Document of
The World Bank

Report No.: 44513

PROJECT PERFORMANCE ASSESSMENT REPORT

KYRGYZ REPUBLIC

HEALTH SECTOR REFORM PROJECT
(CREDIT 2860-KG)

SECOND HEALTH SECTOR REFORM PROJECT
(CREDIT 3506-KG)

June 30, 2008

Sector Evaluation Division
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = Som

Health Sector Reform Project

As of March 29, 1996	As of April 15, 2002
Som 1 = US$0.088	Som 1 = US$
US$1 = Som 11.35	US$1 = Som

Second Health Sector Reform Project

As of January 25, 2001	As of July 28, 2006
Som 1 = US$0.02	Som 1 = US$0.025
US$1 = Som 48	US$1 = Som 39.8

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of (Hospital) Stay
ARI	Acute Respiratory Infection
ARV	Antiretroviral
CA	Chamber of Accounts
CAS	Country Assistance Strategy
CDD	Chronic Diarrheal Disease
CMCC	Country Multisectoral Coordination Committee
DALY	Disability-Adjusted Life Years
DfID	Department for International Development
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short-course
ECA	Europe and Central Asia
EDL	Essential Drugs List
EDP	Essential Drugs Program
FAP	Feldsher-Akusherka Point
FGP	Family Group Practice
FGPA	Family Group Practice Association
FMC	Family Medicine Center
HA	Hospital Association
Health I	Health Sector Reform Project
Health II	Second Health Sector Reform Project
HIV	Human Immunodeficiency Virus
HPAP	Health Policy Analysis Project
HPIA	Highly Pathogenic Avian Influenza
HSFA	Health Sector Fiduciary Assessment
HSPP	Health and Social Protection Project
ICR	Implementation Completion Report
IDA	International Development Association
IEG	Independent Evaluation Group
IEGWB	Independent Evaluation Group (World Bank)
IMCC	Inter-Ministerial Coordination Committee
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JCSS	Joint Country Support Strategy

KfW	Kreditanstalt für Wiederaufbau
LAC	Licensing-Accreditation Commission
M&E	Monitoring and Evaluation
MDR TB	Multidrug-Resistant Tuberculosis
MHIF	Mandatory Health Insurance Fund
MOF	Ministry of Finance
MOH	Ministry of Health
MTBF	Medium-Term Budget Framework
NAC	National AIDS Center
NDRO	National Drug Registration Organization
NCHP	National Center for Health Promotion
NGO	Non-Governmental Organization
OOP	Out-of-Pocket Payment
ORT	Oral Rehydration Therapy
PAL	Practical Approach to Lung Health
PCU	Project Coordination Unit
PHC	Primary Health Care
PHRD	Japan Policy and Human Resources Development Fund
PIU	Project Implementation Unit
PPAR	Project Performance Assessment Report
PPC	Project Policy Council
RICC	Reform Implementation Coordinating Committee
QAE	Quality At Entry
RMIC	Republican Medical Information Center
SDC	Swiss Agency for Development and Cooperation
SES	Sanitary-Epidemiological Services
SGBP	State Guaranteed Benefits Package
Sida	Swedish International Development Cooperation Agency
SWAp	Sector-Wide Approach
TB	Tuberculosis
TCU	Technical Coordination Unit
TTC	Technical Coordination Committee
U5MR	Under Five Mortality Rate
USAID	United States Agency for International Development
WHO	World Health Organization

Fiscal Year

Government: January 1 – December 31

Director-General, Evaluation	:	Mr. Vinod Thomas
Director, Independent Evaluation Group (World Bank)	:	Ms. Cheryl Gray
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IEGWB Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGWB annually assesses about 25 percent of the Bank's lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGWB staff examine project files and other documents, interview operational staff, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGWB peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. IEGWB incorporates the comments as relevant. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEGWB Rating System

IEGWB's use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEGWB evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEGWB website: http://worldbank.org/ieg).

Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High Significant, Moderate, Negligible to Low, Not Evaluable.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

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This report was prepared by Judyth Twigg, IEG Consultant, who assessed the project in August 2007. Marie-Jeanne Ndiaye provided word processing and administrative support.

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PRINCIPAL RATINGS

Health Sector Reform Project

	*ICR**	*ICR Review**	*PPAR*
Outcome	Satisfactory	Highly Satisfactory	Satisfactory
Institutional Development Impact**	Substantial	Substantial	———
Risk to Development Outcome	———	———	Moderate
Sustainability***	Highly Likely	Highly Likely	———
Bank Performance	Highly Satisfactory	Highly Satisfactory	Highly Satisfactory
Borrower Performance	Highly Satisfactory	Highly Satisfactory	Highly Satisfactory

Second Health Sector Reform Project

	*ICR**	*ICR Review**	*PPAR*
Outcome	Satisfactory	Satisfactory	Satisfactory
Risk to Development Outcome	Moderate	Moderate	Negligible to Low
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.
**As of July 1, 2006, Institutional Development Impact is assessed as part of the Outcome rating.
***As of July 1, 2006, Sustainability has been replaced by Risk to Development Outcome. As the scales are different, the ratings are not directly comparable.

KEY STAFF RESPONSIBLE:

Health Sector Reform Project

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Carol A. Hoppy	Robert Liebenthal	Yukon Huang
Completion	Jan Bultman	Armin H. Fidler	Dennis N. de Tray

Second Health Sector Reform Project

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Jan Bultman	Annette Dixon	Kiyoshi Kodera
Completion	Sarbani Chakraborty	Armin H. Fidler	Annette Dixon

PREFACE

This is an Enhanced Project Performance Assessment Report (PPAR) for the Kyrgyz Republic's Health Sector Reform Project (Health I) (US$20.6 million) and Second Health Sector Reform Project (Health II) (US$19.5 million). Health I was the first World Bank-supported health project in the Kyrgyz Republic (other previously active donors included the United States Agency for International Development (USAID), with a project on health finance reform, and the World Health Organization (WHO), which provided significant assistance to the Kyrgyz government on health strategy development). Health I was approved on May 14, 1996, became effective on June 1, 1996, and closed three months later than scheduled, on September 1, 2002. The credit was 93 percent disbursed and the remaining US$1.37 million was cancelled. Health II, an explicit follow-on to its predecessor, was approved on May 8, 2001, became effective on September 1, 2001, and closed six months later than scheduled, on June 30, 2006. The Health II credit was 75 percent disbursed and the remaining US$4.9 million was cancelled.

This PPAR was prepared by Judyth Twigg, IEG consultant. The findings are based on a review of project files; the projects' Mid-Term Reviews and Implementation Completion Reports; published and unpublished literature on health status and health reform in the Kyrgyz Republic; health statistics released by the Government; and interviews with the project task managers, other World Bank managers, staff, and consultants who worked on the project, officials from the Ministry of Health, health providers, and other donors. During a ten-day mission to the Kyrgyz Republic in July 2007, government, health sector, and World Bank staff and donors were interviewed in Bishkek and Issyk-Kul and Chui Oblasts. A list of those consulted is in Annex B. IEG would like to express appreciation to those interviewed and to the World Bank Resident Mission staff, particularly Asel Sargaldakova, Asel Almanbetova, and Gulya Kolakova, who helped make appointments, arranged for transportation, and assembled key documents.

The findings from this PPAR will serve as input for a forthcoming IEG evaluation of the World Bank's support for the health, nutrition, and population sector. A timeline of events with respect to Kyrgyz health reform is in Annex G.

Following standard IEG procedures, copies of the draft PPAR were sent to government officials and agencies for their review and comments. However, no formal response was received.

SUMMARY

The objectives of the **Health Sector Reform Project (Health I, 1996-2002)** were to reform and improve the Kyrgyz Republic's health care system, improve the health status of the population, improve the clinical effectiveness of the service delivery system, improve the economic efficiency of the delivery system, extend access to appropriate care, and assure long-term financial viability of the system. The project emphasized strengthening primary health care, rehabilitating facilities, reforming provider payment mechanisms, and improving pharmaceuticals management.

The project closed three months later than scheduled in September 2002. It was explicitly designed to implement a Government-generated health care reform strategy, with the Bank taking the lead in an active and cohesive donor environment. Despite challenges stemming from the 1998 financial crisis, the project established a nationwide health insurance mechanism that pools resources within a single purchaser, alongside a provider reimbursement mechanism in key oblasts based on capitation at the out-patient level and case-based payments in hospitals. It introduced clinical protocols and trained personnel for a cluster of primary health services, resulting in demonstrable improvements in health outcomes. Inflation and currency fluctuations undermined the planned implementation of improvements in pharmaceutical management.

The outcome of Health I is rated **Satisfactory**, based on substantial efficacy and efficiency in meeting the project's development objectives, and substantial relevance of the project's objectives and design.

Bank performance is rated **Highly Satisfactory**, with strategically important and timely interventions coupled with appropriate willingness to wield the leverage of Bank support to make sure that implementation remained on track. Borrower performance is rated **Highly Satisfactory**, with the Government, led by a small number of "champions," crafting the health system reform strategy and coordinating implementation and donor activities throughout. The risk to development outcome is rated **Moderate**. Many of the project's activities contained built-in strategies to ensure sustainability, including important efforts at institutional development, and the Government's commitment to a follow-on project suggested that the reform process would both persist and deepen. Declining public spending on health, however, called into question the availability of resources to sustain the project's benefits.

The objective of the **Second Health Sector Reform Project (Health II, 2001-2006)** was to continue to improve performance and long-term viability of the health system by adjusting the delivery system to available means, focusing on important health risks and diseases, improving access through better distribution of services, improving access by 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. Health II focused on the restructuring of health services delivery, most centrally the continued support of family group practices and family medical centers and the rationalization of the hospital sector;

the further reform of health care financing; quality improvements achieved through training and a new system of licensing and accreditation of health facilities; and improving attention to public health.

Health II closed six months later than scheduled in June of 2006. The project extended and completed the health financing reforms begun under Health I, with a Mandatory Health Insurance Fund established as the single purchasing agency for health care services, and output-oriented provider payment schemes implemented across the country. A network of family physicians and family group practices was put in place, combining treatment for adults, pregnant women, and children in one location and in many cases with one family practice physician. As a result of the family medicine and financing reforms, in-patient capacity was significantly reduced, hospitals used their remaining capacity more efficiently, and the quantity and quality of health services at the out-patient level was increased. A State Guaranteed Benefits Package explicitly defined entitlements to health coverage, with a system of co-payments introduced (with exemptions for poor and disadvantaged groups) to permit transparency and predictability in an environment that had been corrupted by demands for illegal out-of-pocket payments. Despite these reforms, private payments remained a significant percentage of total health spending, and therefore improvements in access to health care were mixed. Political opposition swelled to significant dimensions during project implementation. Bank intervention and policy dialogue at key moments sustained momentum for reform, but opponents still managed to block key activities, most importantly the restructuring of tertiary hospital facilities in the two major cities.

The outcome of Health II is rated **Satisfactory**, based on substantial efficacy and efficiency in meeting the project's development objectives, and substantial relevance of the project's objectives and design.

Bank performance is rated **Satisfactory**, with the supervision team bringing consistent and appropriate oversight and expertise to the project, and particularly important support from management when necessary, through high-level interventions involving operations and instruments in other sectors. Sector-wide monitoring and evaluation was strong, particularly with the emergence of a WHO/DfID-funded Health Policy Analysis team conducting extensive data analysis. Borrower performance is rated **Satisfactory**, with the Ministry of Health continuing to play a crucial role in successfully coordinating a wide range of donor activity in the sector, while making the transition from purchaser and service provider to steward and policy maker. The risk to development outcome is rated **Negligible to Low**. The project achieved significant institutional development in the establishment of family practice medicine, the purchasing role of the MHIF, and the institutional transformation of the MOH. The decline in public funding for the health sector during the project period was evidence of the need to continue to educate leaders outside the sector on the macroeconomic and multisectoral context of health reform; in the subsequent two years, however, the Government has met all commitments to increase public financing of the health sector. The exodus of project-trained family physicians to Russia and other destinations jeopardizes the project's achievements.

Lessons from Health I and Health II

- **The political economy of health sector reform inevitably creates both winners and losers. Early and comprehensive anticipation of stakeholder interests, institutional analysis to facilitate understanding of those interests, and the generation of a coherent plan to build support for reform and to persuade and/or co-opt potential opponents is essential.** Even the most informed risk assessment and management, however, may not always guarantee success; heavily entrenched interests (in this case, those defending the existing structure of tertiary facilities in Bishkek and Osh) may prove extremely difficult to overcome.

- **The Bank should not, however, underestimate the potential leverage wielded by its financing and expertise.** The opposition to rationalization of health facilities, for example, was fierce everywhere, but the failure in Bishkek and Osh should not overshadow the Bank's success in the rest of the Kyrgyz Republic outside those two cities. The Bank's contributions in terms of reform sequencing, technical inputs, and political positioning were instrumental in effecting meaningful hospital rationalization across the country. On other issue areas as well, at several key points during Health I and II, Bank interventions broke political logjams and moved the reform process forward. Explicit and early political risk analysis is essential to the effective development of this good judgment.

- **One effective mechanism for countering political resistance to reform is strong and consistent M&E, where analytic results can be generated and disseminated rapidly and effectively, building support for project activities in a politically contentious environment.** Positive data and analysis on intermediate project outcomes can generate broad support for further project activities. In this case, the Issyk-Kul region has become a recognized demonstration site whose successes have prompted other regions to accelerate their participation in the reforms.

- **Another important tool for overcoming political resistance to reform is the engagement with civil society organizations** that give health professionals and users of the health care system a voice in the decision process and a clear sense of affiliation and identity. In other words, supporting potential "winners," and creating pathways to transform "losers" into "winners," can be as important as overcoming or sidestepping recalcitrant "losers." The creation in the Kyrgyz case of the Family Group Practice Association and related organizations demonstrates the potential long-term impact of institutional development investments that may at first seem unsustainable or risky.

- **The complexity of health care systems dictates that reforms be carefully sequenced.** In this case, capacity building in the primary care sector through the family medicine and other primary care reforms was a precondition for hospital rationalization; revenue gains from financing and service delivery reforms made possible the later benefits package and co-payment schemes; and the changes in revenue collection and pooling were necessary prerequisites to the introduction of new purchasing arrangements.

- **Tradeoffs between efficiency, equity/access, and quality of care will not be addressed in the absence of explicit and consistent attention to the balance between them and interventions to correct imbalances.** Gains in efficiency do not automatically translate into improvements in equity; in fact, the opposite may be true if there is not sufficient tracking and analysis of inequities. The clear emphasis in Health I and II was on achievements in efficiency; although there were equity and access objectives in both projects, and some evidence to indicate that progress was made in this area, the bulk of the project's major activities and indicators focused on efficiency-related goals. It may be argued, however, that this point illustrates the earlier lesson on sequencing: given limited public financing for health care, enhanced efficiency may be seen as an essential prerequisite for meaningful efforts toward (and adequate resources for) increased equity and access.

- **Targeted interventions to improve clinical quality can demonstrably impact health outcomes.** In the Kyrgyz case, the Bank's efforts to improve the quality and use of clinical practice guidelines for high blood pressure have measurably reduced the incidence of heart disease. While the direct impact of immunization or nutrition interventions, which impact health risks more immediately, may be more easily measured, it is reasonable and should be expected that health systems interventions can similarly affect health outcomes.

- **The presence of a clear sector strategy, authored and wholly owned by the MOH, can play a key role in achieving donor harmonization.** In the Kyrgyz case, the MOH's role as a leader and coordinator of donor activity, in partnership with the Bank, has been central. Longevity and consistency of donor support, along with clear "division of labor" among donors, is also essential in an environment where donor presence is strong. It prevents needless duplication of activity, assigns donors to activities best suited to their comparative advantages, and ensures that there is appropriate donor activity across all issue areas.

- **Improved efficiency may result in the reallocation of public funds to other sectors, reducing the incentives for continued reform.** In the Kyrgyz case, during the second project the government responded to the efficiency gains in the health sector in a classic Soviet manner: if input requirements decline, then public funds should decline. This "stealing" of conserved resources from the health sector diminished enthusiasm for the reforms and reduced the incentive to persist and deepen downsizing efforts. The input-based budgeting process "punished" the health sector for rightsizing health infrastructure and personnel. The introduction of formal co-payments had a similar crowd-out effect on public spending. It is therefore necessary to negotiate proactively with ministries of finance and legislatures on the disposition of proceeds from efficiency gains.

- **Some elements of health sector reform can have "spillover" effects, leading to improvements in governance and accountability practices in other sectors.** For example, modernization in the way that drugs are procured has benefits for all public procurement. Donors agree that success in this area has met or surpassed the expectations of all involved; health reforms have begun to improve the overall governance of the country, and the education sector and chamber of accounts have

begun (albeit in a preliminary manner) to discuss transitioning to the use of internationally-accepted procedures for procurement, financial management, and audit.

In late 2004, the Bank began preparation for a five-year **Health and Social Protection Project** (HSPP) that became effective in March 2006. Its objective is to improve health status by improving access, financial protection, efficiency, equity, and fiduciary performance in the health sector; to ensure sufficient and reliable financing for the health sector; and to strengthen the targeting of social benefits by developing effective administration and information management systems to improve access to social services in general. From the beginning, the HSPP was expected to be implemented through a Sector-Wide Approach (SWAp) centered on a new Government-derived health strategy. Strong donor coordination and policy consistency had already existed in the health sector for several years; under the SWAp, pooled donor financing (without ring-fencing) accounts for 20-25 percent of the total health budget. Even donors who are not formally part of the financing arrangement (most importantly, USAID) are participating in the implementation of the joint strategy. The Ministry of Health is responsible for implementation, with strong joint ownership by the MOH and the Ministry of Finance. The latter has pledged to continue to increase public spending on health incrementally each year with a target of 13.4 percent of all government spending by 2010; so far, this commitment has been met. In a relatively stable fiscal environment, the MOH has been able to focus on the tasks of capacity-building at the national and local levels, particularly in the area of fiduciary management.

Vinod Thomas
Director-General
Evaluation

1. INTRODUCTION

COUNTRY AND HEALTH BACKGROUND

1.1 The Kyrgyz Republic emerged from the ashes of the Soviet Union in 1991 as a poor country with declining health indicators and a decaying health system. GDP per capita in 1990 was about US$1,200; between 1992 and 1995, GDP contracted by half, social expenditure declined significantly, and poverty increased from an already-high level to well over fifty percent. Poverty remains high, with significant differentials in income and access to infrastructure (electricity, water, and roads) between rural and urban areas as well as within and between regions, although there is substantial overall improvement since the early 1990s (World Bank, 2007b; Jakab and Manjieva, 2007).

1.2 Politically, the Kyrgyz Republic has been identified by the international community as one of the few success stories in the region, with nicknames ranging from "island of democracy" to "the Switzerland of Central Asia." Independent media, NGOs, political parties, and civil society organizations have been permitted to develop and thrive. Within this context, however, beginning in the mid-1990s, the President's intermittent attempts to curb these freedoms brought the country close to crisis on several occasions. Unrest came to a head in the early spring of 2005, when Parliamentary elections that were widely perceived as unfair caused mass protests that resulted in the President resigning his post in April and fleeing the country. The new Government has not yet met expectations of accelerated economic, social, and political development, leading to an overall environment of uncertainty that is not conducive to long-term structural reforms (Jakab and Manjieva, 2007).

1.3 The Kyrgyz Republic was the first Central Asian country to join the World Trade Organization in December 1998. Economic growth has been led by an extractive gold-mining industry (40 percent of exports in 2004), with exports also concentrated in cotton, electricity and tobacco. Over half of the population remains employed in the agricultural sector. In May 2001, the Government approved a Comprehensive Development Framework for 2001-2010, setting out a strategy for socioeconomic development and poverty alleviation. A National Poverty Reduction Strategy for 2003-2005 was the first phase in the implementation of that framework.

1.4 The government is a unitary state with a strong central government.[1] It is divided into eight regions (oblasts) and 43 districts (rayons), with the president appointing regional governors. Until 2006, health and education were local government responsibilities, but revenue raising instruments in most localities were never adequate to cover expenses. Beginning in 2006, financing of health services was transferred to the central Republican budget, with the exception of the capital city of Bishkek (Meimanaliev et al, 2005; Jakab and Manjieva, 2007).

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[1] A unitary state is a state whose components are governed constitutionally as one single unit, as opposed to a federal state, where the components making up the federation have a constitutional existence and functions that cannot be unilaterally changed by the central government.

1.5 The Soviet system of health care inherited by the Kyrgyz Republic was riddled with inefficiencies and weaknesses. The system was fragmented into four levels of government administration – republican (national), oblast, city, and rayon – that served overlapping populations (Meimanaliev et al, 2005). It performed well in terms of guaranteeing access to health care and promoting a relatively equitable distribution of health resources, but it was structurally inefficient, with heavy reliance on in-patient and tertiary hospital-based care. The emphasis on costly in-patient care was evidenced in the large numbers of hospital beds and physicians and high use rates compared to Western industrialized countries (25 percent of the population was admitted to the hospital in 1987) (World Bank, 1996). As a result, there was virtually no diagnostic capacity and equipment at lower, less costly levels of the system. Instead of treating patients at these lower levels, patients were typically referred upwards for treatment at the tertiary level.

1.6 This system of health provision was highly specialized and fragmented. The population was serviced by specialized research institutes at the tertiary level, specialized hospitals and clinics at the oblast level, and specialized dispensaries at the rayon level. For example, a woman was not able to go to just one primary health facility in order to receive health care for her children and herself. For gynecological problems, she had to visit a women's consultation clinic; for contraception, a marriage and family clinic; for venereological problems, a dermatovenereal clinic; and for HIV testing, an AIDS clinic (World Bank, 1996).

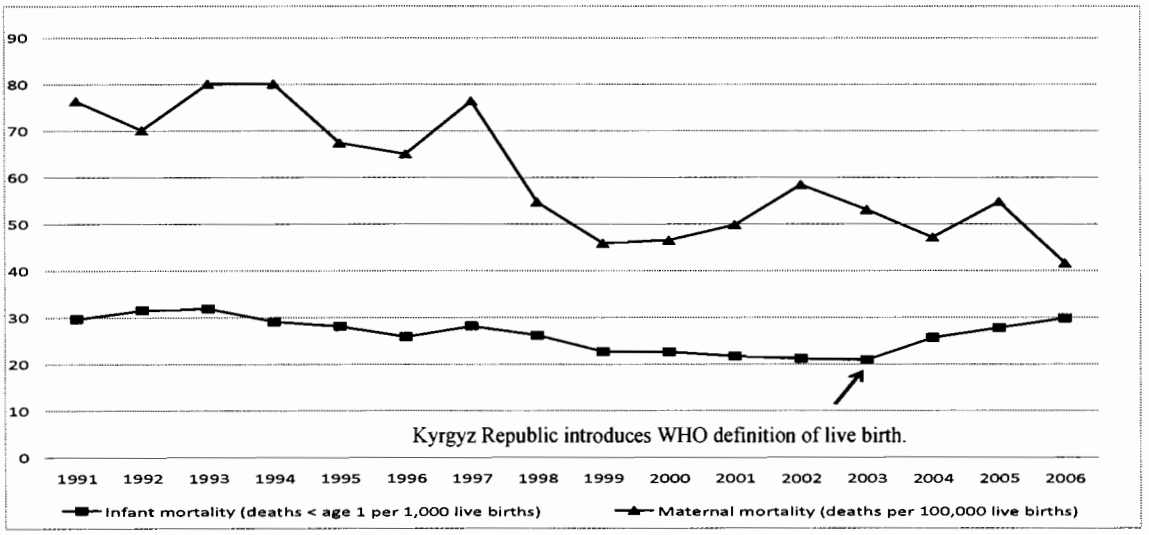
1.7 The system of health financing perpetuated these inefficiencies. Budgeting norms based on physical capacity (numbers of beds or numbers of doctors) encouraged overstaffing, provision of more beds than dictated by medical need, and increased utilization of in-patient services. Combined with a rigidly enforced 18-line budgeting system used to pay medical care providers (hospitals and polyclinics), there were no incentives for primary care providers to use cost-effective ambulatory treatment protocols or to perform a "gate-keeping" function of screening inappropriate referrals. The reliance on capacity-based budgeting promoted inefficiency and waste. The impact of these inefficiencies was exacerbated by the low levels of health spending: US$156 per capita in 1990 (using purchasing power parities), declining to US$37 in 1993 (World Bank, 1996). In the context of these declining levels of budget spending on health care, a rise in informal health payments during the post-Soviet period led to a rapid transition from universal, free-of-charge access to health services to a de facto fee-for-service system.

1.8 Health indicators are poor, with the country facing the double challenge of controlling high rates of communicable and non-communicable diseases simultaneously. In addition to high rates of childhood mortality due to infectious diseases, the Kyrgyz Republic also has very high rates of adult mortality largely due to cardiovascular disease, cancer, and injuries (Jakab and Manjieva, 2007). In the early 1990s, there were significant increases in the incidence of highly infectious diseases such as TB and STIs.

