yes ☐ No

**Why?** As input into a broader sector study, and as an example of a project that achieved significant results in a sector and region where achievement of development objectives has been problematic.

**15. Comments on Quality of ICR:**
The logical chain from the project’s development objectives to its components, inputs, outputs, and outcomes is (in general) clearly established. The ICR’s findings are based on a significant amount of accumulated evidence, most of which is of high quality and whose source is carefully cited. Some of the data provided on project indicators are unclear, with undefined denominators or time frames. It is unclear why the significant amount of collected data was not used to conduct a more extensive analysis of project efficiency. The ICR did not report actual cofinancing.

**a. Quality of ICR Rating**: Satisfactory