1.9 Infant mortality in 2006 was 29.8 deaths per 1,000 live births, and maternal mortality was 41.6 deaths per 100,000 live births. Although there has been a significant improvement in these indicators since the mid-1990s (Figure 1.1), most assessments doubt that Kyrgystan will achieve its Millennium Development Goals by the target date of 2015. Differences across regions are significant, with the high/low ratio between

regions for the infant mortality rate (IMR) in 2004 at 2.1 (Figure 1.2). An increase in the reported IMR and under-five mortality rate (U5MR) in 2004 resulted from the country's mid-2003 adoption of the World Health Organization (WHO) definition of live birth.[2] The current reality is probably still not captured accurately by official statistics due to mandatory investigations with potentially severe disciplinary consequences after maternal and child deaths; in some cases, hospitals have refused to admit pregnant women if the risk of death in hospital is perceived to be high.

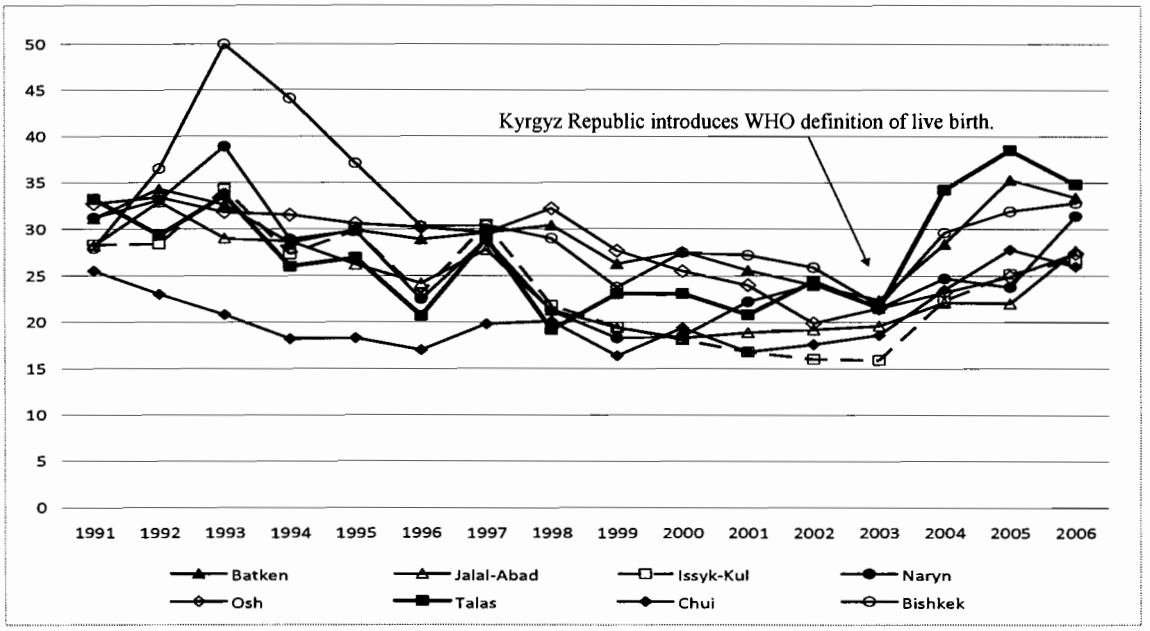
Figure 1-1: Infant and Maternal Mortality, 1991-2004



Source: World Bank (2005), pp. 27-28; Meimanaliev et al. (2005), pp. 6-7; WHO/DfID (2003), p. 1; Kyrgyz Republic Ministry of Health (2005); Kyrgyz MOH web site (www.med.kg)

[2] The WHO definition of a live birth (from which the infant mortality rate is calculated), adopted in 1950 and used in most developed and developing countries, is as follows: "The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached." The Soviet Union maintained an alternate and less rigorous definition of a live birth, classifying only breathing as a sign of life, and presuming infants who were born before the end of 28 weeks of gestation, or who weighed less than 1,000 grams at birth (there is considerable overlap between these two groups), to be non-viable. These were not counted as live births until they survived a full seven days (or 168 hours). If they survived for less than this time, they were considered to be miscarriages and not counted at all, resulting in lower reported infant mortality rates than would have been the case under WHO reporting guidelines (Aleshina and Redmond, 2003).

Figure 1-2: Infant Mortality by Region, 1989-2004



Source: WHO/DfID (2003), p. 2.; World Bank (2005b), p. 81; MOH web site (www.med.kg)

1.10 According to the 1997 Demographic and Health Survey (DHS), infant mortality was 1.8 times higher in the poorest quintile than in the wealthiest, child mortality was twice as high, and the stunting rate was 2.4 times higher. Self-reported ill health, however, has been significantly higher for richer than for poorer households according to household surveys taken since 2001, with 1.6 percent of adults in the poorest quintile in 2007 reporting an episode of acute ill health in the last 30 days compared to 4.6 percent among the richest quintile (this is a decrease from 2001, when 13.3 percent of the poorest quintile and 26.6 percent of the richest quintile reported similar episodes) (WHO/DfID, 2007b). In 2000, there were similar inequities in health services utilization: the utilization ratio of the poorest to the richest quintiles for primary health care services was 2:5, and for hospitalization it was 3:5. In 2001, per capita health expenditures were 2-5 times higher in Bishkek than in other, more rural oblasts in the country. This funding gap had increased by 2003 between Bishkek and the country's poorest regions (Batken, Naryn, and Talas; WHO/DfID, 2005).

1.11 In response to these challenges, the government initiated a series of measures aimed at improving the performance of the public sector. Prominent among these was the adoption in late 1996 of a ten-year program for health systems reform known as the Manas strategy, designed to run from 1996 through 2005. The key goals of the Manas plan were to redress imbalances in the health care delivery network and strengthen its orientation toward preventive and primary health care; to improve equity in resource allocation; and to address financial and non-financial constraints impacting the accessibility of health services.

Box 1-1: The Manas Health Reform Strategy

From 1994 through 1996, the Government worked together with WHO/EURO, the United Nations Development Program (UNDP), and TICA, the Turkish development agency, financed by a US$300,000 UNDP grant, to create a ten-year (1996-2005) health system reform program known as the MANAS program (named after a famous Kyrgyz leader, about whom the 1000-year-old national epic poem "Manas" was written). Adopted by the Government in 1996, the program defined four broad goals: health gain, equity, efficiency and effective and high quality health care. Its program elements were focused on (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 during the first several years of implementation, particularly related to a focus on reorienting the health system towards primary care and away from specialized hospital care. This shift 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 in-patient 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 World Bank's first and second Health Reform Projects were explicitly designed to implement key elements of the Manas Program. While the Manas Program provided a coherent policy framework for personal health care services (both preventive and curative), the public policy framework for public health services was not as well developed, and little change was envisioned for the content or organization of these services or in the Sanitary Epidemiological Services (SES) Department of the MOH (World Bank, 1996 and 2001).

WORLD BANK SUPPORT

1.12 The Kyrgyz Republic joined the World Bank in 1992. Since then, the Bank has financed projects ranging from land reform, which distributed the land of former collective farms to small, private farmers, to village investment and water management improvement. In the social sectors, the Bank completed a US$ 36 million Social Sector Adjustment Credit from 1998-2000 intended to establish a sustainable pension scheme, improve the effectiveness of labor market interventions under conditions of high unemployment, and implement poverty alleviation programs.[3] In fiscal year (FY) 2006, new World Bank commitments to the country were US$38 million, with overall commitments for active projects totaling US$232 million (see Annex E).

[3] IEG rated this project's outcome as Highly Satisfactory.

PART I: PROJECT ASSESSMENT

2. HEALTH SECTOR REFORM PROJECT

BACKGROUND AND CONTEXT

2.1 The health care financing and delivery system was, in 1996, at the time of project preparation, still a vestige of the centrally planned Soviet system. The efficiency and quality of the system were low. An input-based budgeting system still allocated funds to health facilities based on the number of beds and staff positions, with no consideration of actual quality or results of services provided. Managers were not permitted to re-allocate funds across eighteen line-item budget categories (personnel, drugs, utilities, etc.) without a cumbersome permission process. Resources were wasted due to continued overemphasis on specialized in-patient care.

2.2 The Ministry of Health (MOH) received significant technical assistance from the WHO Regional Office for Europe beginning in 1994 for the development and implementation of the Manas health reform program. Also in 1994, the United States Agency for International Development (USAID) began to support an initial health reform pilot project in one of the country's regions (Issyk-Kul) through its ZdravReform program. USAID's work was closely aligned with the development of the Manas program, and many of the specific measures implemented in Issyk-Kul became a part of the Manas strategy. Numerous other donors, including the World Bank, became involved in the health sector beginning in 1995-1996, and the Manas program became the umbrella for all the international and bilateral organizations working in the health sector in the country. As a result of pre-project consultations, the roles of UNICEF- and IDA-supported projects in the area of ARI/CDD were better defined, and the overall contributions of GTZ were delineated, so that promotional activities in adult health lifestyles and family health would complement and support one another. Prior to the Bank's involvement, no other donor had undertaken any serious, comprehensive, and sustainable activity to support tuberculosis control (Annex E).

OBJECTIVES AND DESIGN

2.3 The objective of the Health Sector Reform Project (referred to hereafter as Health I) was the reform and improvement of the health care system, through (i) improvement of the health status of the population; (ii) improvement of the clinical effectiveness of the service delivery system; (iii) improvement of the economic efficiency of the delivery system; (iv) extension of access of appropriate care; and (v) assurance of long-term financial viability of the system.[4]

2.4 The Health Sector Reform Project included four components, plus funding for a separate component for project administration:

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[4] "Reform and improvement of the health care system" is considered here to be a summary statement of the objectives that follow, and it is therefore not evaluated separately here.

a) Primary Health Care (US$3.5 million, 17.4 percent of project costs), meant to reorient health services away from hospitals and toward upgraded primary health care (PHC) centers. It had three subcomponents: strengthening women's reproductive health management, acute respiratory infection and diarrhea disease control, and tuberculosis control. Interventions in this component included providing training to upgrade the skills of primary health care workers, providing primary health care facilities with basic equipment, ensuring those facilities an adequate supply of drugs, and making available culturally appropriate printed materials for the general public on the home management of ARI and diarrheal diseases.

b) Facilities Rehabilitation (US$2.2 million, 10.9 percent of project costs), meant to improve the capacity of the MOH to maintain buildings and equipment and to facilitate the shift of emphasis from curative to ambulatory and preventive care. The project financed the improvement of 30 ambulatory centers and the conversion of 30 rural hospitals into polyclinics, with additional equipment and supplies provided to ensure the efficient performance of the renovated/converted facilities.

c) Medical Care Provider Payment (US$7.3 million, 36.3 percent of project costs), aimed at implementing provider payment reforms that separated payment for care from delivery of care. The payer would then focus on paying for the best care at the lowest cost, on purchasing care rather than managing and maintaining facilities. Providers would be financially accountable for more efficiency and higher-quality care. Interventions in this component included training of health personnel in new provider payment mechanisms (capitation-based payments to clinics, and case-based payments to hospitals made only after referral from the primary-care level) and the management of clinics.

d) Pharmaceutical Management (US$3.9 million, 19.4 percent of project costs), meant to improve the availability of essential drugs directly, by financing procurement and distribution of essential drugs, and indirectly, by supporting reforms that strengthened government regulation and rational and appropriate use of drugs. This component included renovations to the premises of the national drug regulatory organization, technical assistance and training for its staff, broad dissemination of information on drug regulation to health care officials around the country, development and widespread dissemination of a national Essential Drugs List, training of health care officials and managers on the goals and rationale for an Essential Drugs Program (EDP), development of new treatment guidelines based on the EDP, and procurement and distribution of a significant quantity of essential drugs.

e) Project Administration (US$0.6 million, 3.0 percent of project costs), for supporting and ensuring effective administration of project activities.

2.5 The design of Health I took place at the same time that the Government was crafting the Manas program, and therefore the two emerged deliberately in parallel, with the Bank-financed project forming the backbone of Manas program implementation. Although the WHO and the Bank worked hand in hand with Government during project

preparation, ultimately the lead was taken by Government.[5] As a result, the MOH claimed strong ownership of the project and of the reforms, with the project based not on WHO opinion or Bank opinion, but Government opinion. The project was explicitly designed to introduce modern methods of clinical practice and provider payment (separating purchase and payment for services from delivery of care), while at the same time preserving the major positive features of the Soviet-era centrally planned system, most notably universal access to care and a relatively equitable distribution of health resources.

2.6 Intended coverage varied among the components. The primary health care component was planned to be nationwide, focusing on the primary health care facilities offering health care to all of the country's 43 rayons outside of Bishkek. The tuberculosis activities under the PHC component were to be piloted in Bishkek, Issyk-Kul, and Chui during the first year of the project, with expansion to Naryn and Talas during the second year and to the rest of the country during year 3. The provider payment component, by contrast, was planned only for Bishkek and Chui, extending models that had been piloted in Issyk-Kul under the auspices of USAID.

2.7 The project was designed to strengthen primary and ambulatory service delivery as a precursor to in-patient capacity reduction. While recognizing the necessity of hospital facility and staff rationalization, the project preparation team did not think it was reasonable to include an explicit, pre-defined facility and staff rationalization program within the project itself, particularly given limited implementation capacity and likely political opposition. At the time, ODA was developing a detailed facility rationalization plan for Bishkek City, and the Manas program contained a master plan for facility rationalization, but the Bank remained uncertain that these efforts would be sufficient to build the political will in Government necessary to undertake physical and human resource rationalization. It was intended that the new provider payment mechanisms financed by the project would furnish the necessary incentives (financial) to promote primary and out-patient care while eliminating unnecessary in-patient bed capacity. The project's facilities rehabilitation component was explicitly intended to assist the Government in the repair, rehabilitation, and reutilization of existing structures and plant rather than the development of new and unnecessary capital investment projects. The project's pharmaceutical component was intended to make sufficient drugs available at the primary care level and therefore support decreased hospital utilization.

2.8 The overall implementation and administration of the project were the responsibility of the MOH. Policy advice was provided by a Project Policy Council (PPC), formed in July 1995 to oversee the policies undertaken by the MOH and other

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[5] In the Kyrgyz Republic, there exists a wide range of opinion on the explanation for the emergence of strong and sustained Government commitment to progressive health reform, including the existence of a small but committed group of "champions" of reform who were responsible for the creation of the Manas Program. Some respondents attribute the commitment to reform to the Kyrgyz nomadic culture, rendering the country naturally more open to new ideas than its neighbors. Others cite the extreme poverty in the country during the immediate post-Soviet period, claiming that the country had no choice but to adopt strategies to use its scarce resources more efficiently. The unique presence of several strong Kyrgyz "policy entrepreneurs" who were able to collaborate effectively with donors was clearly a major factor.

entities involved in project implementation. The PPC was chaired by the Minister of Health and included MOH deputy ministers, representatives from other MOH departments, regional medical officials, representatives from the medical and pharmaceutical communities, and a representative from the Ministry of Finance.

2.9 The Technical Coordination Committee (TCC), formed in August 1995, managed the technical implementation of the project and served as the secretariat of the PPC. Functioning on a permanent basis during the course of the project, the TCC formulated and recommended for approval any policy reforms associated with the project; coordinated activities among the components; and coordinated the project's activities with other donors in the health sector. The TCC also coordinated the budget planning and control of project funds. It was composed of a full-time Director and four technical Component Coordinators assigned to the four functional areas of activity under the project (primary health care, pharmaceutical management, medical care provider payment, and facilities management).

2.10 The Project Coordination Unit (PCU) of the Bank's Social Safety Net Project served as the procurement and administrative consultant of the MOH for Health I. The PCU served the specific needs of the project with administrative functions required for project management and implementation; it was expected that this arrangement would cost considerably less than setting up a separate PCU in the MOH. The PCU was specifically charged with responsibility for procurement, finance and accounting, disbursements, reporting, design and implementation of a system of supervision of civil works, and accounting training on-site for MOH personnel.

IMPLEMENTATION AND COSTS

Planned Versus Actual Costs and Financing

2.11 Health I was approved on May 14, 1996 and became effective on June 1, 1996. Of the original amount of the credit (US$19.9 million), US$18.5 million was actually disbursed, with more spent than initially planned on provider payment reform and less than initially planned spent on primary health care and project administration (see Annex C). The project closed three months later than scheduled, on September 1, 2002. As a rule, counterpart funds were delivered in full and on time, although delays in receiving counterpart funds at one point led to training sessions at the rayon level being cancelled (November 1998-July 1999).

Implementation Experience

2.12 *Introduction of health insurance.* The project did not initially specify the creation of a nationwide Mandatory Health Insurance Fund, as the provider payments component was planned to be introduced only to the City of Bishkek and Chui Oblast. In addition to the planned formation of family group practices and supporting the implementation of appropriate provider payments mechanisms in those regions, however, it was recognized that a single-payer funding mechanism would have to be established in order to consolidate limited public sector funds and develop risk pooling mechanisms. In 1997, the Mandatory Health Insurance Fund (MHIF) was introduced with a small payroll tax

contribution collected from the economically active population (employees, the self-employed and agricultural workers). Pensioners were funded from the pension fund, and the registered unemployed were financed through the unemployment fund. These monies were collected by the Social Fund, which was to make appropriate transfers to the MHIF. By 1999, coverage had reached only 30 percent due to an array of impediments: lack of trust in the insurance system, limited employment in the formal sector, and low tax compliance. By 2000, coverage reached 70 percent, as the Republican budget began to fund insurance contributions for children under the age of 16 and social welfare recipients. In terms of the specifics of coverage, the benefits of the insured did not differ dramatically from those of the uninsured; the real benefit of the introduction of the MHIF was at first institutional, in that it permitted gradual introduction of output-based purchasing mechanisms in a previously input-based environment (WHO/DfID, 2005).

2.13 *Impact of the financial crisis.* The main external factor impacting project implementation was the devaluation of the som following the economic crisis in Russia in the summer of 1998 (almost 70 percent in 1998 and over 50 percent in 1999 against the US dollar) (National Bank of the Kyrgyz Republic, 2002). The crisis affected the allocation and timeliness of payments of counterpart funds in some instances, but most importantly it impacted the pharmaceutical component. Inflation and the deteriorating exchange rate undermined the drug distribution scheme that had been established, as it became increasingly expensive for the distributors to participate because the loan and interest rate were denominated in dollars rather than soms. The dollar-denominated drugs also became increasingly expensive and more difficult to sell. Because of these factors, the distribution scheme for the third lot of drugs was abandoned. Eventually, all drugs were distributed without losses due to expiry; after having exhausted a number of incentive schemes for distributors, the drugs were distributed free to hospitals.

2.14 *Political economy.* Resistance to efforts to rationalize the health sector was anticipated from medical professionals and auxiliary staff fearing job loss (particularly in the Republic-level tertiary facilities in Bishkek), and also from users in catchment areas of facilities being closed. It was recognized during project design that the Government would need assistance in consulting with various constituencies such as doctors, other medical staff, users in urban and rural areas, MOH staff, Parliament, and others, to develop support for rationalization, design a compensation package, identify retraining opportunities, disseminate information on the need for rationalization, and generally to build a consensus on the issue. The project countered much potential resistance through the creation of institutions that could effectively lobby potentially recalcitrant groups on behalf of reform (the Family Group Practice Association, Hospital Association, and Licensing and Accreditation Commission).

2.15 Some resistance from Government was also expected to the treatment of some social groups with STIs on an anonymous ambulatory basis and to the shift to internationally-recognized standards for treatment of TB, both of which were part of the PHC component. The project built in financial incentives for case detection and cure of TB patients to counter this resistance, including a 60 som payment to a primary health worker who manages a smear-positive TB patient to a documented cure, and a 30 som payment for the management of a smear-negative patient after treatment completion.

2.16 *Impact of governmental reorganization.* In January 2000, oblast-level health departments were eliminated as a part of a more general, unanticipated civil service reform. The MOH responded rapidly and strategically to this decision, using it as an opportunity to further strengthen the health insurance mechanism. Oblast health department economic, financial, accounting, information, and quality control functions were transferred to the Oblast Health Insurance Funds, creating a single-payer health purchaser institutional structure at the regional level comparable to that already established at the national level.

OUTPUT AND OUTCOMES BY OBJECTIVE

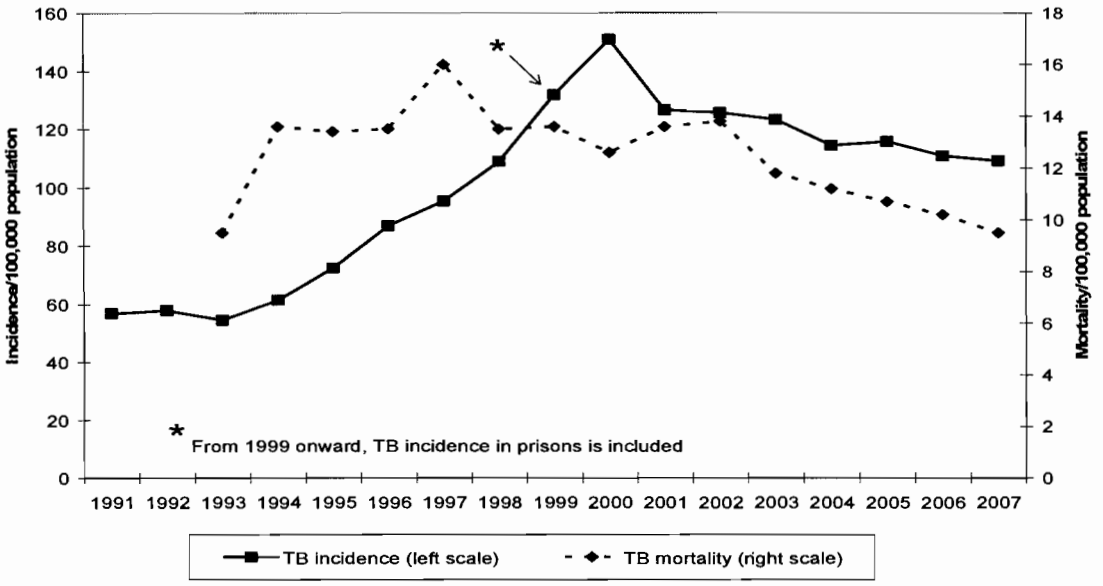
2.17 A number of the project-sponsored activities contributed significantly to the achievement of more than one of the project's objectives. Here the activities will be noted under the objective to which they contributed most strongly, with reference to them in the discussion of other objectives for which they were also important.

Improvement of the health status of the population

2.18 The project implemented a number of activities posited to affect health status. National policies and programs on women's reproductive health and tuberculosis were developed under the auspices of the project. Clinical protocols were introduced and/or updated for a cluster of primary health care services, including women's reproductive health, acute respiratory infections (ARI), chronic diarrheal disease (CDD), and tuberculosis (TB) (years of adoption not specified). Approximately 1,000 health personnel, primarily gynecologists, neonatologists, and primary health care specialists, were trained in Safe Maternity and Childhood Programs, and about 300 were trained in protocols for ARI/CDD; this represented nationwide coverage of the country's 43 rayon hospitals. The project trained an unspecified number of health personnel in modern methods of TB control, including DOTS, and a system of incentives (described earlier) was put in place to encourage health personnel to adhere to the latest clinical protocols for the detection and treatment of TB. Project funds refurbished and equipped a decentralized network of training institutes.

2.19 A number of improved health outcomes can plausibly be linked to these activities. During the life of the project (1996-2002), the IMR declined from 25.9 to 21.2 per thousand live births; of the major causes of infant mortality, the infant mortality rate from asphyxia declined from 23.8 in 1994 to 15.2 in 1999, and the infant mortality rate from ARI declined by 41 percent (from 25.4 cases in 1996 to 13.3 in 2000). The number of cases of early post-natal bleeding declined by 47 percent (25.4 cases/1,000 women in 1996, to 13.3 cases/1,000 in 2000), and the maternal mortality rate declined (from 65 per 100,000 births in 1996 to 45.9 in 2000, but then up to 58.4 in 2002). Tuberculosis incidence, which had been increasing since shortly after independence, continued to rise until 2001, when it dropped sharply (Figure 2.1). While it is likely that some of the increase is due to improved reporting as a result of the project, the trend is also affected by the fact that new cases among prisoners were added to the reporting system from 1999 onward. However, the increase in the reported number of cases did not result in higher mortality, which is consistent with more effective treatment.

Figure 2-1. Tuberculosis Incidence and Mortality, 1991-2007



Source: World Bank (2005), p. 30; Meimanaliev et al. (2005), p. 7; WHO/DfID (2003), p. 4; MOH web site (www.med.kg)

2.20 Because of the many donors involved in the country over this time period, because the health care system (which was the focus of this project) is only one of many determinants of health status, and because the project did not provide for evaluation techniques that would have allowed comparison of health status among groups exposed to project interventions compared to those who were not, it is difficult to attribute any results directly to project activities. However, the project-funded programs in reproductive health, childhood illnesses, and tuberculosis were by far the largest interventions targeted at these diseases during this time period.[6]

Improvement of the clinical effectiveness of the service delivery system

2.21 This objective is defined here as improvement in the quality of health care services. To some extent, this objective could be interpreted as a contributor to the achievement of the first objective, improvement of the health status of the population.

2.22 Interventions aimed at improving clinical effectiveness included clinical protocols being introduced and enhanced, as described above, for ARI, CDD, TB, and sexually transmitted infections. Under the new family practice mechanism, providers were made autonomous and accountable to consumers for their performance. Printed materials were also made available to the general public on the home management of ARI and diarrheal diseases. The project also provided for modernization of bacteriological services of pilot TB facilities, and it supplied drugs for free treatment of all newly disclosed TB patients.

[6] UNICEF donated emergency drugs for winter and summer programs and funded some training of health workers on control of ARI and CDD. WHO provided ongoing technical assistance on TB control.

New laws were passed: "On residents' protection against TB" (April 1998); "On reproductive health" (January 2000); and "On prevention of iodine deficiency diseases" (February 2000). Rehabilitation was completed in 72 facilities in Bishkek and Chui (12 more than the originally-planned 60), including capital repairs and provision of modern equipment.

2.23 Presumably as a result of these interventions, the percentage of caretakers of children under five years of age with diarrhea who knew how to make and administer oral rehydration therapy (ORT) rose from 20 percent to 93 percent over the life of the project, and the percentage of children under 5 with ARI treated at a family medicine clinic who received correct treatment rose from 10 percent to 95 percent. A project-sponsored evaluation in the fourth year of the facility rehabilitation effort indicated that the medical equipment purchased through the project was being used properly (World Bank, 2001).

2.24 However, TB diagnostics by the bacteriological method remained low, with the percentage of patients discovered at the primary care level through bacteriological analysis of smear at 1.1 percent (the WHO norm is no less than 10 percent), and the country's regulatory framework continued to require in-patient treatment of TB patients, in contradiction to the DOTS program; physicians continued to debate appropriate treatment methods in other areas as well.

Improvement of the economic efficiency of the delivery system

2.25 Project activities included establishing the basis of an effective health insurance system that pools resources within a single purchaser, with the MHIF as the purchaser now separate from the providers of health services, and reimbursement of providers in some regions based on capitation at the out-patient level and case-based payments in hospitals. The foundation for modern provider payment mechanisms, initially piloted by USAID in Issyk-Kul oblast, was enhanced by the project and taken to the next stage of implementation in Chui Oblast and Bishkek City. A modern Management Information System was established to connect purchasers and providers and to track health indicators.

2.26 Equally importantly, the foundation was laid for comprehensive restructuring of the primary care sector through the establishment of new primary care group practices (Family Group Practices, or FGPs); these were established in all regions. These FGPs are independent health facilities, accessed by free choice of the population and an open enrollment process, subject to reimbursement based on financial incentives for quality

Figure 2-2: Adults and Children Visiting Family Medicine Clinic in Issyk-Kul

and cost-effectiveness of care. In accord with international best practices, family physicians were trained to treat adults, pregnant women, and children (Figure 2.2). By the end of the project period, there were 798 FGPs in operation: 106 in Bishkek City, 144 in Chui, 72 in Issyk-Kul, 38 in Talas, 57 in Naryn, 175 in Osh, 142 in Jalal-Abad, and 64 in Batken. The project provided these centers with a minimum set of equipment and instruments, computers, and office equipment. From 80-95 percent of the population in these oblasts were enrolled in FGPs by the end of the project, due in part to an extensive public information campaign that reached about 400,000 people. In addition, 1,362 doctors and 889 nurses were trained in family medicine, and 90 people were certified as family medicine trainers, in three-month, full-time training courses. Ninety-nine percent of the trainers and 87 percent of the physicians trained were tested and received certificates. Additional shorter workshops were offered to approximately 10,000 professionals in all regions.

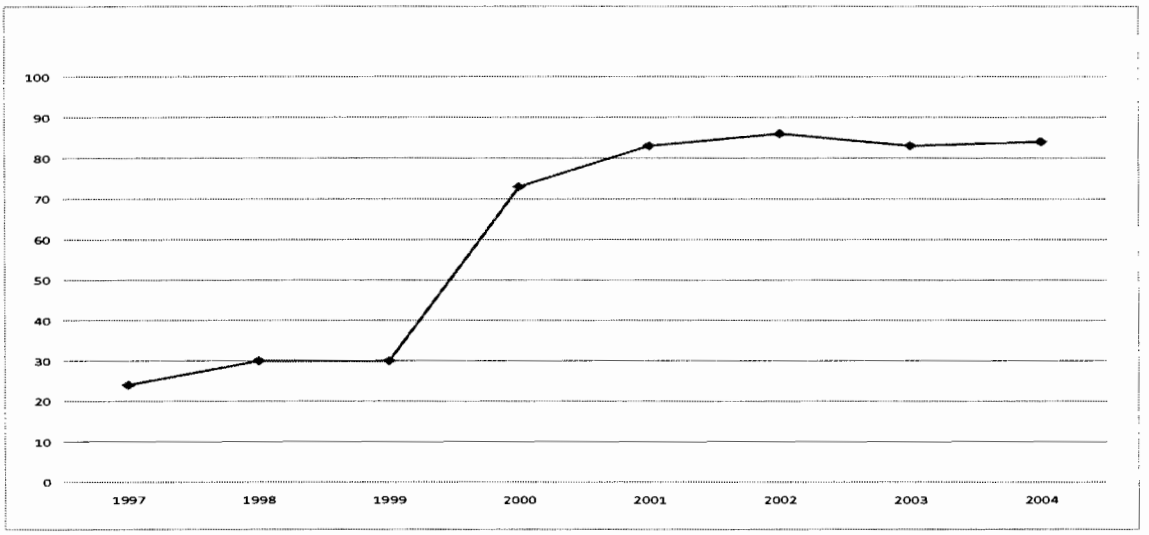
2.27 The project also supported the development of a network of non-governmental organizations to support and sustain these reforms and to strengthen the autonomy of health facilities: the Family Group Practice Association (FGPA), the Hospital Association (HA), and the Licensing-Accreditation Commission (LAC). Each of these was instrumental in creating and sustaining the new provider payment mechanisms, in the contracting process between providers and the MHIF, and in the evaluation and quality control function. Over the life of the project, the LAC licensed and accredited 78 multi-profile in-patient facilities, 13 rural catchment area hospitals, 19 multi-profile out-patient facilities, and 425 FGPs.

2.28 Although there were challenges facing the pharmaceutical sector, as described above, the introduction of a management structure and of a legislative and policy framework contributed to the process of privatization of the pharmaceutical market. In particular, the project's development and operationalization of an Essential Drugs List in 1996, along with the emergence of ten new distributors on the national market during the project period (bringing the total to fifteen), contributed to greater competition and a resulting drop in the prices of essential drugs.

2.29 A wide range of outcomes are posited to have resulted from these project activities. By June 2000, 3.4 million citizens, or about 73 percent of the total population, including retired and unemployed people, children, and people receiving social benefits, were insured by the MHIF (Figure 2.3). This achievement, while an indicator of increased access to the health care system, is more relevant to efficiency in this case; the state budget was still accounting for the majority of public health spending, and therefore the MHIF was initially aimed not at improving access so much as building the efficiencies inherent in a single-payer model. A total of 66 hospitals and 403 family practice centers (representing almost complete coverage in Issyl-Kul and Chui) were operating in the MHIF system and were financed according to the new provider reimbursement methods; by the end of the project, more than 800,000 hospital cases were processed according to the new hospital payment system. As a result of the new incentive structures, there was significant capacity reduction in in-patient health care facilities in Issyk-Kul and Chui (Figure 2.4). New provider payment mechanisms were introduced in these regions during the project period, and pooled financing for health care

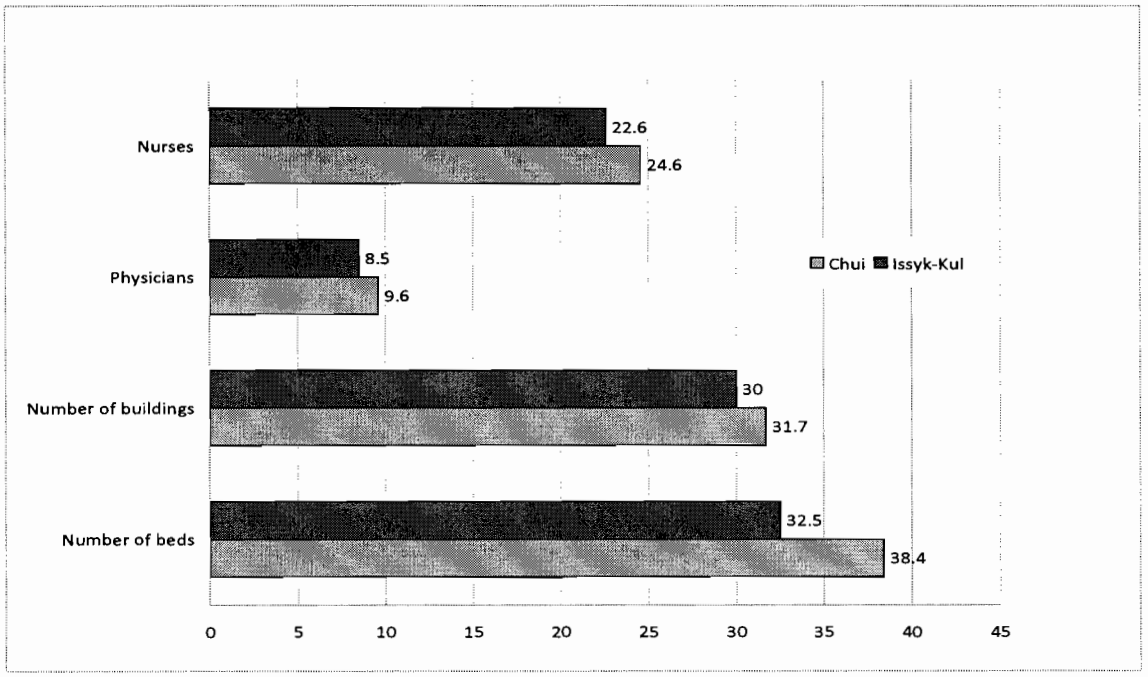
through the MHIF represented an increasing percentage of total health spending in the country (Figure 2.5).

Figure 2-3. Percent of Population Covered by MHIF, 1997-2004



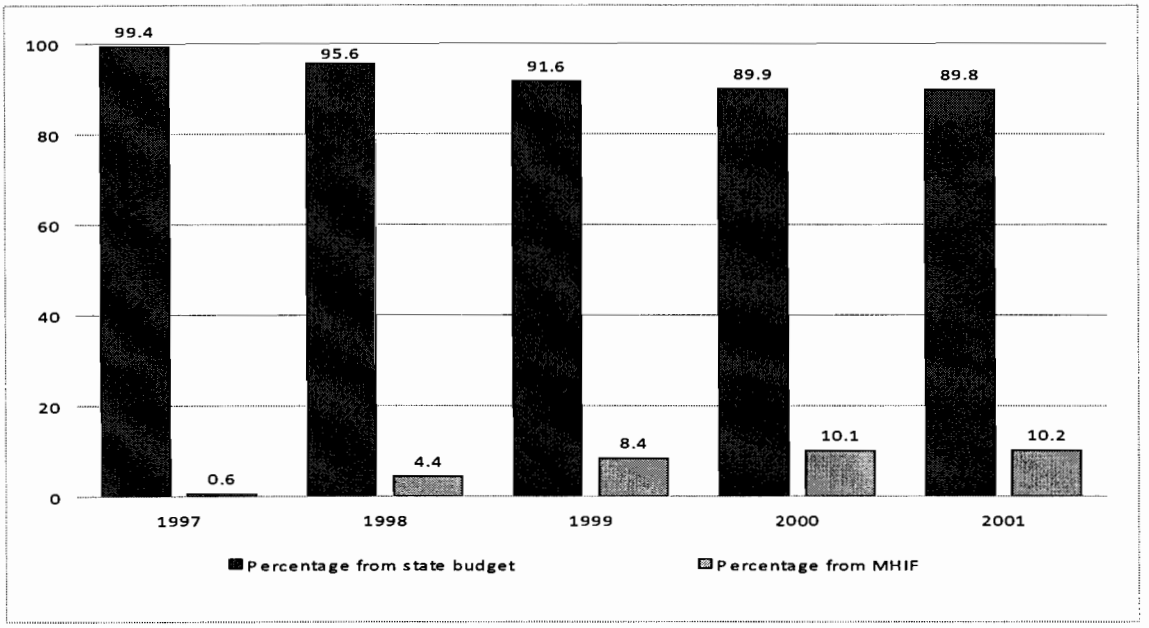
Source: Meimanaliev et al. (2005), p. 30 ; the dramatic increase from 1999-2001 was caused by the addition of children and other categories of participants to the system in 2000.

Figure 2-4. Capacity Reduction in Health Care Facilities, percent Reduction 2000-2001



Source: WHO/DfID (2003), p. 35.

Figure 2-5. State vs MHIF Health Expenditures, 1997-2001

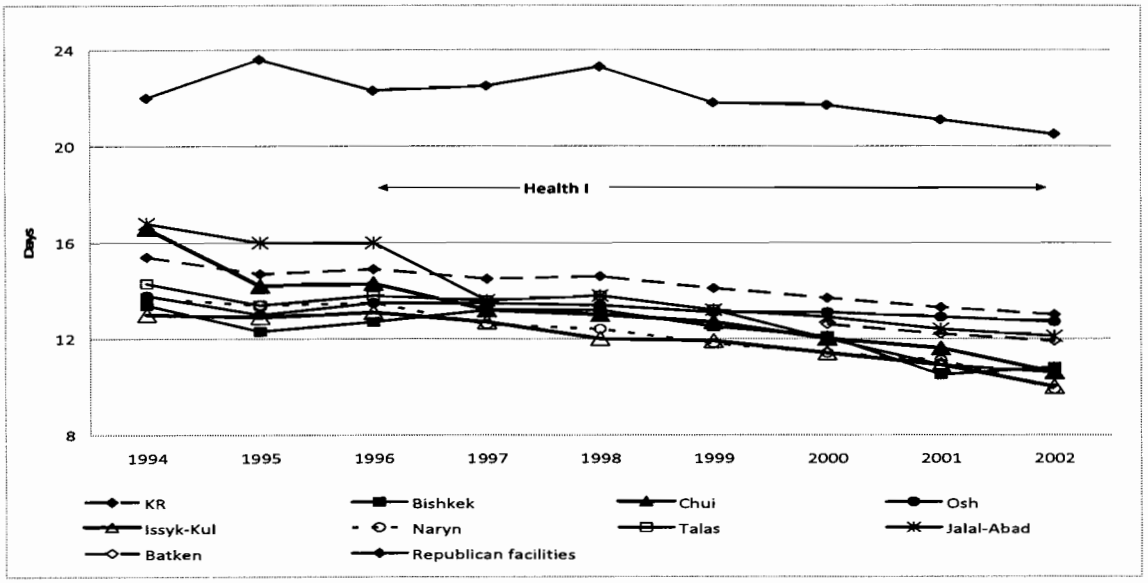


Source: Jakab and Manjieva(2007), p. 287; WHO/DfID (2003), p. 18.

2.30 There was a stable and consistent decline in the average length of hospital stay (ALOS) over the life of the project, although ALOS also declined in non-project hospitals where the new payment mechanisms were not yet introduced, and it had begun declining before the project was effective, calling into question the attribution of these outcomes to the project-sponsored activities (it has been speculated that decrease in ALOS can also be attributed to the demand by hospital personnel for informal payments, driving down hospitalization rates and lengths of stay). A regional analysis, however, indicates that ALOS declined more dramatically in those regions where the new provider payment mechanisms were first introduced (Issyk-Kul and Chui), indicating that the project-sponsored reforms had a demonstrable impact (Figure 2.6).

2.31 There was also a significant decline in self-referrals to in-patient facilities participating in the new payment system during the project period – a 58 percent decline between August 1997 and August 1999 – indicating that the population was making greater use of more efficient primary care, and/or that the hospitals were responding to financial disincentives to admit self-referred patients. As of August 1999, the self-referral rate for hospitals participating in the MHIF system was 11 percent, compared to 26 percent for hospitals not participating in the system.

Figure 2-6. Average Length of Hospital Stay, by Region, 1994-2002



Source: World Bank (1999); Meimanaliev at al. (2005), p. 64

Extension of access to appropriate care

2.32 The family medicine reforms, while contributing significantly to enhanced efficiency, also contributed to improved access to appropriate care. Family group practices were supplied with equipment and with essential drugs for maternal health protection and TB, enhancing the population's access to services delivered in appropriate settings by practitioners trained in appropriate clinical protocols. In addition, US$ 8.3 million worth of drugs were procured and distributed, the first lot through private distributors, and the second and third (due to the impact of the financial crisis) directly to hospitals at no charge.

2.33 The introduction of new ambulatory alternatives to in-patient care should have enabled the poor, who may not have been able to afford costs associated with in-patient care (lost wages, food, bed linens, etc.) to access treatment they may otherwise have foregone. Specific data collection and analysis to demonstrate this increased access, however, was not performed. Improved services at primary care facilities should also have reduced transportation costs (time and material) that patients would have borne to access in-patient care at the more centralized tertiary care institutions. Public resources, however, remained insufficient to cover pharmaceutical needs, with patients still forced to pay out-of-pocket and substandard counterfeit drugs still estimated at 25 percent of drug consumption.

2.34 The project appears not to have monitored the potential impact on access to medically appropriate care of the new provider payment mechanisms and their disincentives for in-patient admissions.

Assurance of long-run financial viability of the health care system

2.35 The rationalization of the health care system's structure and provider payment mechanisms is intended to assure more efficient use of scarce resources; this increase in efficiency contributes to the long-run financial viability of the system by increasing the viability of the system even during possible future periods of resource scarcity. Despite the Government's clear commitment to the principles of reform, however, the overall economic and budgetary environment remained unstable, and it was unclear that the Government would be able to sustain many of the activities essential to the project's success. Health spending as a percentage of GDP declined from 3.1 percent in 1996 to 2.2 percent in 2002 (Meimanaliev et al., 2005). At project closing, it was also not clear that most of the new private pharmaceutical distributors would be in a position to remain in the market due to the deteriorating economic situation and exchange rate losses.

PROJECT RATINGS

Outcome

2.36 The outcome of the project as a whole, based on the relevance of its objectives and design and its efficacy and efficiency in meeting those objectives, is rated Satisfactory (Table 2.1).

Relevance

2.37 The assessment of relevance is based on the relevance of the objectives themselves and the relevance of the project's design in meeting those objectives. The relevance of the objectives is uniformly high. The May 2007 Joint Country Support Strategy (JCSS) for the Kyrgyz Republic[7] focuses on four areas identified in the Country Development Strategy as especially important for the achievement of overarching goals; the third of those areas is "building sustainable human and social capital through improved health and education outcomes, including access to and improving the quality of health, education, and social protection services." The JCSS also highlights the need for progress in public financial management, improving effective public administration, and legal reform, all of which were core elements of the health system reforms. The project's objectives are also highly relevant to the government's pursuit of the health-related Millennium Development Goals: reducing maternal and child mortality rates, and stemming the spread of infectious diseases.

[7] The JCSS was developed by the World Bank, the Asian Development Bank, DfID, the Swiss Agency for Development and Cooperation, and United Nations Agencies.

Table 2.1: Outcome Ratings by Objective

Objective	Relevance	Efficacy	Efficiency	Outcome
Improve the health status of the population	Substantial	Substantial	Substantial	Satisfactory
Improve the clinical effectiveness of the service delivery system		Substantial		Satisfactory
Improve the economic efficiency of the delivery system		High		Satisfactory
Extend access to appropriate care		Modest		Moderately Satisfactory
Assure the long-term financial viability of the system		Modest		Moderately Satisfactory
Overall outcome rating	Satisfactory			

2.38 The relevance of the project's design was substantial. The project design concept was very strong, reforming the provider payment system (thus increasing incentives to shift care to the ambulatory level) while simultaneously strengthening primary health care through improving clinical practice, rehabilitating facilities, and making drugs more available on an out-patient basis – in effect, a multi-pronged approach to reversing inefficiency in the service delivery system. Careful cost-benefit analysis informed the choice of specific diseases and conditions targeted by the PHC component. The focus on acute respiratory infections and diarrheal disease was appropriate, since in 2004 almost half of all infant deaths were due to ARI, 26 percent were due to perinatal causes, and another 10 percent were due to severe diarrhea; pre-project analysis concluded that an ARI/CDD program was the most cost-effective health intervention to reduce IMR in the country.

2.39 The objectives map coherently onto the components (see Table 2.2), but there are two objectives for which there were few or no indicators specified in the monitoring and evaluation plan. In particular, the project might have included more direct indicators for access to appropriate care and for enhancing the long-term viability of the health care system. In addition, there were no indicators to measure the impact of the quality assurance system set up as part of the provider payment component to ensure that the quality of services was not compromised as care was shifted to the ambulatory sector (and as primary health care services were integrated). For both Health I and the follow-on project, Health II, the formally specified indicators did not capture completely the projects' achievements. The M&E system conducted a significant amount of data collection and analysis that was directly relevant to an assessment of the projects' efficacy but not captured by the indicators.

2.40 Perhaps most importantly, the project's design was based explicitly on the Government's health policy, so that the Bank could effectively facilitate the conversion of the Government's objectives under the Manas strategy into a coherent and implementable project plan. Indeed, the Government's Manas strategy itself contained an unusually high level of feasibility analysis and implementation details, and the Bank-sponsored project was derived squarely and logically from this detailed set of Government priorities.

Table 2.2: Mapping of Objectives, Components and Indicators

Objective	Component	Major Indicators
Improve the health status of the population	All components	Under 5 mortality rate; Maternal mortality rate; Perinatal mortality rate
Increase the clinical effectiveness of the service delivery system	PHC; facilities rehabilitation; pharmaceuticals management	Percentage of infant deaths due to diarrhea and ARI; Percentage of neonatal deaths due to asphyxia; Percentage of maternal mortality due to eclampsia
Increase the economic efficiency of the service delivery system	Facilities rehabilitation; medical care provider payment reform; pharmaceuticals management	Reduction in energy use at rehabilitated facilities; Reduction in hospital admission rates, ALOS, referral rate of primary care physicians, and number of hospital beds/facilities; Reduction in referral rates of primary care physicians
Extend access to appropriate care	PHC; facilities rehabilitation; medical care provider payment reform; pharmaceuticals management	Change in availability and price of all drugs, and drugs on the EDL, at each level of the pharmacy system
Assure the long-term financial viability of the system	Medical care provider payment reform; pharmaceuticals management	No direct measure, although increasing the economic efficiency of the service delivery system by definition will enhance the long-term financial viability of the system

Efficacy

2.41 The efficacy of meeting each of the project objectives is assessed as follows: substantial efficacy in improving the health status of the population and improving the clinical effectiveness of the service delivery system; high efficacy in improving the economic efficiency of the delivery system; and modest efficacy in extending access to appropriate care and assuring the long-term financial viability of the health care system. Overall efficacy was therefore substantial.

Efficiency

2.42 The efficiency of the project in meeting its objectives is also substantial. During preparation, the team used the Disability-Adjusted Life Years (DALY) methodology to select for intervention those medical conditions that represented the highest disease burden, and to choose interventions that were both cost-effective and that could be provided in an out-patient setting. The focus on ambulatory care, and the explicit redirection of demand toward an integrated, strengthened PHC level of care, was designed to demonstrate the potential for savings that would be released if excess in-patient capacity were reduced. At the beginning of the project, it was estimated that a 10 percent reduction in hospital admissions and average length of hospital stay (ALOS), and a concurrent 10 percent increase in out-patient visits, would reduce the cost of care by 13 percent; a 20 percent decrease in in-patient visits and 20 percent increase in out-patient visits would reduce the cost of care by almost 25 percent. It was also estimated that the successful adoption of the out-patient-based TB protocols could reduce the cost of TB treatment by 25-50 percent, primarily through a reduction in the use of costly in-patient bed-days.

2.43 Although specific analyses were not conducted to assess the realization of anticipated cost reductions, the project successfully shifted the provision of care toward the more cost-effective ambulatory sector. It is reasonable to speculate that the achievements in reduction of ALOS and hospital admissions, along with the expansion of primary care, produced meaningful efficiency gains. The project's activities built explicitly on the prior work of other donors, most specifically USAID for the provider payment reforms, in order to avoid duplication of effort and achieve maximum possible synergy. This project marked the beginning of what would be an ongoing habit of donor harmonization, permitting cost-effective use of human, physical, and financial resources to facilitate health reform.

Risk to Development Outcome

2.44 Risk to development outcome is rated Moderate. Many of the project's activities contained built-in strategies to ensure sustainability. For example, the training-of-trainers model was designed to ensure that the education and development of family health care providers would outlive the project. The institutions developed, including the MHIF, FGPA, HA, and LAC, created a robust foundation for the continuation of reform efforts; through these institutions, those most directly affected by the reforms – health care providers – have been given a direct stake in the success of the reforms. Perhaps most importantly, the strong Government support for the follow-on project, the Second Health Sector Reform project, suggested that the reform process would both persist and deepen.

2.45 However, while there was little basis to question Government commitment to the project's goals and methods, since these emerge directly from the Government's own health reform strategy, the availability of resources to sustain the project's benefits remained uncertain. Not only in the Kyrgyz Republic, but throughout the former Soviet Union during this time period, the level of financing directed to health suffered as federal government divested responsibility and financial support to struggling regional and local government, and as central financial authorities were under pressure from international financial institutions with regard to fiscal deficits. Because of declining budgets, as the project closed, there were concerns about the operations and maintenance of rehabilitated facilities, and some facilities lacked the spare parts necessary to operate equipment procured with project funds. The overall economic situation in the country remained volatile, and the MOH was not well-positioned to argue for an increased share of the national budget.

Bank Performance

2.46 Bank Performance is rated Highly Satisfactory.

2.47 Quality at Entry is rated Highly Satisfactory. The Bank intervened at a strategically important time, taking advantage of Government initiative and commitment to facilitate a deep and lasting reform process. A detailed burden-of-disease analysis was combined with cost-effectiveness analysis to identify those areas where the health status of the population could be promoted through ambulatory care in the most cost-effective possible manner (the possibility of gaining the greatest number of DALYs for the lowest cost). Careful analysis informed the selection of project regions for activities that were

not planned to be nationwide; for example, Chui and Bishkek were chosen as the sites for the provider payment reforms because of their relatively dense, urban populations, their relative affluence, the relative sophistication of their medical institutions and personnel, the relative excess of medical care providers, their proximity to health sector leadership and technical coordinating staff (Bishkek is the capital, and Chui is the region surrounding the capital), and their geographic contiguousness. The Bank also made explicit efforts to incorporate the lessons of other donors into the design of the project, particularly with regard to the provider payment component, which was a direct extension of a USAID-funded demonstration project in Issyk-Kul.

2.48 A significant amount of analytic work was carried out to support the design of the project, including an October 1994 assessment of the existing sexually transmitted diseases program in the country, a March 1995 analysis of the tuberculosis situation, a June 1995 report on maternal and perinatal health, a July 1995 report on existing ARI/CDD programs, and several 1995 reports on health spending.

2.49 Quality of Supervision is rated Highly Satisfactory. At several points during implementation, when there was a conflict with elements within the Government who wanted to move in a direction contrary to what had initially been planned, the Bank stood its ground until key issues were resolved. Throughout, the task managers were willing to wield the leverage of Bank support to make sure that implementation remained on track. Bank staff might have paid even greater attention to the political economy of change, specifically the receptivity of major political groups to the reforms, and public education and outreach programs required to reach interested stakeholders, including the general public.

Borrower Performance

2.50 Borrower Performance is rated Highly Satisfactory.

2.51 Government performance is rated Highly Satisfactory. Certainly the most critical contribution of the Borrower was the fact and substance of the Manas health reform plan around which the project was built. A small handful of key Kyrgyz players, including an eventual Minister of Health and an eventual General Director of the MHIF, were instrumental throughout: they initiated the creation of the Manas strategy, brought donors into the conversation and coordinated donor activities throughout the life of the project, sustained the intellectual and political energy driving the reforms, and steered the reforms through sometimes turbulent political waters. They served as archetypal "champions" of reform. Despite difficult challenges to the overall reform program, including the almost-constant risk of availability of counterpart funds, these champions managed to keep health reform high on the political agenda and successfully defended against political attack.

2.52 Implementing agency performance is rated Highly Satisfactory. The MOH handled several specific potentially catastrophic situations with considerable political and administrative skill, most notably the elimination of the oblast-level health departments in January of 2000. The MOH and TCC were similarly assiduous in monitoring the

distribution of drugs during the complicated implementation of the pharmaceutical program, with all of the drugs eventually distributed and no losses due to expiry.

Monitoring and Evaluation

2.53 Monitoring and evaluation is rated Substantial.

2.54 M&E Design is rated Modest. The M&E design contained a comprehensive and detailed set of input, output, and outcome indicators for each component to be monitored throughout the life of the project, including specification of baseline data for most indicators. The project's indicators, however, did not cover all of its objectives, particularly access to appropriate care. Monitoring was to be carried out by the TCC, assisted by consultants, who were to complete annual progress reports and action plans supplemented by quarterly reports. The PAD acknowledged that some of the data were not routinely collected at the start of the project, and that it would require substantial effort to collect and compile the appropriate data into a form suitable for analysis.

2.55 While the monitoring plan was comprehensive, the evaluation plan was weak. Several of the project's interventions were specifically designated as pilots. There were two pilot projects (each covering up to 200 patients) to evaluate the feasibility of providing ambulatory treatment of tuberculosis through the primary health care system, as compared to drug administration through hospitalization of all patients at the initial phase of treatment; these were to be evaluated before rollout to the entire country in the second and third year of the project. The construction activities of the facilities rehabilitation component in the Chui region were set to be evaluated before nationwide application. The provider payment scheme (including the cost accounting and clinical information systems and the quality assurance program) was also envisioned as a pilot, with continued evaluation planned for activities in the Issyk-Kul region, and extension of the demonstration to Chui and Bishkek. For the latter, a Module Leader was specifically assigned to evaluate and refine the Issyk-Kul products to fit Chui and Bishkek. The project design did not, however, contain specific plans or timelines for the evaluation of these pilots, nor did it contain an evaluation plan to determine the impact of the project interventions in comparison with non-project facilities and regions. It should be noted that this shortcoming was explicitly identified during implementation, and plans were put in place to correct it for the follow-on project.

2.56 M&E Implementation is rated Substantial. The project monitored indicators in a thorough and consistent manner, using data from the Republican Medical Information Center (RMIC) under the MOH and its subsidiary organizations at the oblast and rayon/city levels. In addition, coordinators of some of the individual project components carried out repeated evaluation exercises, gathering data and feedback from participants and stakeholders.

2.57 M&E Utilization is rated Substantial. While procedures were not in place from the beginning of the project to evaluate the impact of the reforms on project regions and facilities compared to non-project areas, the positive results in affected areas were not only monitored closely but immediately analyzed and publicized. Feedback provided by Bank supervision missions, component coordinator-led evaluation exercises, and

stakeholder input was continuously incorporated into further refinement and implementation of some project interventions. Some components benefited from this mid-project evaluation activity more than others; while it was successful for the family medicine training programs, for example, there was no monitoring and evaluation exercise to ensure further communication and implementation of the study tours, seminars, and training sessions attached to the pharmaceutical component. In many cases, positive mid-project results were used to generate political support for the reforms among political leaders, physicians and other direct stakeholders, and the general public.

3. SECOND HEALTH SECTOR REFORM PROJECT: PROJECT ASSESSMENT

BACKGROUND AND CONTEXT

3.1 By the time of the transition from the first to the second Health Sector Reform Project (Health II) in 2001-2002, commitment to reform remained high, but declining overall public expenditures meant that there were continuing budget shortfalls in the sector. As a result, patients were being asked to pay out-of-pocket for a variety of consumables as they sought health care, in addition to frequent demands for informal payments directly to health care personnel. By 2000, the mean out-of-pocket payment (OOP) was 337 soms, or around US$ 8. Total OOP were composed of expenditures for out-patient visits (14 percent), out-patient drug purchases (58 percent), and in-patient expenses (28 percent) (Jakab and Manjieva, 2007).

3.2 In addition, despite the progress achieved due to the first project, there remained outstanding issues of allocative efficiency of health expenditures between the out-patient and in-patient sectors. In 2001, only 15 percent of total health expenditures were spent in primary care facilities, and hospitalizations remained frequent for conditions that could be treated well and comprehensively on an out-patient basis. There was widespread recognition that further reduction in hospital capacity and further enhancement of primary care was a necessary precondition to improving efficiency and equity in the health system.

3.3 As the first health project transitioned into the second, corruption had become a significant factor plaguing the economy. In the 2005 Business Environment and Enterprise Performance Survey, 59 percent of businesses cited corruption as a significant obstacle to doing business, and the 2006 Transparency International Corruption Index ranked the country 142nd out of 163. Covering a wide range of services, corruption had a corrosive effect on the health as well as other social sectors, primarily via demands for informal payments in order to access health services.

3.4 The World Bank completed a variety of analytic work in preparation for Health II, including the studies "Health Status and Private Health Expenditures in the Kyrgyz Republic" (1999); "Who Is Paying For Health Care Reform in Eastern Europe and Central Asia" (2000); "Kyrgyz Health System: Performance, Organization, and Financing" (2000); "Informal Health Payments in Eastern Europe and Central Asia: Issues, Trends, and Policy Implications" (2000); "Review of the Sanitary

Epidemiological Services (SES) in Kyrgyz Republic" (2001); and a social expenditure review in 1999/2000.

3.5 There was a wide range of donors active in the health sector during the time of Health II (2001-2006; see Annex E). The Bank's main partner was USAID through its ZdravPlus program, which was active in the development of the new health financing arrangements and the phased introduction of the single payer system. USAID also was instrumental in the development of the web of non-governmental associations (FGPA, HA, LAC) supporting the sustainability of reform and independence of health care organizations. The Bank also worked closely with the UK Department for International Development (DfID), the Swiss Government, and WHO.

3.6 Health reform in the Kyrgyz Republic has benefited from the continuity of donor personnel in place. USAID and WHO have kept the same personnel on the ground for over a decade, and there has been similar longevity among many of the key Bank personnel. Over time, a productive division of labor has developed, where each donor – at the initiative and prodding of the Kyrgyz "champions" who launched the Manas strategy -- has successfully carved out its own "niche" of comparative advantage in the health sector reform effort. This continuity has contributed to a remarkably strong sense of familiarity and teamwork within the donor community, and between the donor community and the government. It is widely acknowledged that the Bank has served as the convener and leader of donor efforts.

3.7 The Bank also supported the ongoing health reforms through other operations and instruments in other sectors. For example, the 2002 Governance and Structural Adjustment Credit (GSAC) included policy action on the health sector that helped institutionalize the insurance reforms through the adoption of a legal framework, as well as actions on reforming the public expenditure management system to better support output-based payment mechanisms in the health sector.

OBJECTIVES AND DESIGN

3.8 The objectives of the Second Health Sector Reform Project (referred to hereafter as Health II) were to continue to improve performance and long-term financial viability of the health system in the Borrower's territory by (i) adjusting the delivery system to available means; (ii) focusing on important health risks and diseases; (iii) improving access through better distribution of services; (iv) improving access through offering financial protection for the population against potentially impoverishing levels of out-of-pocket health spending; and (v) improving the responsiveness of the health system to the expectations of the population.[8]

3.9 The Second Health Sector Reform Project included five components:

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[8] "Continue to improve performance and long-term financial viability of the health system in the Borrower's territory" is considered to be a summary of the objectives that follow, and it is therefore not evaluated separately.

a) Health Services Delivery Restructuring (US$7.5 million, 43.1 percent of project costs), aimed at modernization and improvement in the management of primary and secondary health services, and at support for ongoing reforms of primary care services. It had six subcomponents: (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 MOH strategy for mental health services reform (activities to be financed in parallel by DfID); and (vi) building capacity for sustainability of reforms through estate management, hospital management training, and functional services planning. Health II therefore continued the sequencing plan for restructuring begun under Health I, where the first project laid the groundwork for further reform by strengthening the primary care sector, a necessary precondition for the rationalization of the hospital sector that was the focus of Health II;

b) Health Financing (US$2.7 million, 15.5 percent of project costs), 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 the 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; and (iii) development of the health information system. Once again, Health II continued a sequencing arrangements started by Health I, where the first project created the MHIF, but with the majority of health financing still channeled through the budget, and pooling into the MHIF as a single payer (as well as the co-payment mechanism) rolled out gradually to all regions during Health II;

c) Quality Improvement (US$3.5 million, 20.1 percent of project costs), 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; and (iii) improvement of pharmaceutical management (activities to be financed in parallel by DfID);

d) Public Health (US$2.0 million, 11.5 percent of project costs), for strengthening, reforming, and reorienting public health activities to tackle effectively the main health burdens of the population by restructuring the system of disease prevention and health promotion. Three subcomponents included: (i) establishment of a National Center for Health Promotion; (ii) development of a new and improved pattern of operation for health promotion activities; and (iii) reform of the sanitary and epidemiological services (SES) system; and

e) Project Administration and Evaluation (US$1.7 million, 9.8 percent of project costs), for supporting and ensuring effective administration of the overall project program, as well as project monitoring and evaluation under the Project Implementation Unit (PIU).

3.10 A key element of project implementation was the development of the State Guaranteed Benefits Package (SGBP). Created by government decree in February of 2002, the SGBP explicitly defined entitlements to health coverage, including the following (Jakab and Manjieva, 2007; Meimanaliev et al, 2005):

- free primary care, with co-payments for some laboratory and diagnostic tests;
- hospital care provided for a flat fee co-payment, payable upon admission; this co-pay varies with insurance status, exemption status (designed to protect populations with high expected usage of health care), case type, and whether or not the patient has a written referral from a primary health care physician; and
- an Additional Out-patient Drug Benefit to subsidize the price of medicines provided on an out-patient basis for the management of primary care sensitive conditions like anemia, ulcers, pneumonia, and hypertension, in order to reduce unnecessary hospitalizations.

3.11 Another key element of the reforms involved health care financing. Referred to as the "single payer reforms," their main goal was to create regional purchasing pools and therefore end the fragmentation of the pooling mechanism. Although the MHIF had been created in 1997, its role became significantly more important with the introduction of the single-payer system. The MHIF became the sole purchasing agency for health care services at the regional level, combining state budget resources and health insurance premiums. These pooled funds were then distributed to out-patient facilities on a capitation basis and to hospitals on a case-based payment model. The case-based payment system introduced the concept of output-oriented payment to the health system (WHO/DfID, 2005). The single payer reforms were introduced in two oblasts (Issyk-Kul and Chui) in 2001, and then systematically rolled out to the rest of the country, adding two additional oblasts each year, until the entire health financing system operated on the single-payer model in 2004. The perceived effectiveness of the reforms was so strong that two regions scheduled to implement them in 2004 requested permission to do so a year earlier. In 2006, the oblast purchasing pools were further centralized into one national purchasing pool. The latter shift provides the opportunity for cross-national subsidy of poorer regions and expands the risk pool to the national level.

3.12 The project was explicitly intended to benefit the poor, through a more equitable distribution of funds (from the relatively rich and overserviced Bishkek to the regions). In addition, through health promotion, training of health care providers, and the expansion of primary health care centers closer to those in the relatively poor rural areas, the project was intended to enable the health care system to address health risks and diseases (such as infectious diseases) more common among the poor.

3.13 Overall responsibility for the implementation of Health II rested with the MOH. Within the MOH, a Deputy Minister of Reform Policy, Planning, and Coordination held responsibility for overseeing the project's overall implementation; this Deputy reported

directly to the Minister. A newly created Coordination and Evaluation Division and a strengthened External Relations and International Projects Division within the ministry reported to the Deputy on project progress.

3.14 The MOH also established a Health Project Implementation Department, also reporting to the Deputy, to oversee the Project Implementation Unit (PIU) and the Technical Coordination Unit (TCU). This new department was intended to contribute to long-term implementation capacity and sustainability. The PIU was responsible for overseeing all project management activities, including procurement, disbursement, and general administrative issues, while the TCU coordinated all technical aspects of project implementation. The two units maintained separate identities to ensure that procurement and disbursement issues were treated separately from technical aspects of the project. Essentially, this extended the PIU-TCU relationship that had worked well during Health I; the Project Coordination Unit (PCU) under Health I simply became the PIU for Health II, with most of the staff continuing to work in their previous technical capacities.

3.15 The contribution of other donors to implementation of the project was acknowledged from the beginning, and there were regular donor consultations and meetings throughout the life of the project. Donor representatives were invited to participate in all supervision missions and aides-memoire were shared with other primary donor agencies.

IMPLEMENTATION AND COSTS

Planned Versus Actual Costs and Financing

3.16 Health II was approved on May 8, 2001 and became effective on September 1, 2001. Of the original amount of the credit (US$19.5 million), US$14.58 million (75 percent) was actually disbursed, with more spent than initially planned on public health and less than initially planned spent on health services delivery restructuring, health financing, and project administration (see Annex C). The project closed six months later than scheduled, on June 30, 2006.

3.17 Counterpart funds were lacking throughout project implementation. By the second year, these shortages led to errors in information submitted to the Bank for reimbursement of expenses, with counterpart funds informally offset with funding from IDA. Eventually, Country Financing Parameters were changed to allow the financing of the project entirely from IDA sources.

3.18 At project appraisal, DfID had made a commitment of US$3 million to provide parallel financing for parts of Components A, C, and E. Later, the Government was informed that DfID had approved a smaller sum for the project than originally planned, leaving the mental health sub-component unfunded. Also, during implementation a USAID grant of US$22 million became available to the Government, part of which (US$2.5 million) was used for technical assistance under Component C. Cost savings were also generated due to depreciation of the dollar. 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.

Implementation Experience

3.19 *Attention to the political economy of reform was key, from the very beginning of the design process.* The PAD contains an explicit recognition that health sector reform is a lengthy and often politicized process, and that it was therefore necessary to create realistic expectations and to build flexibility into the project's design; that the institutional aspects of reform were as important as the technical approaches; and that reforms would have to be "marketed" to lawmakers, the general public, and the medical community.

3.20 Throughout project preparation, workshops were held in all regions to inform and discuss with all stakeholders the need for reform and various strategies for reform. Technical Working Groups (TWGs) were established by the MOH for project preparation, drawing key stakeholders from the MOH, MHIF, the associations of FGPs/FMCs and Hospitals, the Licensing and Accreditation Commission, and other health professionals. Focus groups were conducted with staff members from urban and rural family group practices and family medical centers, and with the trainers involved in family medicine education, to confirm their continued support for the project's interventions. Chairpersons of relevant committees in the Parliament were consulted on a routine basis, as were governors and mayors in the regions. A formal roundtable was held to consult with the head doctors in the Bishkek republican health facilities and city hospitals. Focus groups were held with health professionals in both urban and rural areas. On August 11-12, 2000, a formal conference was held to discuss project design.

3.21 *Consultations with physicians, a key group potentially opposed to the project's interventions, were important.* In contrast to much of the rest of the former Soviet Union, the Kyrgyz Republic was not over-endowed with doctors, but staff were maldistributed. First, there was a need to redeploy and retrain staff from hospitals and polyclinics to primary care. Second, there was an uneven geographic distribution of services, with Bishkek over-provided and some of the regions under-provided. Third, in Bishkek the ratio of doctors to nurses indicated that the former were performing tasks more appropriate for the latter. Fourth, there were shortages in some specialties and over-provision in others. Given these distortions, the restructuring process would require some staff to be displaced from their current jobs through one of three mechanisms: redeployment to underserved areas and/or service sectors; retirement of pension-aged staff (11 percent of physicians were within five years of retirement age) to allow faster intake of newly qualified staff with new ideas and more modern training; and elimination of those staff who could not or would not be retrained or redeployed as the restructured health care system required. It was expected that fear of job loss, unwillingness to work in rural areas where staff were in short supply, and the financial disincentives to retire would generate a natural resistance to reform among staff and even managers. It was therefore anticipated that policies would need to be developed and appropriate funding provided across three areas: severance payments to staff for whom redundancy was the preferred option; a retirement package to compensate older doctors opting for retirement; and incentive payments such as relocation expenses or bonuses for staff opting to work in places where health care staff were in short supply. The project itself offered no direct financial contributions for severance payments or early retirement, but it did provide training and financial incentives for a redistribution of doctors, and in particular it offered

training and access to international knowledge and equipment as an incentive to advance the proposed reform measures.

3.22 *Despite these efforts, political commitment to the reforms was volatile throughout.* At one critical point in mid-2002, it appeared as though opposition to reform would cause some of the project's key elements to be dramatically altered or abandoned. This opposition emerged from several directions: parliamentarians who were physicians and had financial stakes in the "old" system; those who still stressed the superiority of the Soviet system; politically well-connected physicians who were profiting from private practices run out of the tertiary hospitals in Bishkek (significant, as these nine republican-level national facilities employed 18 percent of all doctors in practice in the country); and political antagonists whose ultimate interests lay in other issue areas. There was also significant opposition to the family medicine reforms, as many physicians and consumers felt that children and adults should be treated separately, and that the loss of out-patient specialists in pediatrics would result in poorer quality of care and less efficient care. This opposition to the development of a system based on family medicine was supported by governments of other Central Asian countries who tried to influence events in the Kyrgyz Republic.

3.23 During a peak period of opposition in October 2002, the Parliament conducted a formal assessment of the first Bank-sponsored project, as well as the Manas health sector reform program overall, reaching a conclusion that these reform efforts were "unsatisfactory." The Parliament gave no reason for this judgment. The Bank team successfully mobilized donor response to this opposition, threatening an Unsatisfactory project rating at a point when this action would have tipped the country into a low-case IDA lending scenario. The Bank also organized a February 2003 Roundtable on health reforms that resulted in a renewed Government commitment to reform and a revised action plan, endorsed by Parliament and by the President, for the implementation of project activities; the personal intervention of the Bank's Country Director was a key element of the political turnaround. These events underline the importance of effective and sustained communication with clear, consistent, and focused messages about the purpose and anticipated results of reforms.

3.24 *The most significant impact of the political opposition was limited progress in the rationalization of health services delivery in Bishkek and Osh.* These powerful local governments did not want to relinquish their authority over financial resources. In addition, the Bishkek city government did not want to subsidize national-level health facilities located in the capital. Corruption also played a significant role, as the number of potentially lucrative head-of-hospital positions, frequently for sale to the wealthy and the influential, would be diminished with the closure of in-patient facilities. The Bank team continued to push for the development of the single-payer system and the implementation of the Bishkek rationalization plan. When it became clear that the plan would not be implemented in its totality, the Bank shifted to a phased approach. This sequence of events had a negative impact on development of increased geographic access to health services, as it limited the planned redistribution of resources from the richer capital city to the poorer regions.

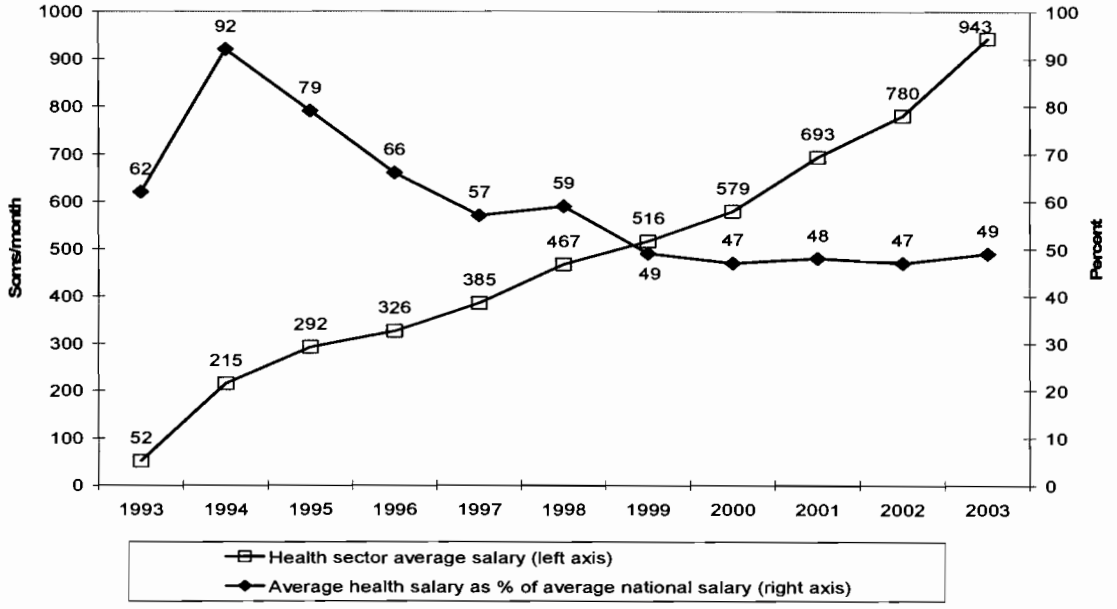
3.25 *Public expenditure management remained a challenge*, as public financing for health care declined throughout the life of the project, from 13.5 percent of total government spending in year one to 9 percent in 2005. In addition, there was a significant roadblock involving the Social Fund, the government institution responsible for collecting all insurance fees. It was initially thought that having the Social Fund collect health insurance premiums and then transfer them to the MHIF would save money on administration, but by the year 2000, the Social Fund had incurred debt to the MHIF in an amount over three times its annual commitment. In essence, the money intended for the MHIF was cross-subsidizing other sectors, particularly pensions (Meimanaliev et al, 2005). Repeated attempts to erase the arrears throughout 2001 and 2002 resulted in a series of inadequate responses, including such measures as paying off part of the debt in kind (with wheat and furniture, among other commodities). Recognizing the extent to which the MHIF served as the flagship of health care financing reform, the Bank intervened. The Country Manager raised the subject in meetings with the President and Prime Minister; the Bank highlighted the need to erase the debt in the country's National Poverty Reduction Strategy; and ultimately, there were threats to withhold further Bank and IMF tranches unless the situation were resolved (a benchmark was introduced in the IMF's Poverty and Growth Reduction Facility that disallowed buildup of arrears from the Social Fund to the MHIF). These interventions led to an elimination of the arrears, ensuring consistent, sustainable funding of the sector (WHO/DfID, 2003; Meimanaliev et al., 2005).

3.26 Another public expenditure management challenge was the disposition of resources saved through the restructuring of hospitals. A significant level of political support for the reforms was generated by the promise that those resources would be channeled back into the hospitals themselves, for capital investment, salary increases, and other health sector improvements. Instead, however, the Ministry of Finance directed the funds to other priorities (primarily education), and the premises that were freed were often turned over to the private sector. This dynamic, perhaps more than any other, has dampened enthusiasm for reform among health sector professionals. What is the point of health reform, they reason, if they cannot realize directly the benefit of the money saved through their efforts? The project was scaling up output-based health financing reforms through a traditional, input-based public expenditure management system. A similar dynamic surrounded the introduction of co-payments, where the advantage in budget negotiations and the allocation of marginal public resources accrued to those sectors that did not have a similar opportunity to collect additional revenues. It was not well understood that the co-payments were not intended as substitutes for general tax revenues (WHO/DfID, 2005). The Bank forcefully argued against, in effect, punishing the health sector for its reform efforts.

3.27 *Toward the end of the project, one of the most serious emerging issues facing the health sector was significant human resource emigration.* In 1994, according to official statistics, the average monthly wage of health personnel was 92 percent of the national average of all occupations, falling to 49.2 percent in 2003 (Meimanaliev et al, 2005) (Figure 3.1). Significant emigration started in 2005, and the situation is now repeatedly referred to as a "catastrophe," with the best-trained and qualified professionals leaving for destinations like Kazakhstan, Russia, or Yemen, and new young specialists not entering the health sector. When physicians schooled in the Kyrgyz Republic,

particularly those who have benefited from training offered by the Bank-sponsored project or other donor efforts, emigrate, they frequently rise very quickly to head doctor and other managerial positions because of the skills and reform mentality they have acquired at home.

Figure 3-1: Health Sector Average Salary, 1993-2003



Source: *Meimanaliev et al. (2005), p. 88*

3.28 *In sum, the implementation experience of the second project was considerably rockier and more challenging than that of the first project.* Despite explicit consideration of political economy risks and institutional analysis performed during project preparation, political opposition began to coalesce in an effective manner among groups whose interests were most directly challenged: out-patient specialists; the heads of the national health care institutions, who lost resources and influence as funds were distributed directly to regional levels; regional governors and others opposed to the co-payment mechanism; and a myriad of others. In addition, the overall macroeconomic situation remained difficult after the 1998 economic crisis. The Bank-sponsored project went through a series of rapid changes in task team leadership. Ultimately, however, the results generated by the reforms, along with key interventions and intensified dialogue by the Bank, effective guidance from key Kyrgyz counterparts, and the existence of a cohesive donor environment, sustained the momentum for reform.[9]

[9] The spring 2005 "Tulip Revolution," which resulted in a new President, Government, and health minister by the summer of that year, had relatively little impact, within this context of volatile political support for health reform.

OUTPUTS AND OUTCOMES BY OBJECTIVE

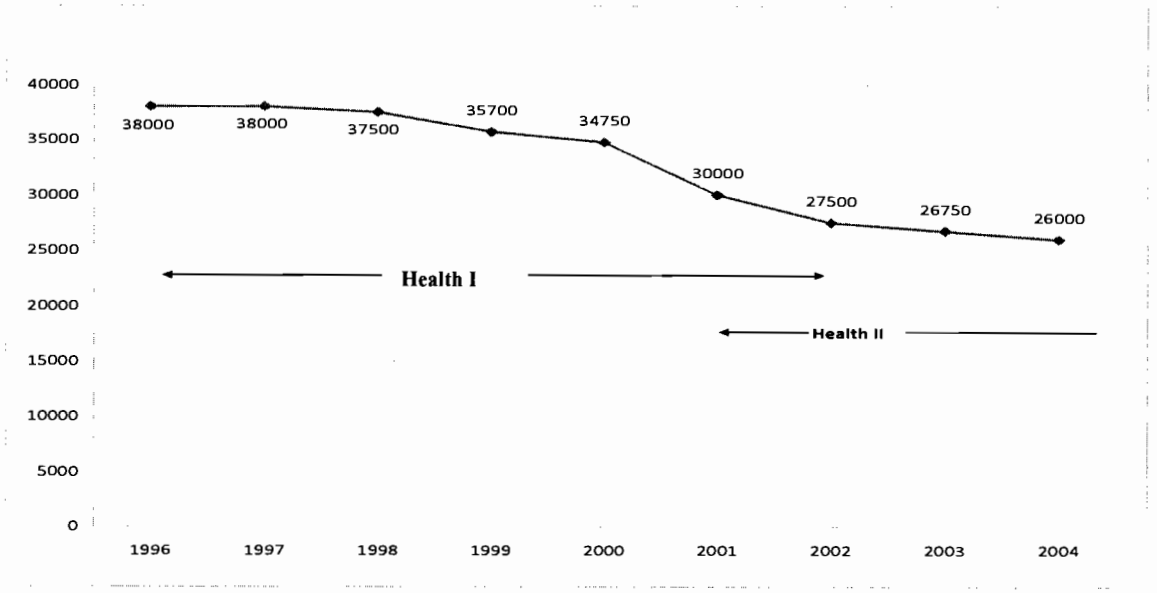
Adjusting the delivery system to available means

3.29 Numerous interventions were intended to improve the efficiency of health care delivery. A single-payer system was put in place, with the number of purchasing pools reduced from 62 to 2. A case-based payment system was introduced in the hospital sector nation-wide, with hospital administrations given significantly greater autonomy in managing their budgets. Legally autonomous primary health care (PHC) centers were established and began to perform a gate-keeping function. The project financed renovations and purchasing of new instruments and equipment for these facilities, as well as an extensive system of family medicine training centers.

3.30 Undergraduate, postgraduate, and continuous medical education curricula were reformed to support the new model of health services delivery. The number of primary care physicians per 1,000 population rose from 5.8 in 2001 to 8.2 in 2005 (Atun, 2005). The number of facilities that were dues-paying members of the Family Group Practice Association rose from 1,221 to 4,819. By the end of 2004, around 75 percent of all primary care physicians and nurses in the country had been retrained as family physicians and family medicine nurses, and the focus of training shifted to the development of a national system of continuing medical education serving family medicine (Atun, 2005). Between 2001-2005, 924 physicians, 2,604 medical nurses, 503 feldshers (low-level health workers providing care at rural outposts), and 348 ambulance feldshers were trained. A training-of-trainers model was established, with 23 physician-instructors, 43 medical nurse-instructors, and 22 feldsher-instructors trained and active. Family Medicine Training Centers were established in all but one of the oblasts. At project closure, there were 87 Family Medical Centers (FMCs) incorporating 675 family doctors, as well as 34 independent Family Group Practices (FGPs), all contracting with the MHIF and linked to the national health information system. As a result of this expansion, per capita expenditures on primary care tripled from 2001 to 2005, despite the constraints on the overall health budget. Salary and benefits of primary care personnel increased accordingly, with the average wages of physicians up by 70 percent, nurses by 78 percent, and support staff by 77 percent; these raises were intended to contribute to retention.

3.31 With the continuation of the family medicine and provider payment reforms begun under Health I, the number of hospital beds and bed capacity in the in-patient sector was reduced by almost 25 percent from 2000 to 2005 (Figures 3.2, 3.3). Between 2001 and 2003, 97 hospitals were closed, and the number of buildings was reduced from 1464 to 784. The number of hospitals per 100,000 population decreased from 7.03 in 1999 to 3.01 in 2004. The total square footage occupied by hospitals decreased by 39.6 percent (WHO/DfID, 2005a).

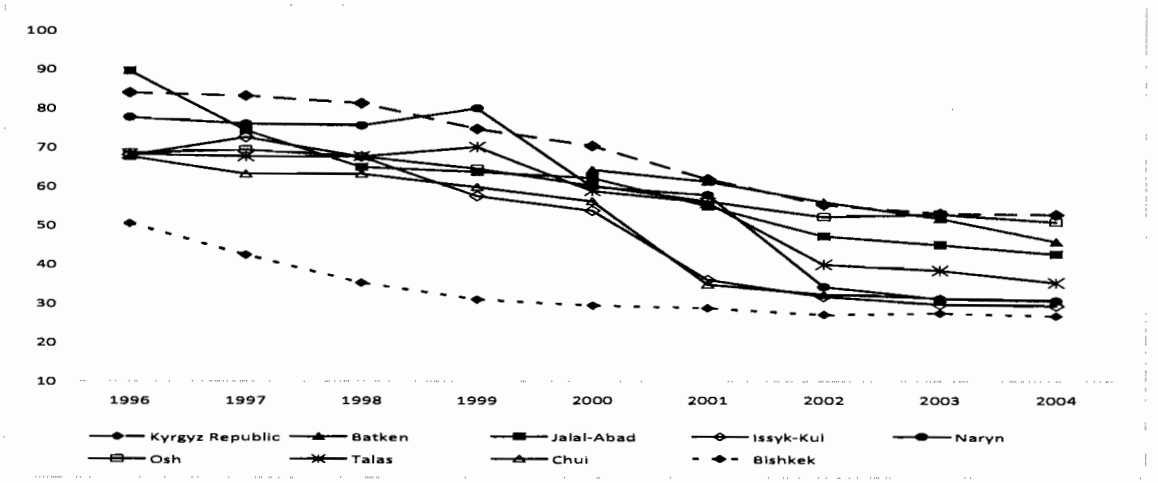
Figure 3-2: Total Number of Hospital Beds, 1996-2004



Source: Kyrgyz Republic Ministry of Health (2005), p. 16; World Bank (2003), p. 50

3.32 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. Health promotion units were established at the FMCs and FGPs in order to link health promotion service with primary health care. Two hundred health promotion trainers were trained at the city/rayon level. The Sanitary-Epidemiological System (SES) was restructured, with excess laboratory capacity closed and 120 lab scientists trained in modern methods of laboratory research and procedure and 75 epidemiologists trained in issues of modern epidemic control.

Figure 3-3: Hospital Beds Per 10,000 Population, 1996-2004



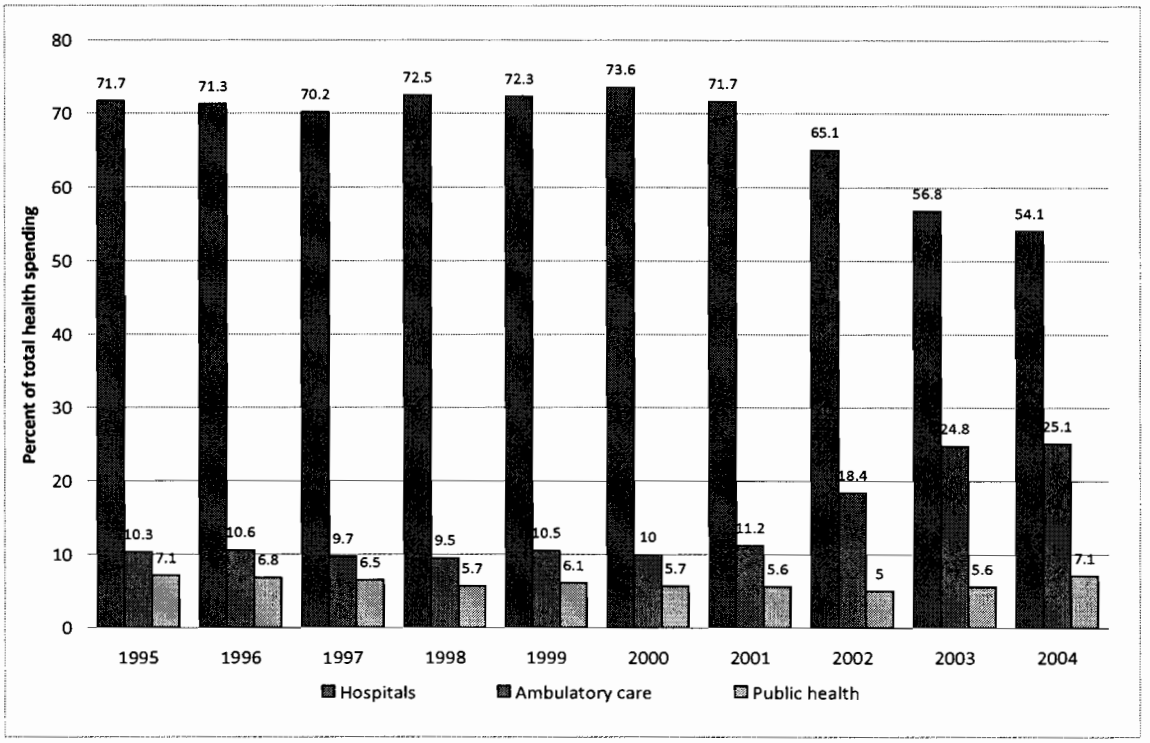
Source: Kyrgyz Republic Ministry of Health (2005), p. 16; World Bank (2003), p. 50

3.33 Political opposition effectively blocked the pooling of funds and implementation of a single-payer system in Bishkek and Osh cities. As a result, most hospitals there were not downsized or restructured. Some reorganizations were implemented, including the

merger of in-patient pediatric services into one facility, but the overall rationalization and consequent redistribution of resources to other regions was not completed.

3.34 A variety of outcomes are presumed to have resulted from these interventions. The goal of reallocating scarce resources away from the Soviet-era focus on unnecessary and wasteful in-patient and specialized care, and toward the delivery of more cost-effective primary care on an out-patient basis, was substantially realized, continuing and deepening the achievements of Health I. The share of country and local government spending on health care devoted to PHC rose from 11.2 percent in 2001 to 25.1 percent in 2005, and the share devoted to public health rose from 5.2 percent in 2001 to 7.1 percent in 2005 (World Bank, 2005) (Figure 3.4). By the time Health II closed, 98.5 percent of the population had access to primary health care services; although this is an indicator for access to health care services, it is equally important in demonstrating increases in efficiency, as care is shifted from the in-patient to out-patient, primary care sector.[10]

Figure 3-4: Distribution of State Health Spending, 1995-2004



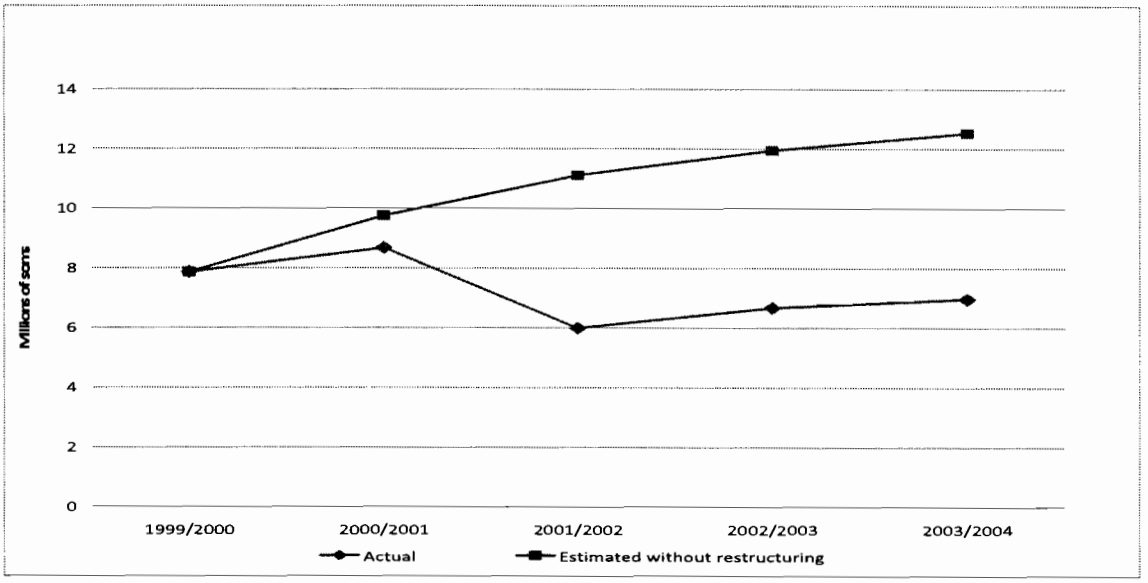
Source: WHO/DfID (2003), pp. 19-20; Kyrgyz Republic Ministry of Health (2005)

3.35 Fixed costs were reduced in hospitals from 21.3 percent of total hospital budgets in 2000 to 12.4 percent in 2005, allowing expenditures for meals and drugs in hospitals to increase from 18 percent in 2000 to 20 percent in 2004. Hospital utility expenditures decreased by 10 percent from 1999 to 2004 (WHO/DfID, undated (c)). One key analysis

[10] Due to the continued shortage of family doctors in rural areas, the Government decided to permit FAPs to continue to provide core primary health services in rural areas for the next 3-5 years, even though nearly 100 percent of the population is enrolled with family medicine.

demonstrated the significant cost savings on utilities alone in the restructured environment, versus what would have been the case in the absence of restructuring; this element of savings was particularly important given the Government's phasing out of subsidies for public utilities, putting those expenses on a "true" cost-recovery basis (Figure 3.5).

Figure 3-5: Utility Costs with and without Restructuring, 1999-2004



Source: Ibraimova (2007)

3.36 Average length of hospital stay decreased by 12 percent from 2000 to 2005, with hospitalization rates for several important chronic diseases declining significantly from 2000 to 2004 (hypertension from 21.5 percent to 13.9 percent; peptic ulcer from 45.4 percent to 37.3 percent; bronchial asthma from 54.6 percent to 22 percent (WHO/DfID, 2005a)

3.37 Between 1999 and 2004, hospital admissions per staff decreased by 50 percent, and per bed by 25 percent (WHO/DfID, 2005a). The share of unnecessary referrals from PHC to hospitals decreased from 2.5 percent of total hospital referrals to 0.6 percent. These outcomes clearly represent a more effective and efficient use of scarce resources. Anecdotal evidence, however, suggests that family medical centers are still perceived not to be as well equipped as out-patient departments at hospitals, and therefore some patients are willing to pay to bypass the primary care "gatekeeping" function.

3.38 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 enhancing efficiency or to prioritizing focus on important health risks and diseases.

Focusing on important health risks and diseases

3.39 This objective did not involve explicit inputs, outputs, or outcomes. The leading cause of death at the time of project design was disease related to the circulatory system, with morbidity and mortality from specific types of heart and cerebrovascular disease worsening from 1990 to 1995; despite improvements beginning in 1996, late 1990s mortality levels still exceeded those for 1990. Mortality from all forms of cancer in the under-65 population had been declining since 1992. Death rates from liver disease and cirrhosis increased over the same period. Overall, mortality rates from non-communicable diseases remained high.

3.40 Incidence and mortality for several communicable diseases were also increasing. The Kyrgyz Republic had the highest levels of respiratory disease mortality of any former Soviet country. Mortality from infectious and parasitic disease was considerably higher in 1998 than in 1990. The incidence of syphilis and tuberculosis had increased, with the latter probably influenced by better case detection by the DOTS strategy and the inclusion of prisoners in the reporting system from 1999. Yet the TB mortality rate was stable throughout the mid-late 1990s, suggesting an effective treatment strategy.

3.41 High rates of non-communicable diseases and the rising rates of several were aggravated by excessive consumption of tobacco, alcohol, and high-fat foods. Social factors were associated with the rapid increase in some STIs. The disproportionate burden of infant and child mortality and under-nutrition among poorer households was thought to be associated with economic factors. Health II sought to address these causes, but more importantly to deliver specific, cost-effective clinical interventions.

3.42 The design of Health II emphasized the availability and quality of primary curative care (e.g. treatment of respiratory infections, STIs, and TB), as well as preventive interventions to reduce the burden of alcohol, tobacco, and diet-related diseases and cross-sectoral social interventions such as informing young people about preventing STIs.

Improving access through better distribution of services

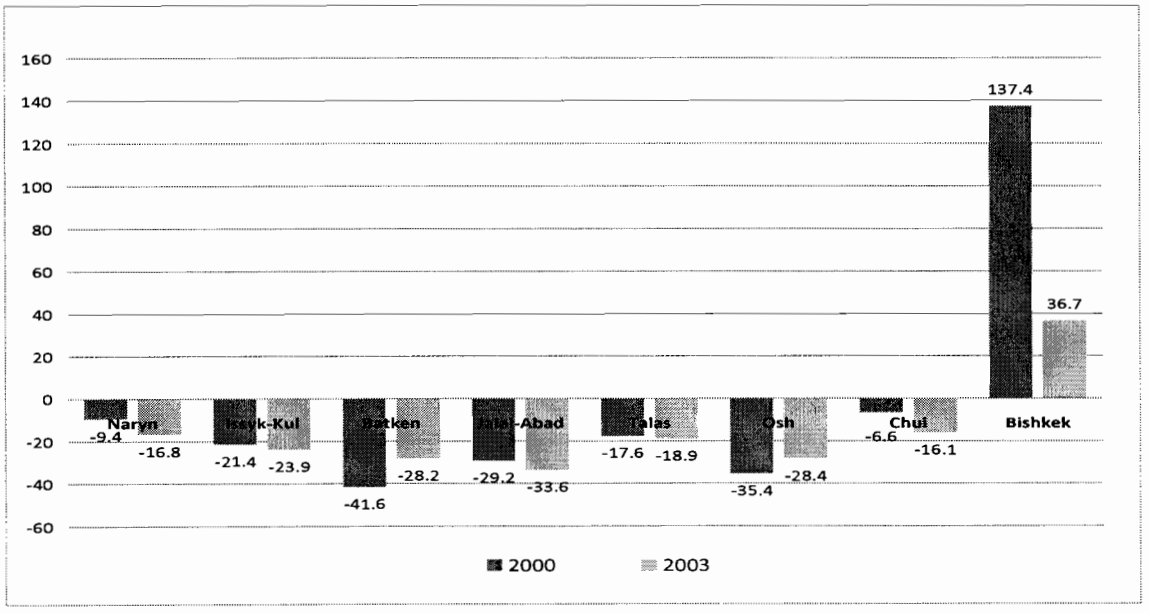
3.43 Health II supported a rationalization of health services that was intended not only to redistribute money from hospital to out-patient care and from secondary to primary care, but also from Bishkek to the poorer regions. The main cause of geographic inequity was expenditures from the Republican budget going to the specialized Republican facilities located primarily in Bishkek. These tertiary facilities serve primarily the populations of Bishkek and Chui oblast, as the poor are unable to afford travel and other costs associated with treatment in these facilities (WHO/DfID, Undated(b)). Unless these issues were addressed, progress toward the provision of universal access to quality primary care would be hindered. It was therefore considered essential that the reform process include a progressive reallocation of resources from Bishkek to the regions.

3.44 Despite the lack of progress in rationalizing the Republican health facilities in Bishkek and Osh, the extent to which geographic inequities were resolved was mixed. As stated earlier, 98.5 percent of the population had access to primary care services by

the end of the project. According to household surveys, the poor (who are located primarily in rural areas) are still more likely than the wealthier urban population to seek primary care at a FAP rather than at a polyclinic or other facility, with 22 percent of the bottom economic status quintile in 2007 receiving care at home (which implies a nurse or feldsher visit) or at a FAP, compared with 9 percent of the richest quintile. This is an improvement, however, over 2004, when 47 percent of the poorest quintile received care at home or in a FAP, compared with 24 percent of the richest quintile. In 2004, 40 percent of the poorest fifth of households (again, mostly rural) saw a doctor at an FGP or FMC; by 2007, this figure had risen to 76 percent (WHO/DfID, 2007b).

3.45 Regional analysis indicated that total per capita public health funding rose in all regions throughout the life of the project. Per capita distribution of Republic funds allocated to MOH for tertiary institutions rose in some areas, including Bishkek, Issyk-Kul, and Batken, but fell in all other oblasts. In 2001, total per capita health expenditures were 2-5 times as high in Bishkek as in other regions in the country; by 2003, this gap had increased between Bishkek and the poorest regions (Batken, Naryn, and Talas). Also between 2000 and 2003, the total amount of health care resources spent in Bishkek declined considerably as a percentage of the national average; some other regions experienced an increase relative to the national average over that time frame, while others experienced a relative decline (Figure 3.6).

Figure 3-6: Distribution of Health Care Resources, Percent Deviation from National Average, 2000 and 2003



Source: WHO/DfID (2005a), p. 33.

3.46 In addition to rationalization of the Bishkek hospitals, the project's restructuring plans also targeted a number of small, rural in-patient facilities for closure or conversion to primary care facilities. This aspect of restructuring was successfully accompanied by other changes, such as enhanced ambulance services, to ensure access to needed in-patient services for the population living in or near the villages where these hospitals were closed.

Improving access through offering financial protection for the population against potentially impoverishing levels of out-of-pocket health spending

3.47 The project's interventions in this area were chosen based on a pre-project analysis of household surveys and other analytic work indicating that the need to make payments for health care was, by the late 1990s, imposing a substantial financial burden on families that experienced illness or injury, and that these burdens had grown more substantial as the need to make payments for health care had grown. Among the reasons for this increasing burden on families was a pervasive lack of medical supplies provided through the budget, as well as the fact that salaries of medical staff were very low and usually were not paid on time or for long periods of time. As a result, there was an increasing incentive for medical staff to seek informal payments. In 1994, the total out-of-pocket cost of an illness episode for one member of a family exceeded the monthly income of the entire household in 20 percent of households experiencing an illness. Almost 50 percent of out-patients reported severe difficulty finding the money to pay for their hospital stays. Many had to borrow money or sell assets (such as farm animals) in order to make the necessary informal payments for hospital care. Existing arrangements for financing health care did not protect individuals and families from falling into poverty as a consequence of health care expenditures (Meimanaliev et al, 2005)

3.48 The most important interventions in this area were the State Guaranteed Benefits Package and the introduction of co-payments. The basic guaranteed health benefits package was intended to improve access to primary care by making it free for the whole population. The co-payment system, introduced for secondary and in-patient care, was intended to substitute formal co-payments for out-of-pocket payments, with exemptions for pregnant women, children under 16, pensioners, and other socially vulnerable groups. The co-payment mechanism aimed to increase the transparency of the system, replacing requirements for unpredictable informal payments with a clear system of benefits and entitlements and clarifying the responsibility of the state in the provision of health care. As was the case with the single-payer reforms, the co-payments were introduced gradually in four waves: initially in Issyk-Kul and Chui in 2001; in Talas and Naryn in 2002; in Jalal-Abad and Batken in 2003; and finally in Osh and Bishkek in 2003/2004.

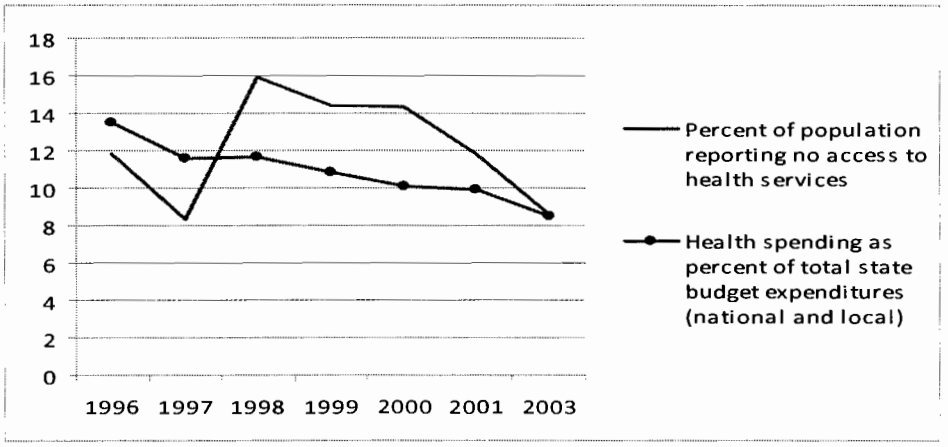
3.49 An out-patient drug benefit (ODB) was introduced as the centerpiece of pharmaceuticals financing, with the objective of improving population access to essential drugs. Insured patients were to purchase prescribed drugs at lower prices, with the MHIF reimbursing the difference between the retail price and the amount covered by the patient to contracted pharmacies on a retrospective basis. Initially, 37 generic drugs received the subsidy. The ODB was intended to improve both financial and geographic access to drugs for the management of primary care-sensitive conditions.

3.50 The outcomes resulting from these interventions were affected by the continuous decline in public financing for the health sector throughout the project period, from 13.5 percent of government spending at the national level in 1996 (when the reforms began) to 9 percent in 2004 (and from 25 percent to 22 percent at the local level). Since public financing was critical for the effective financing of the guaranteed benefits package and the additional package and co-payment exemption for vulnerable groups, the shortfall was detrimental to achieving the goal of enhanced financial protection for the population,

resulting in either increased out-of-pocket payments or reduced services through implicit rationing. One analysis estimated, for example, that the total cost of the benefits package in 2005 was 2.5 billion soms, while the actual financing for the program was 1.8 billion soms, resulting in a 27.4 percent coverage gap (WHO/DfID, 2007a). This coverage gap undermined one of the key goals of the introduction of the benefits package: clear definition of the rights and responsibilities of patients and the state with regard to provision of health services, and clarification of entitlements for different population groups.

3.51 Nevertheless, the vast majority of the population gained access to primary health services through the guaranteed benefits package, and after the introduction of the package, the percentage of the population reporting no access to health care services steadily declined. According to household survey data, the percentage of the population who said that they needed health care but did not seek it due to expense or distance to facility has fallen from 14.7 percent in 2001, to 5.7 percent in 2004, to 3.6 percent in 2007. Similarly, the percentage of the total population (regardless of stated need) who did not seek health care due to expense or distance to facility has fallen from 1.9 percent in 2001, to 0.9 percent in 2004, to 0.6 percent in 2007 (WHO/DfID, 2007b). It is reasonable to speculate that the project's interventions prevented access to health care from becoming significantly worse in a context of declining public financing for health care (see Figure 3.7).

Figure 3-7: State Health Spending and Access to Health Services, 1996-2003



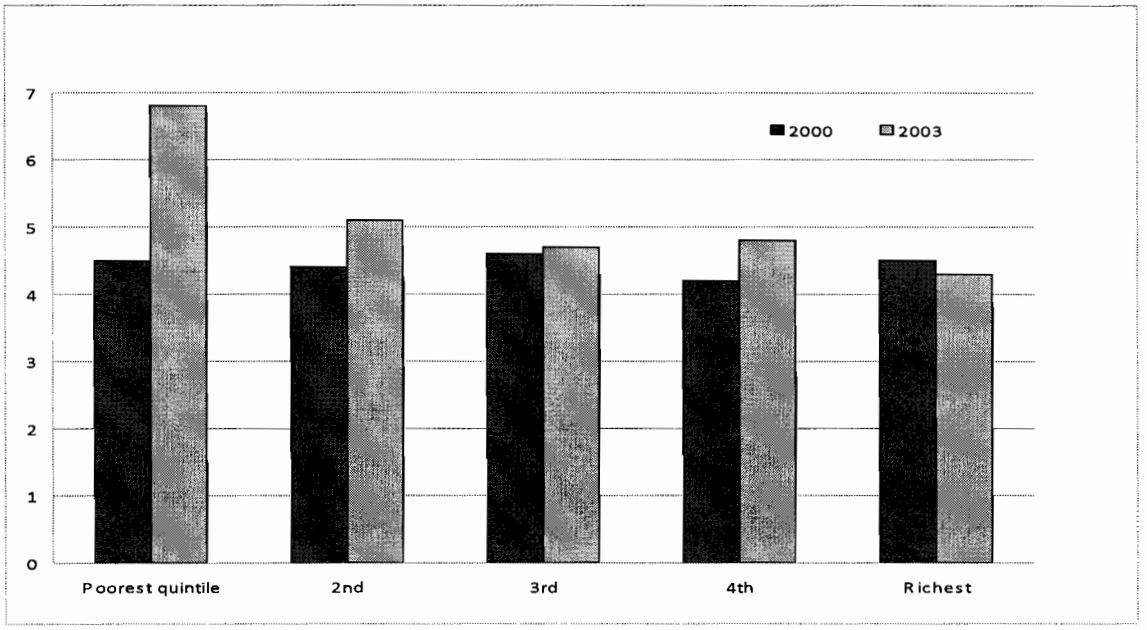
Source: WHO Europe (undated); WHO National Health Accounts data (www.who.org)

3.52 Total household expenditures on health services increased moderately during the first half of the project, with an increase in the price of utilization and a decline in service utilization. Health spending as a percentage of total household and per capita consumption increased from 2000 to 2003, with a larger increase for poor households than for richer ones. This was likely due to the declines in public financing and the subsequent inability of the guaranteed benefits package to cover all services. Out-of-pocket payments as a percentage of household income increased more for the poorest income quintile than for other income groups, and actually decreased for the richest income quintile, between 2000 and 2003 (Figure 3.8). Data on visits to doctors by income groups, however, indicates that while the number of total visits declined from

2000 to 2003, the decline was largest for the 4th and 5th richest income quintiles, while the poorest and middle income quintiles experienced very minor changes, and there was actually an increase in usage among the second poorest quintile (WHO/DfID, 2005a).

3.53 Expenditures for out-patient drugs remain significant, so that the burden of health care expenditures on households is still markedly larger for the poor than for the rich. According to the 2007 household survey, total payments for health care among those who consulted a health professional in the last 30 days constituted 7.6 percent of monthly household expenditure for the bottom expenditure quintile, compared with 5.8 percent for the richest quintile. This gap has narrowed, however, since the 2001 survey, when the poorest 20 percent paid 10.4 percent of monthly expenditures for health care (among those who had sought care), compared with 5.2 percent for the richest quintile (WHO/DfID, 2007b).

Figure 3-8: Mean Out-of-Pocket Payment as Percentage of Annual Per Capita Household Resources, by Income Quintile, 2000, 2003



Source: WHO/DfID (2005), p. 33

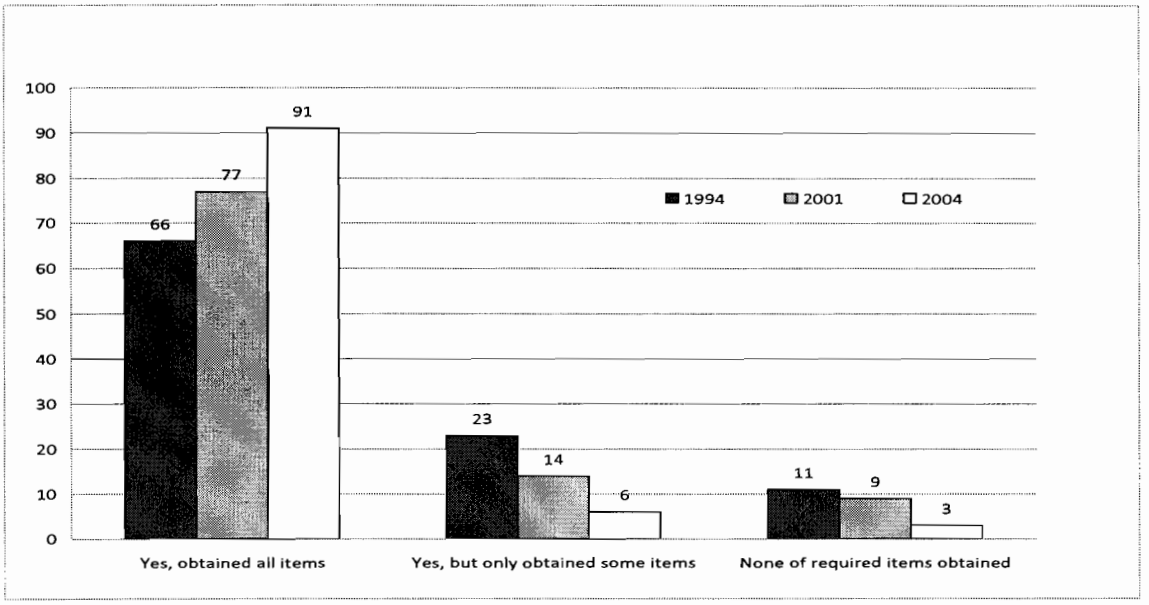
3.54 The reforms also had an impact on patients' financial burden for hospitalizations, particularly for the poor. Analysis of household surveys conducted both before the benefits package and co-payment reforms were implemented (2001), and then when some regions had experienced reform and some had not (2004), shows that the reforms were successful at limiting the increase in out-of-pocket payments for hospitalization over that time period by 400 soms for an average household (with the average increase in reform regions at 200 soms, but the average increase in non-reform regions 600 soms). Furthermore, the reforms had a proportionally greater impact on lower income groups, with the poorest 40 percent experiencing a significant increase in out-of-pocket payments for hospitalization in non-reform regions but a slight decline in reform regions. By contrast, out-of-pocket payments increased in all regions for the richest 40 percent, with

the reforms not appearing to impact their level of out-of-pocket expenditures (Jakab, 2007).

3.55 The introduction of the drug package led to the strengthening and geographical expansion of the pharmaceutical market, allowing 91 percent of the enrolled population to have access to medicines (WHO/DfID, undated(e)). The drug package also had a positive impact on pharmaceutical price regulation; for example, there was a 30 percent decrease in the price of the most frequently used drugs for hypertension.

3.56 The per capita number of prescriptions increased by 14 percent between 2000 and 2003, perhaps reflecting the increased emphasis on out-patient treatment and resulting need for pharmaceutical access at the out-patient level (WHO/DfID, 2005)). The price per prescription increased by 60 percent over this same time period, although this varied across drugs; there was a 30 percent decrease in the price of the more frequently used drugs for hypertension. The percentage of the population reporting that they were able to obtain prescribed medicines increased significantly after the drug benefit was put in place (Figure 3.9).

Figure 3-9: Of Those with a Prescription, Percent Reporting That They Were Able To Obtain Prescribed Medicines, 1994, 2001, 2004

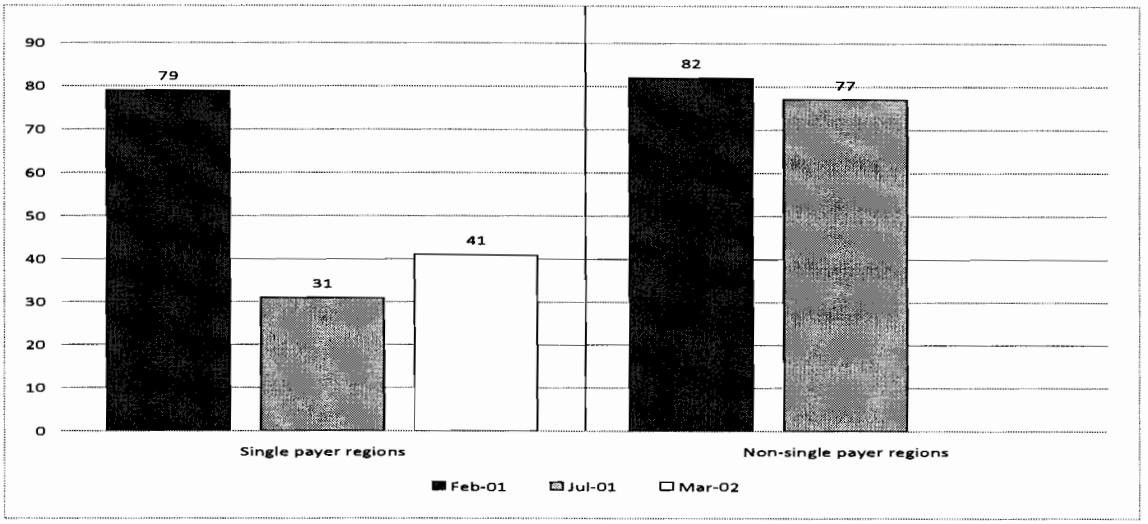


Source: WHO/DfID (2005b), p. 57

3.57 Surveys were conducted in Issyk-Kul and Chui immediately after the introduction of the co-payment in those regions, and the findings were compared with other regions that had not yet adopted that reform. In Issyk-Kul, there was a decline from 64 percent of patients reporting making informal payments to health care personnel before the introduction of the co-payment, to 28 percent doing so five months later, and 38 percent a year after the reforms. About 75 percent of interviewed patients in another study said that the co-payment policy was preferable to the previous system of informal payments, with low-income respondents answering the question similarly to high-income respondents (WHO/DfID, undated (a)). Similar results were obtained for questions about paying for drugs or medical supplies in hospitals, and for paying a health worker "under

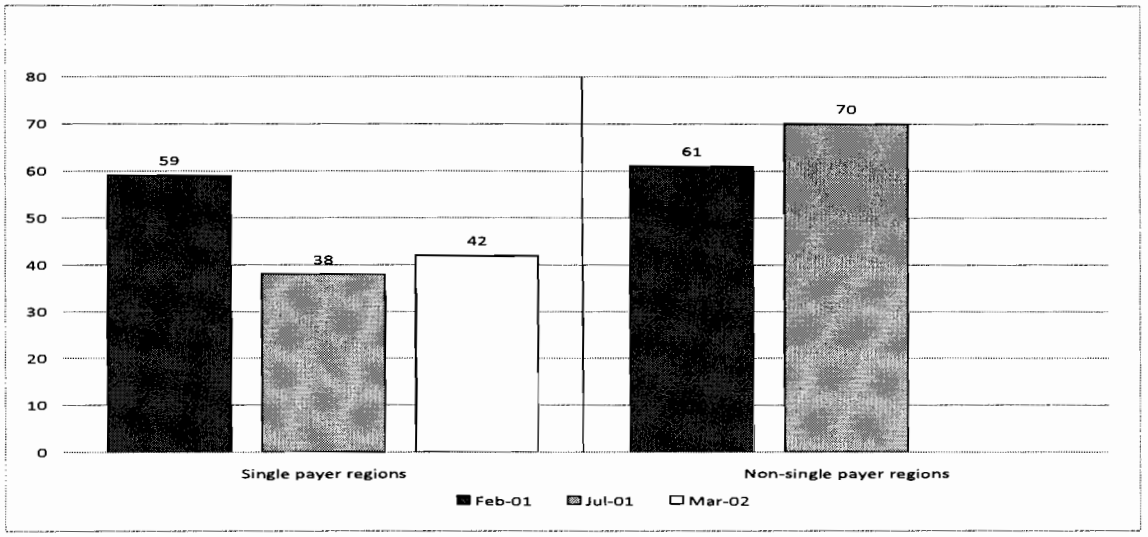
the table" (Figures 3.10, 3.11). Overall, it appears that the co-payments are not adding additional resources to the health care system, but rather are replacing the old, unpredictable, corrupt system of informal payments with one that is predictable and transparent, if not provably less financially burdensome.

Figure 3-10: Percent of Patients Who Paid for Drugs/Medical Supplies in Hospitals or Brought Their Own, Before and After Introduction of Co-Payments



Source: WHO/DfID (2003), p. 31

Figure 3-11: Percent of Patients Who Paid a Health Worker "Under the Table," Before and After Introduction of Co-Payment



Source: WHO/DfID (2003), p. 32

3.58 The system of exemptions from co-payments is also functioning as intended. On average, in 2007 just under 10 percent of the population reported seeking health care in the last 30 days. However, 27 percent of those falling into one of the "exempt" categories had sought care, with these "exempt" categories accounting for 8 percent of all consultations. Only 9 percent of exempt people reported making any kind of payment for a consultation, compared with 21 percent of non-exempt people; this is an improvement

over the situation in 2004, when 15 percent of exempt patients made an out-of-pocket payment (WHO/DfID, 2007b).

Improving the responsiveness of the health system to the expectations of the population

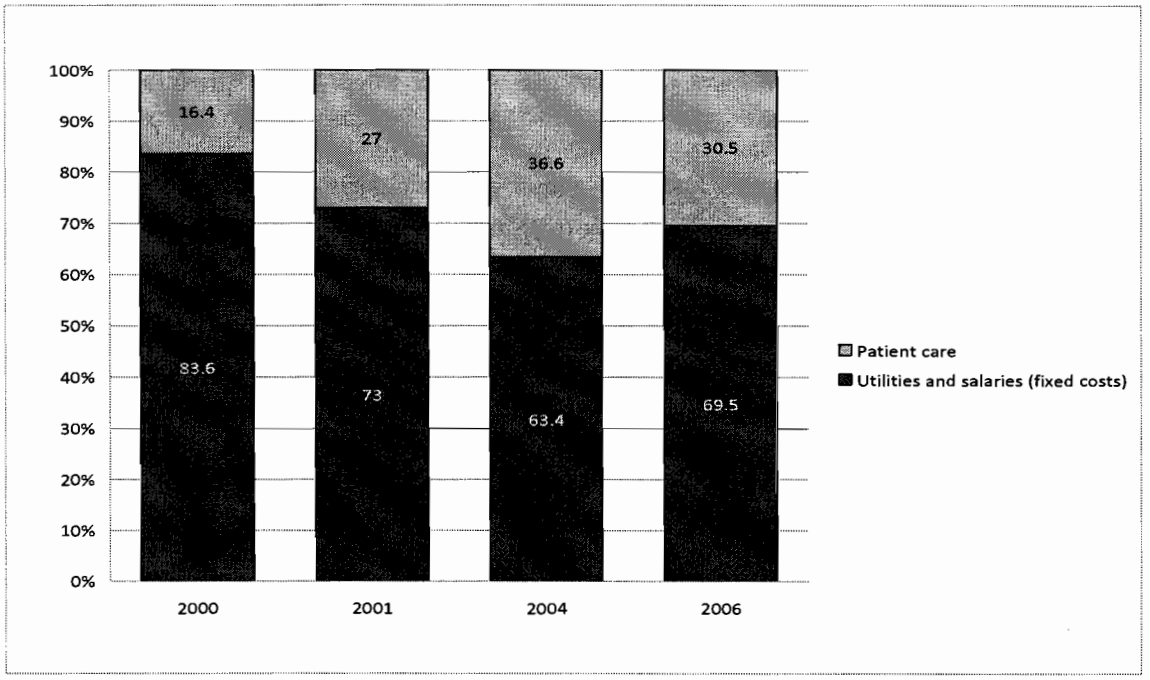
3.59 The PAD explains this objective as covering aspects of an individual's interaction with the health system other than the health and financial consequences. "Responsiveness" is explicitly defined as "something of an extension of the concept of consumer satisfaction," with four specific aspects to be evaluated: increasing the level of consumer choice in the health system for the entire population; improved timeliness in access to care and the receipt of the results of diagnostic tests; improved basic amenities in health facilities; and increased respect for the dignity and privacy of individual patients in health facilities. It was an explicit goal to improve both the level and distribution of health system responsiveness defined in this manner.

3.60 Several of the project's activities were designed to contribute to the achievement of this objective. The capitation-based family medicine model gave patients a choice of providers under the guaranteed benefits package. There was active development of new clinical protocols, with 80 protocols for the primary level, 65 for the secondary level, and 60 for the tertiary level established. Collections of these protocols were published and disseminated with the support of the FGPA and HA.

3.61 Stakeholder interviews carried out by the ICR mission team indicated that one of the major achievements of the project was user choice of provider and free enrollment in the PHC system. Increased user satisfaction in the system was identified as stemming from improved physical and financial access, continuity of care, the existence of a single provider responsible for care, comprehensiveness of care, and increased awareness of patients' rights. In particular, increased satisfaction with care was attributed to the ability of family doctors to address most health problems at the PHC level, reducing the need for cross-referrals within PHC and for referrals to secondary care. The new consumer-provider relationship was said to encourage doctors to deliver higher-quality health services in order to attract more patients to enroll.

3.62 The increased efficiency of resource consumption in hospitals meant that there was more money available for direct patient care. Between 2000 and 2003, the share of health expenditures allocated to direct patient care in Issyk-Kul and Chui oblasts increased from 16.4 percent to 36.6 percent; this percentage declined somewhat by 2006 (Figure 3.12).

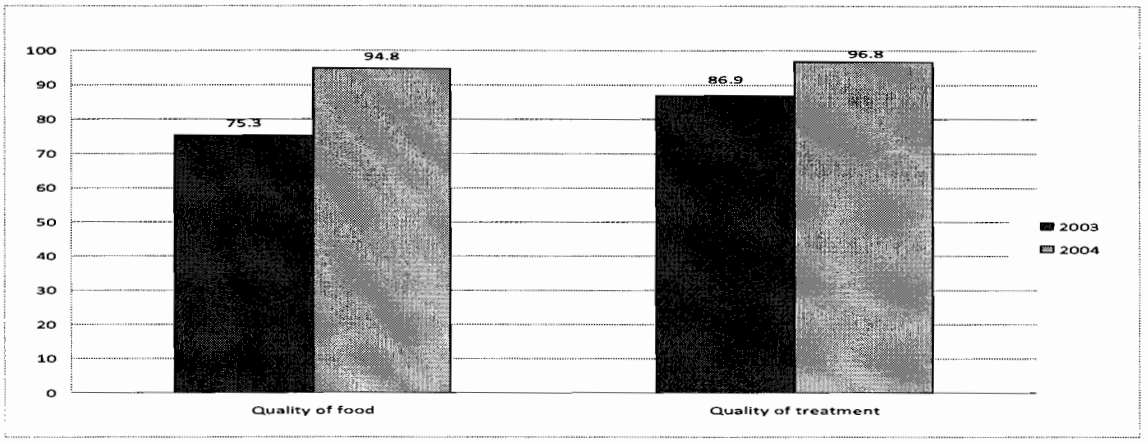
Figure 3-12: Expenditure Structure for Health Facilities in Chui and Issyk-Kul, 2000-2006



Source: WHO/DfID (2003), p. 36; Ibraimova (2007); Jakab and Manjieva (2007), p. 302

3.63 The percentage of in-patientss rating the cleanliness of hospitals as "good" or "very good" rose in some regions and fell in others, and overall patient satisfaction with quality of health and hospital services increased (Figure 3.13).

Figure 3-13: Patient Satisfaction with Quality of Hospital Care, 2003-2004

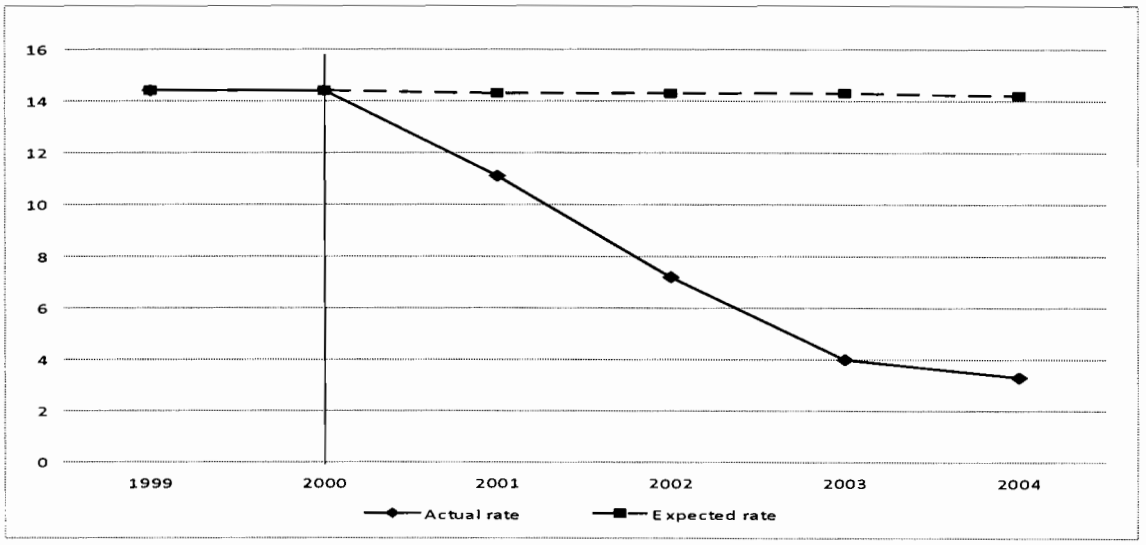


Source: World Health

3.64 The percentage of cases of hypertension for which clinical practice was considered to be appropriate and in accord with MOH clinical guidelines rose from 48.6 percent in 2001 to 68.4 percent in 2005, and for peptic ulcer, from 27.7 percent in 2001 to 57.0 percent 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. One analysis demonstrated that a significant amount of heart

disease was prevented through the introduction of and adherence to these clinical protocols (Figure 3.14).

Figure 3-14: Prevented Cases of Hemorrhagic Insult, per 1,000 Cases of Arterial Hypertension, Chui, 1999-2004



Source: World Health Organization Europe (no date)

3.65 The percentage of drug tests at two monitored quality control laboratories that were rejected or faulty fell from 5.24 percent in 2001 to 1.94 percent in 2004 in Bishkek, and from 10.55 percent in 2001 to 2.03 percent in 2004 in Osh City.

PROJECT RATINGS

Table 3.1. Rating by Objective

Objective	Relevance	Efficacy	Efficiency	Outcome
Adjust ~~delivery system to~~ Introduction of available means clinical protocols	Substantial	High	Substantial	Satisfactory
Focus on important health risks and diseases		Substantial		Satisfactory
Improve access through better distribution of services		Modest		Moderately Satisfactory
Improve access through financial protection for the population against potentially impoverishing levels of out-of-pocket spending		Substantial		Satisfactory
Improve responsiveness of the health care system to the expectations of the population		Modest		Moderately Satisfactory
Overall outcome rating				Satisfactory

Outcome

3.66 The outcome of the project as a whole, based on the relevance of its objectives and design and its efficacy and efficiency in meeting those objectives, is rated Satisfactory (Table 3.1).

Relevance

3.67 The project's relevance is rated 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 in-patient and specialized care and toward excessive funding to health facilities in the capital city. Health I had successfully supported the Government health reform program, and the Government very strongly encouraged 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, through the intended restructuring of the Bishkek hospitals and the introduction of the co-payment mechanism. 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.

3.68 As cited above, Health II also falls squarely within the framework of the May 2007 Joint Country Support Strategy, and also of the Bank's most recent Country Assistance Strategy (CAS, 2003-2005), whose major elements were the support of private sector-led growth, the provision of essential services, and the strengthening of governance. Continuation of health reforms was identified in the CAS as important to facing the country's development challenges, with one of its lessons that "follow-through on past policy actions is as important as initiating new ones, to prevent dilution of important past reforms, such as in the pension and health sectors." The project also reflects several of the priorities of the 2007-2010 Country Development Strategy prepared by the Kyrgyz authorities, which is anchored on four pillars: growth-oriented economic development and improving the business environment, governance and transparency in public administration, human resource development, and environmental sustainability and natural resources management. Health II is specifically and centrally cited as one of the cornerstones of the CAS and as key to preparation for programmatic support in the form of a Sector Wide Approach (SWAp) in health and social protection beginning in 2006.

3.69 The relevance of project design is also rated Substantial. The project documents create a clear and logical chain between objectives, components, activities, performance indicators, and data sources for monitoring achievements, with a specific time schedule specified for the achievement of performance indicators (Table 3.2). A December 2000 policy research paper by the WHO/DfID Manas Health Policy Analysis Project, "Performance Indicators and Evaluation Framework for 2nd World Bank-Funded Health Project for the Kyrgyz Republic," carefully explains the project's results chain, evaluation strategy, and key performance indicators (WHO/DfID, 2000). Most of the indicators were initially expressed in qualitative rather than quantitative terms, and no targets were set, but the indicators were refined during the first year of implementation and finalized in 2002-2003 (although end-of-project targets remained unspecified), with a detailed analysis of indicators, their significance, and data source/collection/reporting plans contained in a September 2002 MOH/HPAP report, "Kyrgyzstan: Indicators for Monitoring Health System Performance and the Effects of Reforms" (MOH, 2002).

Table 3.2: Mapping of Objectives, Components, and Indicators

Objective	Component	Major Indicators
Adjust the delivery system to available means	Health services delivery restructuring; health financing; quality improvement; public health	Increased share of health spending devoted to primary health care and public health; number of closed hospital buildings and hospitals; percent of population enrolled with accredited FGPs; total number of beds and beds per capita; hospital admissions per doctor per year; number of purchasing pools, by region and nationally; number of family medicine residents trained and graduating per year
Focus on important health risks and diseases	Quality improvement; public health	Number of training courses organized by health promotion center; number of informational-education materials on health promotion and disease prevention issued by RPHC
Improve access through better distribution of services	Health services delivery restructuring; health financing; quality improvement	More equitable per capita distribution of Republican-level funds and of public funds across regions; percent of population enrolled with accredited FGPs; number of insured persons participating in Additional Drug Package program; number of trained and re-trained FGP physicians and nurses per 10,000 population (nationally and by region)
Improve access through offering financial protections for the population against potentially impoverishing levels of out-of-pocket health spending	Health services delivery restructuring; health financing; quality improvement	Health spending as a percent of total household and per capita consumption; reduction in the percentage of out-of-pocket spending in total health spending
Improve the responsiveness of the health system to the expectations of the population	Health services delivery restructuring; health financing; quality improvement; public health	Percentage of cases of asthma, hypertension, peptic ulcer disease, and ARI in children for which clinical practice is considered to be appropriate and in accord with MOH clinical guidelines; percent of total payments to primary care from pooled resources steered by consumer choice of FGP; percent of in-patientss rating the cleanliness of hospitals to be good or very good; percent of accredited health facilities; percent of drugs tested at the two quality control laboratories that are rejected/faulty

3.70 The health services delivery restructuring component, through improving quality and efficiency of primary care, establishing legally autonomous centers for primary care services, and rationalizing the number of hospitals and eliminating duplication, was expected to result in significant gains for patients in terms of quality and choice of services and access to services, and for the Government and the health care system in terms of better quality and cost savings. The health financing component, through the development of an efficient, equitable, and sustainable health care financing system and the development of a health information system, was expected to contribute to improved access for patients and improved efficiency in the financing and provision of health services (and therefore contribute to cost savings). The quality improvement component, through the creation of an appropriate infrastructure that would enable self-sustainable quality improvement capacity and by increasing the role of primary care, was expected to contribute to patient access, improved quality and choice of services, and reduced costs due to better treatment of illness. The public health protection and promotion

component, through expanded availability of new equipment for laboratory analysis and consolidation of the existing health protection system (SES), and through investment in nation-wide capacity building for health promotion, was expected to contribute to overall better health conditions, reduced morbidity, higher life expectancy, and enhanced cost savings due to a reduction in treatment costs.

3.71 The phased approach to reform facilitated learning-by-doing over time and the potential accumulation of political support for reform based on prior demonstrated success. The design of the project took into account the planned activities and contributions of other donors, successfully avoiding duplication or overlap. It also anticipated effectively some of the potential negative impacts, such as the displacement of staff by health system reform. Key stakeholders were integrally involved in the design process through a series of workshops in all oblasts, engaging the key professional associations, independent health professionals, head doctors, and political figures (including members of Parliament).

3.72 The project anticipated a range of risks and put in place detailed provisions for risk mitigation, including a series of covenants. These included the risk that savings of fixed costs from closures and mergers of hospitals would not be retained for reallocation within the health system, addressed with a dated covenant on the issuing of a Government decree on retaining saved funds for reinvestment in the health care sector; and the risk of resistance to rationalizing the in-patient sector, addressed with a dated covenant on a Government decree on pooling of funds for the city of Bishkek and on the implementation of a plan to rationalize the Bishkek facilities and redistribute resources to other regions, as well as provisions for incentives aimed at professionals in those tertiary care facilities.

3.73 One particularly successful element of the project's design was the introduction of the co-payment for in-patient services, in recognition of the widespread corruption throughout the health care system in the guise of informal payments.

3.74 The project did not incorporate activities for the rural health outposts known as feldsher-akusherka points (FAPs) that deliver a significant amount of primary care to residents outside the cities (as of mid-2005, FAPs were delivering primary care to 24.4 percent of the population, compared with 75.6 percent of the population that received most primary care from a family physician) (HPAP website). A 1995 assessment, carried out prior to Health I, had indicated that the FAPs, usually small buildings in rural areas where a limited staff of a nurse and midwife carry out essentially a district nursing function on behalf of a small population, were generally neat and clean, not requiring technical or financial support to continue carrying out their present functions. In 2005, the MOH conducted an inventory of the approximately 900 FAPs and discovered that they had fallen into poor condition (in fact, the inventory revealed that there were 914 FAPs rather than the 867 that were formally registered). The follow-on strategy to the Manas program, Manas Taalimi, features funding for special equipment bags to improve the capacity of rural health services.

Efficacy

3.75 The efficacy of meeting each of the project objectives is assessed as follows: high efficacy in adjusting the delivery system to available means; substantial efficacy in focusing on important health risks and diseases and improving access through financial protection for the population against potentially impoverishing levels of out-of-pocket spending; and modest efficacy in improving access through better distribution of services and improving the responsiveness of the health care system to the expectations of the population. Overall efficacy is rated Substantial.

Efficiency

3.76 Efficiency is rated Substantial. At appraisal, it was estimated that savings in costs from the restructuring of health services delivery would amount to US$8.92 million, from the reform of health care financing US$2.96 million, from quality improvement activities US$12.38 million, and from public health protection and promotion activities US$7.49 million, all over a 15-year period. Overall savings compared to costs, including IDA, Government, and DFID contributions, were estimated at appraisal to be US$32.75 million compared to costs of US$17.59 million. Since many project activities (particularly those intended to improve efficiency) were implemented successfully, and since actual expenditures were lower than initially estimated, it might be assumed that overall savings were even higher.

3.77 A comprehensive cost-benefit study was not conducted at the end of the project. Calculations based on data collected after project closure showed that project activities in the area of quality improvement resulted in annual cost savings due to restructuring of in-patient services of about 4 percent. 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 primary care sector.

Risk to Development Outcome

3.78 Risk to development outcome is rated Negligible to Low. The project achieved significant institutional development, particularly in terms of the establishment of family practice medicine, the activity of the NCHP, and the purchasing role of the MHIF. In particular, the MOH is now engaged in policy making, priority setting, resource mobilization, budget formulation linked explicitly to policy priorities, and monitoring and evaluation. It no longer envisions itself as the purchaser of health services. Financial and management practices have evolved similarly, with the adoption of new payment methods, the abolition of line-item budgeting, and the reinvestment by managers of saved funds. 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, the follow-on to the Manas program, and support for a sector-wide approach (SWAp) in the follow-on project.

3.79 The fact that the project's underlying principles and activities remained consistent through a change of government and repeated change of health ministers testifies to the resilience of the reforms' perceived legitimacy. The decline in public funding for the health sector during the project period was indicative of the need to continue to educate leaders outside the sector on the macroeconomic and multisectoral context of health reform. The mutual agreement of the MOH and the Ministry of Finance to work collaboratively to implement a sector-wide approach, including a Bank-financed follow-on project, and the Government's consistent fulfillment of a commitment to increase annually the level of public financing of the health sector, have been significant positive developments.

3.80 The major factor currently perceived as a risk to the longevity of the project's achievements is the exodus of project-trained family physicians to Russia, Kazakhstan, and other destinations. The extent of this problem has not yet been quantified, but Russia has recently accepted the Kyrgyz family medicine diploma for its own licensing purposes, making successful emigration even easier. Ironically, it now seems to be the case that neighboring countries are benefiting from the Bank's support for Kyrgyz health reform. Human resource management assumes a high priority under the Manas Taalimi program and the SWAp, and unless there is progress in this area, some of Health I and Health II's achievements will be in jeopardy.

Bank Performance

3.81 Bank Performance is rated Satisfactory.

3.82 Bank performance in assuring quality at entry is rated 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 Health I. Consultation and coordination with other donors, as described earlier, was particularly strong. The preparation process could have attempted to identify more effective mechanisms to counter the political economy risks of rationalizing the tertiary-level institutions in Bishkek, and of implementing complex, outcome-based payment systems in the context of an input-based overall budget environment. For the latter in particular, more consultation in advance with the Ministry of Finance might have been appropriate, as it was challenging for the MOF to determine how to treat health differently than all other sectors.

3.83 The quality of Bank supervision is rated Highly Satisfactory. The supervision team brought consistent and appropriate oversight and expertise to the project, with particularly important support from management when necessary, through high-level interventions involving operations and instruments in other sectors. This was particularly true during the period in mid-2002 when project activities stalled due to political opposition. The Bank team used regular supervision and monitoring to dialogue proactively with the Ministry of Finance on budget problems in the health sector and implications for project implementation. For much of the project period, the Bank's Country Representative was a respected health specialist, making him particularly effective when he engaged the President or Parliament. In fact, the key Kyrgyz

champions of reform came to recognize that they could rely on Bank intervention for support in political battles with other players. The Bank helped these champions retain their jobs during turbulent times. Effective Bank-sponsored workshops, training sessions, and study tours were also key tools in overcoming resistance to reform.

3.84 The project had three task team leaders, but the supervision of project activities, relationships with other donors, and policy dialogue activity continued relatively seamlessly. Other development partners looked to the Bank as the one institution that could coalesce them all into a common view. Overall, the Bank's role as coordinator and leader 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.

Borrower Performance

3.85 Borrower Performance is rated Satisfactory.

3.86 Government performance is rated Satisfactory. The Government was willing to embark on and sustain many politically sensitive reforms, and significant constituencies maintained commitment to the reforms under volatile 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. However, non-transparent cash management and a shortage of Government funding were consistent themes throughout implementation, and changes in top political leadership created significant challenges at several points during implementation, particularly with regard to support for rationalizing the hospital sector in Bishkek and Osh cities.

3.87 Implementing agency performance is rated Highly Satisfactory. The MOH took ownership of the project in the preparation stage, with the generation of the initial concept paper and the formation (by the Minister) of the Technical Working Groups that supported the development and acceleration of the preparation process. 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 it was implemented by the MOH itself (with the PMU providing fiduciary services and support as an integral part of the ministry). This arrangement enhanced ownership of the project at all levels. It is testimony to the strength of this project's PMU that it was able to administer a PHRD grant to support project preparation activities on behalf of all four countries involved in the Central Asia AIDS Control Project.

3.88 The TCU and PCU continued timely and effective project implementation despite externally-imposed challenges. The institutional transformation of the MOH is a unique development in the ECA region, demonstrating the Borrower's commitment to the emergence of a modern system of public health and health care.

Monitoring and Evaluation

3.89 Monitoring and Evaluation is rated Substantial.

3.90 M&E Design is rated Modest. Given the project's support to the Government's overall health reform strategy, it was appropriate to choose a comprehensive sector monitoring framework rather than a narrower project monitoring framework. The goal was to establish M&E suitable for the wide range of donor-financed projects supporting health sector reforms, measuring project-specific outcomes as well as overall health sector performance. Much of the project's monitoring and evaluation activity was to be financed by DfID (through WHO/Denmark), and it was explicitly intended to strengthen the health policy evaluation and policy making capacity of the MOH (as well as to evaluate the project itself). In addition to data generated by the information systems of the MOH, in order to understand the effects of the project's interventions on the population it was planned to undertake household surveys in 2001 and again in 2003-2004, as added modules to the National Statistical Committee's ongoing annual household budget surveys, called the Kyrgyz Integrated Household Surveys. USAID also planned to conduct a Demographic and Household Survey in late 2002 or early 2003, following the first DHS implemented in 1997. Planned analyses from these data included a focus on changes in service use and health status across different social groups, at the national and regional levels; the impact of rural hospital closures/transformations on access to essential in-patient care; and the impact of the introduction of explicit hospital co-payments.

3.91 It was also anticipated that, because the implementation of reforms would proceed on a phased, step-by-step basis, there would be the opportunity for analysis of "natural experiments," for example, the pooling of funds in some oblasts earlier than others permitting an explicit comparison between the single-payer and fragmented-payer systems.

3.92 At the time of project approval, specific project baseline data and targets were not fully developed, although a list of qualitatively-specified indicators was in place. It is possible that the comprehensive sector monitoring approach evolved initially at the expense of focus on project-specific monitoring. Baseline data and quantitatively-specified indicators were eventually developed during the first year of implementation and finalized in 2003, when the DFID-WHO Health Policy Analysis team prepared a comprehensive codebook of health sector monitoring indicators and began to issue biannual "Health System Monitoring" reports that covered indicators for health financing, health care quality, and public health, and that provided a framework for evaluation. Project indicators were well aligned with the project's development objectives and components; an effective plan was put into 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. These M&E plans were carefully delineated in a research paper published by HPAP during the project preparation period (WHO/DfID, 2000). Project design explicitly acknowledged that it may not be possible to assess the extent to which different outputs contributed to changes in sectoral performance indicators, since broad sectoral goals tend to be determined by multiple factors, only some of which are part of the project and sectoral reforms.

3.93 M&E Implementation is rated Substantial. Monitoring and evaluation was the responsibility of HPAP, tasked with pooling together all data from routine sources,

analyzing those data, and producing policy briefs and policy recommendations. Household survey data were collected and analyzed extensively, as planned; USAID and other donors jointly decided not to conduct the planned follow-on DHS, as UNICEF was already performing Multiple Indicator Cluster Surveys (MICS).

3.94 There was limited M&E in Bank supervision reports until May 2003. During the Mid-Term Review, the Bank organized a workshop with the HPAP project coordinators to discuss the M&E framework and suggest changes, including a simplification of the log frame of the project and reduction of the number of indicators. After this mid-course correction, data were collected across a variety of sources, for many of the indicators at both the country and oblast level, and extensive (and extensively communicated) analysis was performed with those data. Key outputs included a sector performance monitoring framework and regular reporting of progress (quarterly for some indicators and biannually for others). By the end of the project, the monitoring function was institutionalized within the MOH, as planned, and evaluation was institutionalized within the HPAP, under the umbrella of the Center for Health Systems Development. Health sector managers and MOH departments experienced significant capacity building in M&E, including the development of capacity within the MOH to monitor overall health sector performance as well as specific reform areas to inform policy makers on required readjustment of reform design.

3.95 M&E Utilization is rated High. Data and analysis generated by the M&E process were regularly used to inform policy making and policy interventions of the MOH (for example, health financing data were used to further policy dialogue with the Ministry of Finance). The phased implementation of the reforms allowed learning-by-doing, permitting continual analysis of strengths and weaknesses of specific elements of the reform and application of lessons learned to the immediate next phases. The Health Policy Analysis unit produced numerous publicly-available policy briefs and recommendations, most of which were promptly approved and implemented. Evaluation studies of lessons learned under Health II, and under the Manas health reform program as a whole, contributed significantly to the development of the next phase of health reforms.

4. LESSONS FROM HEALTH SECTOR REFORM PROJECTS I AND II

4.1 **The political economy of health sector reform inevitably creates both winners and losers. Early and comprehensive anticipation of stakeholder interests, institutional analysis to facilitate understanding of those interests, and the generation of a coherent plan to build support for reform and to persuade and/or co-opt potential opponents is essential.** Even the most informed risk assessment and management, however, may not always guarantee success; heavily entrenched interests (in this case, those defending the existing structure of tertiary facilities in Bishkek and Osh) may prove extremely difficult to overcome (Paragraphs 2.14-2.15, 3.24-3.29, 3.38).

4.2 **The Bank should not, however, underestimate the potential leverage wielded by its financing and expertise.** The opposition to rationalization of health facilities, for example, was fierce everywhere, but the failure in Bishkek and Osh should not

overshadow the Bank's success in the rest of the Kyrgyz Republic outside those two cities. The Bank's contributions in terms of reform sequencing, technical inputs, and political positioning were instrumental in effecting meaningful hospital rationalization across the country. On other issue areas as well, at several key points during Health I and II, Bank interventions – ranging from the firm but positive persuasion of the President by a Country Manager with considerable expertise in the health sector, to the threatened stick of suspended disbursements and withdrawn IMF support – broke political logjams and moved the reform process forward. On the other hand, the Bank must exercise judgment in deciding when to insist on implementation of the initially agreed-upon reform program, and when instead to be more flexible and accommodating of the political environment. Explicit and early political risk analysis is essential to the effective development of this good judgment (Paragraphs 2.49, 3.29, 3.30, 3.88).

4.3 **One effective mechanism for countering political resistance to reform is strong and consistent M&E, where analytic results can be generated and disseminated rapidly and effectively, building support for project activities in a politically contentious environment.** Positive data and analysis on intermediate project outcomes can generate broad support for further project activities. In this case, the Issyk-Kul region has become a recognized demonstration site whose successes have prompted other regions to accelerate their participation in the reforms (Paragraphs 2.23, 3.100).

4.4 **Another important tool for overcoming political resistance to reform is the cultivation and even creation of civil society organizations** that give health professionals and users of the health care system a voice in the decision process and a clear sense of affiliation and identity. In other words, supporting potential "winners," and creating pathways to transform "losers" into "winners," can be as important as overcoming or sidestepping recalcitrant "losers." The creation in the Kyrgyz case of the Family Group Practice Association and related organizations demonstrates the potential long-term impact of institutional development investments that may at first seem unsustainable or risky (Paragraphs 2.14, 2.27).

4.5 **The complexity of health care systems dictates that reforms be carefully sequenced.** In this case, capacity building in the primary care sector through the family medicine and other primary care reforms was a precondition for hospital rationalization; revenue gains from financing and service delivery reforms made possible the later benefits package and co-payment schemes; and the changes in revenue collection and pooling were necessary prerequisites to the introduction of new purchasing arrangements (Paragraphs 2.7, 2.12, 2.25, 3.55).

4.6 **Tradeoffs between efficiency, equity/access, and quality of care will not be addressed in the absence of explicit and consistent attention to the balance between them and interventions to correct imbalances.** Gains in efficiency do not automatically translate into improvements in equity; in fact, the opposite may be true if there is not sufficient tracking and analysis of inequities. The clear emphasis in Health I and II was on achievements in efficiency; although there were equity and access objectives in both projects, and some evidence to indicate that progress was made in this area, the bulk of the project's major activities and indicators focused on efficiency-related goals. It may be argued, however, that this point illustrates the earlier lesson on

sequencing: given limited public financing for health care, enhanced efficiency may be seen as an essential prerequisite for meaningful efforts toward (and adequate resources for) increased equity and access (Paragraphs 2.34, 2.39).

4.7 **Targeted interventions to improve clinical quality can demonstrably impact health outcomes.** In the Kyrgyz case, the Bank's efforts to improve the quality and use of clinical practice guidelines for high blood pressure have measurably reduced the incidence of heart disease (Paragraph 3.69). While the direct impact of immunization or nutrition interventions, which impact health risks more immediately, may be more easily measured, it is reasonable and should be expected that health systems interventions can similarly affect health outcomes.

4.8 **The presence of a clear sector strategy, authored and wholly owned by the MOH, can play a key role in achieving donor harmonization.** In the Kyrgyz case, the MOH's role as a leader and coordinator of donor activity, in partnership with the Bank, has been central. Longevity and consistency of donor support, along with clear "division of labor" among donors, is also essential in an environment where donor presence is strong. It prevents needless duplication of activity, assigns donors to activities best suited to their comparative advantages, and ensures that there is appropriate donor activity across all issue areas (Paragraphs 2.5, 2.43, 2.47, 2.51, 3.5-3.6, 3.20, 3.76).

4.9 **Improved efficiency may result in the reallocation of public funds to other sectors, reducing the incentives for continued reform.** In the Kyrgyz case, during the second project the government responded to the efficiency gains in the health sector in a classic Soviet manner: if input requirements decline, then public funds should decline. This "stealing" of conserved resources from the health sector diminished enthusiasm for the reforms and reduced the incentive to persist and deepen downsizing efforts. The input-based budgeting process "punished" the health sector for rightsizing health infrastructure and personnel. The introduction of formal co-payments had a similar crowd-out effect on public spending. **It is therefore necessary to negotiate proactively with ministries of finance and legislatures on the disposition of proceeds from efficiency gains** (Paragraphs 3.31, 3.87). The Bank does not always speak with one voice in this area. Some Bank constituencies continue to push for reforms like increased budgetary flexibility for hospitals (including residual claimant status for small extrabudgetary income from user fees), while others stress the importance of strict input controls and of reflecting all revenue sources in the treasury system. It is therefore important to sustain dialogue on this issue within the Bank itself.

4.10 **Some elements of health sector reform can have "spillover" effects, leading to improvements in governance and accountability practices in other sectors.** For example, modernization in the way that drugs are procured has benefits for all public procurement. Donors agree that success in this area has met or surpassed the expectations of all involved; health reforms have begun to improve the overall governance of the country, and the education sector and chamber of accounts have begun (albeit in a preliminary manner) to discuss transitioning to the use of internationally-accepted procedures for procurement, financial management, and audit.

4.11 A variety of lessons from the experience of Health I and II, and the implementation of the Manas I program, were explicitly applied to the development of follow-on activities: the Manas Taalimi health reform program, and the sector-wide approach (SWAp) through which Manas Taalimi is being implemented (box 4.1). These include the need to synchronize the financing base and budget formulation and execution systems with health reforms, so that health providers can retain and allocate funds saved through rationalization of health infrastructure and health budgets can be formed according to output-based formulas; a focus on governance, acknowledging the institutional transformation of the MOH by investing heavily in stewardship functions such as M&E and stressing transparency and accountability in the health sector; a commitment to deepen the rightsizing of the health sector and completing the process of structural reform in Bishkek and Osh cities, where the process remains incomplete; and stress on donor coordination, acknowledging that the highly successful informal collaboration supporting Manas I should be sustained through an explicit, Government-directed Program of Work and through periodic, formal, structured meetings for sector monitoring and donor coordination. The attention to transparency is particularly important given the acknowledged extent of corruption in the public sector; the follow-on activities put special emphasis on disclosure and transparency and on strengthened complaint handing mechanisms coupled with specific remedial measures.

Box 4.1: Manas Taalimi Health Reform Program

The Manas Taalimi Health Reform Program was developed in 2005 by the MOH as a successor to the Manas strategy. It is an extension of the health goals embedded in the 2002 National Poverty Reduction Strategy and Comprehensive Development Framework. The objective of the Manas Taalimi program is, broadly, to "improve health status through the creation of an effective, comprehensive, and integrated delivery system of individual and public health services, and through increased responsibility of every citizen, family, society, and public administration bodies for the health of each person and for society as a whole." It explicitly aims to institutionalize the reforms initiated under Manas I and to strengthen the parts of the health care system that were relatively less emphasized under the earlier strategy.[a] In particular, it seeks to strengthen the targeting of resources and interventions at groups with worse health outcomes, including MDG outcomes; implement structural improvements in the public health and health promotion systems; enhance capacity in the MOH and other relevant institutions in policy formulation, priority setting, policy-based budget planning, and monitoring and evaluation; and strengthen quality of care with a focus on priority health problems including maternal and child health, cardiovascular disease, respiratory illnesses, HIV/AIDS, and TB.

Manas Taalimi was developed and refined in an open and transparent manner through extensive stakeholder consultation, including town hall meetings throughout the country, consultations with senior government officials, and numerous formal and informal consultations with health sector donors – although it should be stressed that the core strategy and Program of Work were developed by the Government through a genuinely indigenous process. The Government gave extended leave to fifteen key health specialists from the MOH, MOF, MHIF, SES, and other institutions to work on the strategy, providing re-entry guarantees to their original posts once the strategy was finished. The preparation of Manas Taalimi thus overcame any accumulated negative experience and mistrust, evolving not only a consensus-based technical process, but also a process in which the players knew and understood one another's personalities, institutional constraints, and motivations.

a. The name "Manas Taalimi" is significant: Manas is the Kyrgyz national hero, and it was considered desirable to keep that name for the sake of continuity with the prior health reform program. "Taalimi" is an ancient Kyrgyz word signifying a vast sense of heritage and legacy. The name Manas Taalimi therefore stresses the extent to which this reform program is explicitly based on the lessons learned from Manas I.

PART II: EVALUATION QUESTIONS

5. HEALTH OUTCOMES AMONG THE POOR

5.1 The Kyrgyz Republic is a predominantly agrarian society, with two-thirds of its population living in rural areas even though the agricultural sector contributes only modestly to the national economy. Income per capita was US$ 450 in 2005, placing it second to lowest in the Europe and Central Asia region (ECA), just above Tajikistan. Estimated poverty in 2005 was 43.1 percent of the population, with extreme poverty – those whose consumption was inadequate to meet even food needs – was 11.1 percent. Poverty is largely, though not exclusively, a rural phenomenon; the incidence of poverty is higher in rural areas (51 percent of the rural population) than in urban areas (30 percent of the urban population). About three out of every four people in poverty lives in a rural area, and extreme poverty is twice as high in rural (14 percent) as in urban (7 percent) areas. Inequality as measured by the Gini coefficient was high in 2005, 0.28, which is better than in many parts of ECA. Regional poverty rates are polarized, with the regions of Batken, Issyk-Kul, Jalal-Abad, Osh, and Naryn experiencing poverty rates in excess of 50 percent, while Bishkek's and Chui's poverty rates are 11 percent and 22 percent respectively (Talas falls in between at 44 percent) (World Bank, 2007b).

5.2 The economy grew moderately by 3.7 percent annually from 2000-2005. Concurrently, poverty fell from about 63 to 43 percent of the population, and extreme poverty fell from about 33 to 11 percent. This high rate of poverty reduction was accompanied by improvements in inequality and a rise in per capita consumption among the poor (World Bank, 2007b).

5.3 Overall, while Health I and II improved the efficiency of the health care system, which could be interpreted as a necessary precondition for availability of funds to support increased access to resources for the poor and equity in distribution of resources, **the Bank's interventions achieved mixed success in redistributing funds in favor of the poor or addressing the needs of the poor.** Neither project specifically tracked health outcomes among the poor.

5.4 Specific achievements that benefited the poor included the following: primary care was strengthened, broadened, and made more widely available, with documented achievements in the relative access to care of poorer versus richer populations; the introduction of co-payments made more predictable (and in some cases lowered) the burden of out-of-pocket payments, although much of the evidence in this area is essentially neutral with respect to access of the poor; and the out-patient drug package made prescription drugs more widely affordable and accessible. Although entitlements were clarified through the State Guaranteed Benefit Package, the deficit of public funding for the health sector meant that these benefits were not universally implemented. Previously fragmented pooling arrangements were centralized, enhancing opportunities for efficiency and cross-subsidization, although again, it is not clear that this actually occurred to the benefit of the poor. **It is reasonable to speculate that, even in cases where the reforms resulted in outcomes that were essentially neutral in terms of their impact on the poor, the reforms prevented access to health care for the poor**

from becoming significantly worse in a context of declining public financing for health care.

5.5 **While Health II cited the poor, and specifically the rural poor, as the intended beneficiaries of the more equitable distribution of health care resources from the relatively rich and over-serviced Bishkek to the oblasts and of the expansion of primary health care/family medicine centers in poor rural areas, this redistribution did not occur.** Inequities persist; for example, in early 2005, while the number of registered citizens per FGP physician was 1500, in rural areas there remained a shortage, with the number of citizens per FGP in some areas reaching 10-12,000 persons (Atun, 2005).

5.6 The State Guaranteed Benefits Package included provisions for the poorest of the poor. Hospitals established reserve funds to subsidize co-payments for the very poor that are uninsured and not covered by any of the exemption categories; these funds were financed by setting aside ten percent of all co-payments (Jakab and Manjieva, 2007). From March through December 2001, about four percent of patients in the Chui and Issyk-Kul regions were given care through these reserve funds, but there is no ongoing systematic monitoring of the functioning and impact of this mechanism.

5.7 According to Atun (2005), the median distance from patients' homes to a primary health care facility is 1-2 kilometers. While this is a positive indicator of overall access, it does not address the specific situation of the poor. For most patients (73 percent), the travel time to the nearest health facility is less than 30 minutes (Jakab and Manjieva, 2007). The majority of patients walk to health facilities, with only one in three incurring travel expenses in order to access health care; if it is assumed that poorer people make up the bulk of the 27 percent whose travel time to the nearest health facility is over 30 minutes, and if those patients are walking to health facilities, then clearly the poor continue to suffer a significant physical barrier to access.

5.8 Since independence from the Soviet Union about one-third of the population of the country has migrated, primarily to the capital; by 2004, 26 new districts had been created around Bishkek to accommodate these population movements, serving (according to various estimates) between 80,000 and 300,000 people, and creating a new class of urban poor (WHO/DfID, undated (d)). Surveys of the residents of these development districts indicate that, in addition to general problems of access to health care, these people have limited access to ambulance services and inadequate enrollment mechanisms for FGPs.

5.9 Under Manas Taalimi, inequities in access to care, specifically the targeting of resources and interventions at groups with worse health outcomes, have received particular attention as part of a deliberate effort to strengthen parts of the health system that were earlier relatively less emphasized. New health budget mechanisms have been created to redress inequalities in geographic and financial access. Correction coefficients that account for differences in age, gender, population structure, climatic characteristics, remoteness from administrative centers, and terrain are being introduced. In contrast to a budgetary strategy that simply reallocates existing money between regions – which was judged to be managerially feasible and politically palatable – the newly-adopted strategy

not only promotes equity in the allocation of resources but also directly targets remote, rural areas of the country that are predominantly poor. The national pooling of health care financing, begun in 2006, has strengthened the country's capacity to cross-subsidize health services for the poor and vulnerable and to distribute resources according to an appropriately weighted and nationally applicable per capita formula. In addition, as public financing for health care increases under Manas Taalimi, it is envisioned that there will be a shift away from the burden of out-of-pocket payments for health care. The Manas Taalimi Mid-Term Review demonstrates success in this area, with out-of-pocket expenditures declining from 7.1 percent of the annual household budget in 2004 to 4.9 percent in 2006 for the poorest income quintile, and from 5.5 to 4.2 percent for the second poorest quintile (MOH, 2008).

5.10 The Bank's follow-on project to support Manas Taalimi contains a component explicitly intended to enable the social protection and health systems to more effectively target assistance and subsidies to poor or disadvantaged households. It streamlines coordination between the health and social protection systems by clarifying (through the social protection system) those households eligible for reduced co-payments when they need health care. It also supports efforts to consolidate and restructure cash social assistance benefits, specify eligibility conditions for benefits, and build a more efficient administrative system for implementing benefits.

6. SECTOR-WIDE APPROACH (SWAP)

6.1 **From the outset, it was envisaged that the Manas Taalimi program would be implemented through a SWAp, defined as a comprehensive approach to sector development.** The SWAp in the Kyrgyz health sector context was defined as having four core elements:

- a government-led process to define the vision for the health sector in the form of an explicit health sector strategy with clear goals, priority interventions, and costs;
- a medium-term budget framework (MTBF) to program annual spending with mechanisms to ensure that annual budgets will correspond to the MTBF, and that budgetary execution matches agreed commitments;
- a joint sector performance monitoring and evaluation system integrated with the monitoring and evaluation framework of the MTBF as well as of the National Poverty Reduction Strategy; and
- a formalized government-led aid coordination mechanism, with the MOH responsible for overall coordination of international partners' contributions to the program and for setting up a system of regular meetings, forum for discussion/negotiations, and joint review meetings.

6.2 **The expectations for the SWAp** include improved quality of delivered health care, targeted at strategic priorities; increased efficiency in the use of health care resources; increased fiduciary standards; increased institutional capacity; and improved health outcomes, although it is recognized that health outcomes change slowly and in response to many factors in addition to the quality and availability of health care. While the first two goals – improved quality and efficiency of health care – most likely would

have continued to evolve under a third "traditional" Bank-financed health project, the expectation of the SWAp is that the fiduciary and institutional capacity building, including open and transparent procurement, will be the most significant development.[11]

6.3 **The genesis of the health sector SWAp lay largely in the fact that many of its elements had already been in place for years.** The government-developed Manas sector strategy dates to 1996, and strong donor coordination and policy consistency were longstanding. Nonetheless, the SWAp approach in the health sector was controversial when it was first introduced in 2004, with several players concerned about the level of corruption in the country and its lack of overall institutional development. **The Bank team was instrumental in encouraging other players to move forward, in particular convincing them that the SWAp was an effective instrument for building institutional capacity and for facilitating meaningful donor impact.** On the second day of its initial project identification mission in late 2004, the Bank held a dinner for over fifty representatives of fifteen donors and agencies, an indication of the Bank's early commitment to generating broad support for the sector-wide approach.

6.4 **World Bank involvement:** In spite of the considerable progress in health reform and major gains in the efficiency of health sector performance over the previous decade, in 2005-2006 the Kyrgyz Republic remained a poor country with weak health indicators and a continued need for investment and reform in the sector. There was significant rationale for continued Bank involvement: the Bank's long experience in the country and the sector, its successful record of supporting health reform, its experience with sector-wide approaches in other countries, and its ability to draw connections across multiple sectors and reform areas, including health, public financial management, civil service reform, and fiduciary functions, that are of particular relevance when moving toward a sector-wide approach.

6.5 The Bank therefore began preparation in late 2004 of a **US$15 million, five-year Health and Social Protection Project (HSPP)** as a follow-on to Health I and II. Effective on March 1, 2006 and scheduled to close on June 30, 2010, it is a Specific Investment Loan (SIL). Its objectives are: (1) to improve health status by improving access, financial protection, efficiency, equity, and fiduciary performance in the health sector; (2) to ensure sufficient and reliable financing for the health sector; and (3) to strengthen the targeting of social benefits by developing effective administration and information management systems to improve access to social services in general. The project contains two components: (i) US$13 million to support implementation of the Manas Taalimi Health Reform Program through a Sector-Wide Approach (SWAp); and (ii) US$2 million to strengthen the administrative system of the Ministry of Labor and Social Protection, to help implement policy reforms and strengthen administration systems to enable the social protection and health systems to target more effectively assistance and subsidies to poor or disadvantaged households.

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[11] Privately, MOH and MOF officials concede that the requirement to follow Bank-specified procurement and financial management standards is welcome in that it insulates them from corruption; they can rebuff proposals to skirt procurement procedures by citing the need for strict adherence to Bank rules.

6.6 **Specific anticipated health outcomes** include improvements in life expectancy, the infant and under-five mortality rates, the maternal mortality rate, TB incidence and mortality rates, and the cardio-vascular disease mortality rate, all with baselines and specific annual target values specified, and outputs expected to lead to those outcomes delineated in an explicit results chain.

6.7 **Other donors:** In addition to the HSPP, a Kreditanstalt für Wiederaufbau (KfW) Grant of €14 million, a DfID grant of £7 million, and further financing from the Swiss Agency for Development and Cooperation (SDC) and the Swedish Agency for International Development (Sida) contribute to pooled financing for the SWAp.[12] Together, donor funding now constitutes 20-25 percent of the total health budget. Even donors who are not contributing pooled funds (most significantly, USAID) are participating in the strategy. The pooled funds finance a share of MOH's annual development plans under Manas Taalimi and, separately, efforts to strengthen information systems in the Ministry of Labor and Social Protection.

6.8 **Tools and mechanisms of the SWAp:** Expenditures for the health sector and contributions to Manas Taalimi are not defined in detail *ex ante* as in a traditional World Bank investment operation, but IDA grant funds flow through Treasury to the budget and then MOH to finance a share of the combined Government of Kyrgyzstan and external assistance budgets for the Manas Taalimi Program. In other words, there is no ring-fencing of pooled donor funds. The basis for decisions on the level of distribution of funds is provided by the Manas Taalimi Program of Work;[13] detailed annual work programs, budgets, and procurement plans; progress against agreed sector monitoring indicators, including budget targets; and results of biannual "Health Summits" at which all of these factors are discussed by Government and health donors. The Bank's annual contribution is approved in November of each year by the Country Director, based on recommendations of the Bank team resulting from discussions with the Government, development partners, and other key stakeholders.

6.9 Three mechanisms of coordination govern the process of donor coordination supporting Manas Taalimi: the twice-yearly Health Summits, one in May and one in September, intended to review progress and develop Programs of Work for successive years; memoranda of support and understanding, the latter among the joint financiers and the Government, specifying issues of special relevance to the pooled funds (institutional arrangements, fiduciary arrangements and capacity building requirements, assessment and monitoring provisions, disbursement arrangements, information-sharing and conflict resolution expectations, and arrangements for adding new partners during implementation); and joint supervision arrangements, including regular joint supervision missions and coordination of policy dialogue.

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[12] The pooled contributions from DfID, SDC, and Sida are channeled through the World Bank (using trust funds), while those of KfW are channeled separately. All disbursements, however, including KfW's, are subject to the Bank's approval, ensuring a coherent and harmonized approach.

[13] The Program of Work encompasses eight themes/sections: population involvement, health financing, individual health services, public health, priority programs, evidence-based medicine, stewardship, and human resources.

6.10 Overall policy oversight and project steering is the responsibility of a new Inter-ministerial Coordination Committee (IMCC), chaired by the Minister of Health, that focuses on the coordination of activities and harmonization across ministries and sectors, and the already existing Health Policy Council, serving as the forum for implementation coordination. Within the Health Policy Council, two sub-committees have been formed: an internal Reform Implementation Coordinating Committee (RICC) for internal MOH coordination, and an external health sector RICC for external dialogue and coordination. The MOH and its Department of Strategic Planning and Reform Implementation hold responsibility for program management and day-to-day implementation, with a 64-person staff tasked explicitly to implementation of Manas Taalimi.

6.11 **M&E has been rigorously designed and implemented to date.** The evolution of M&E capacity developed under the Manas program built an appetite for information and policy analysis on the part of policy makers. It also developed the capacity of health sector staff to collect, analyze and interpret data, and it made vital contributions to policy development and eventually to the development of the Manas Taalimi program itself. Building on the monitoring codebook developed under Manas and Health I, the MOH and the Health Policy Analysis Project team, in consultation with donors and other stakeholders, developed a package of M&E indicators for Manas Taalimi. A ministerial decree formally identified these indicators and defined the institutional arrangements and frequency of collection of data; subsequent Health Summits have confirmed the validity of the indicators and of the M&E arrangements. There are three sets of indicators: a panel of "dashboard" indicators for broad sector monitoring and for the attention of high-level policy makers and donor agencies; performance/outcome indicators corresponding to the goals and objectives of the Manas Taalimi strategy (health status, access and equity in access, financial protection, quality of care, efficiency, and responsiveness/ transparency); and implementation progress indicators, covering inputs, processes, and outputs, corresponding to the Manas Taalimi components (population and community involvement, health care financing, service delivery, and stewardship). Most of these indicators are collected on a cycle intended to inform the biannual Health Summits. The institutional arrangements for M&E are intended gradually to absorb the Health Policy Analysis Project's functions into the core MOH; in the meantime, the HPAP continues to conduct and disseminate extensive analysis of collected data.

6.12 **One of the key risks identified early in the design of the SWAp was financial management.** Implementation responsibility for financial management tasks lies with the Deputy Minister of Health/General Director of the MHIF and the Economics and Finance Department of the MOH. A comprehensive Health Sector Fiduciary Assessment (HSFA) for the SWAp was conducted in mid-2005, intended to assess and mitigate risks associated with the use of Bank funds, and to facilitate a common understanding by the Bank, Government, and donors of the fiduciary risks attached to the financial management and procurement arrangements of the project in order that appropriate capacity-building programs could be designed and implemented. The HSFA found that financial management capacity across health sector institutions was weak, mirroring weakness in public sector financial management across the country, and therefore a comprehensive risk mitigation framework, including an immediate action plan and longer-term capacity building measures, was developed. It has been acknowledged that a significant amount of financial capacity building is necessary, and therefore from

inception it has been planned to strengthen and integrate functions into the Economics and Finance Department over time. Also, due to weak capacity, the Bank had not in the past placed any reliance on audits performed by the Chamber of Accounts (CA), the Supreme Audit Institution; the Manas Taalimi is audited annually by the Chamber of Accounts, but there is also a twinning program between the CA and experienced auditors. Experienced auditors also perform an annual Operational Review of the program focusing on key areas of fiduciary risk.

6.13 This overall implementation arrangement – high-level policy coordination under the Minister of Health, fiduciary/procurement functions gradually integrated into the MOH, and technical decisions taken in each of the Ministry's own technical units – is seen as an appropriate evolution from the PIU/TCU model used in Health II. While the PIU's performance during Health II was strong, it was felt that the MOH was too often aloof from the reform process. The MOH's position as the implementing agency was intended to cement its sense of ownership and its consequent development of institutional and human resource capacity.

6.14 **Another key risk was whether the MOH would both sustain ownership of the Manas Taalimi reform program and make the "right" policy and investment choices.** A decision was taken to build capacity-building tasks into the SWAp itself, rather than waiting until the capacity was in place before implementing the pooled arrangements. Because of the significant preliminary progress already made on fiduciary reform, it was felt that this would be a successful strategy. For example, the MOH initially had limited capability to process and disburse funds, now that the PIU and its staff are gone. The ministry staff is handling the processing of the program's activities, and they are gradually becoming more knowledgeable about the sector. Because assistance under Manas I came from various donors, it was difficult for the MOH to see the "big picture" of the entire health reform situation. Now MOH staff are receiving special training at a WHO-run Health Management Institute so that they know how to program resources coming from various donors, and financial specialists in the MOH work side by side with technical specialists actually implementing programs, so that the MOH as a whole has learned to take into account the entire resource envelope in the sector: what are the resources available, where to get those resources, who the major players are, and what are the priorities. Similarly, during the first year of the SWAp, the MOH exhibited the traditional reluctance to spend money on technical assistance and training; after just one year of implementation, however, the MOH realized that budgets should be programmed based not on what it wants to buy, but what objectives it wants to achieve – and it is spending around 15 percent of its procurement budget on technical assistance. Rather than deciding the correct approach in this and other cases on behalf of Government, the donors' role has now transitioned to one of continuous engagement, dialogue, and persuasion, with the expectation – fulfilled in this case -- that the Government will eventually mature to make the "right" decision. The MOH is no longer a passive beneficiary of external aid.

6.15 The past year of implementation has constituted a significant turning point, where the MOH and MOF have realized that their goal is not simply to satisfy donors, but also to satisfy broad development objectives. Capacity is being pushed down, from the ministerial/deputy ministerial level to the department heads and below; as this process

develops, the prospects for sustainability no longer lie in the hands of just a few champions, but instead in personnel and institutional capacity across the MOH. In the words of one interview respondent, the institutional transformation of the MOH cannot be overstated. The MOH and MOF now work collaboratively, and they co-chair the biannual Health Summits, while donors are rapidly transitioning from a supervisory to an advisory role.

6.16 This "push-down" of capacity also applies to the center-region relationship. Whereas the MOH under Manas I would instruct the regions on reform measures in a top-down manner, now it increasingly transmits objectives to work teams at the oblast and rayon levels, offering only broad guidance as the work teams figure out how to meet those objectives.

6.17 **A third risk was whether budget financing would meet the health sector's priority needs**, a legitimate question given the steady decline in budget financing for health care throughout Health I and II. During SWAp preparation, the Government expressed a commitment to increasing health spending, and in particular it recognized the need to compensate for the decreases in public expenditures on health since the late 1990s. The National Poverty Reduction Strategy and Comprehensive Development Framework set a target for health spending of 3.6 percent of GDP by 2010, with interpolated intermediate targets for 2006-2009. These targets were incorporated into the Government's 2006-2008 Medium-Term Budget Framework (MTBF). Similarly, public spending on health as a percentage of total government spending was pledged to increase incrementally from 10.3 percent in 2005 to 13 percent by 2010, with explicit annual intermediate targets (Table 6.1).

Table 6.1: Health Spending, 2005-2010 (projected)

	2005	2006	2007 (projected)	2008 (projected)	2009 (projected)	2010 (projected)
GDP (billions of soms)	101.4	111.5	124.7	137.1	150.8	165.9
State budget spending on health, including investment from domestic sources (billions of soms)	21.3	22.3	23.8	26.2	28.8	31.7
Health spending as percent of GDP	2.2	2.1	2.1	2.3	2.4	2.5
Health spending as percent of state spending, recurrent plus investments from domestic sources	10.3	10.6	11.2	11.8	12.4	13
SWAp Pool: recurrent spending (millions US$)	NA	5.0	8.0	9.0	7.0	3.0
SWAp Pool: recurrent spending (billions of soms)	NA	0.20	0.32	0.36	0.28	0.12
Health spending: state budget plus SWAp pool (percentage of GDP)		2.6	3.0	3.5	3.9	4.2
Health spending as percent of state budget (SWAp + Government recurrent)		11.5	12.5	13.2	13.4	13.4

Source: World Bank (2005), p. 103

6.18 Donors, during development of the SWAp, expressed willingness to provide recurrent financing to bridge gaps, but only to the extent that the Government would make a good-faith effort to increase its own health spending to the anticipated levels. This leverage – which is significant, given the magnitude of donor financing compared to the overall size of the health budget – is thought to ensure increased budgetary allocations to health that might not have occurred in the absence of the sector-wide approach. The Ministry of Finance has made it clear that, although meeting this goal will be a challenge as the budget grows, it is absolutely committed to compliance with these arrangements – and **so far, this has been the case, with the Bank never having to entreat the MOF to meet these commitments.** The MOF is clear about its interest in the success of Manas Taalimi: it has invested significant funding into the strategy, and it wants results to emerge. This stability permits the MOH and MHIF to focus on managing funds properly, rather than worrying about whether funds will be available; it also provides an incentive for providers to enter contracts with the MHIF without fear of payment delays.

6.19 **The May 2008 Mid-Term Review of the SWAp indicates that it has achieved strong and sustained progress toward meetings its targets on financial protection, access, efficiency, and transparency, with mixed results in the achievements of goals for health outcomes and quality of care (MOH, 2008). The SWAp appears successfully to be simultaneously focusing on the sector-wide approach itself as well as on health inputs and outputs.** Some key analytic lessons have emerged:

6.20 **The Bank's success emerges as much from its efforts at supervision as from project or strategy design.** In a weak institutional environment, a significant investment in supervision missions, "Health Summits," and other efforts carries the potential for substantial payoff. High transaction costs (and a high supervision coefficient) characterize the Kyrgyz HSPP, with large amounts of staff time necessary for communication and coordination with other donors, procurement, financial management, and general supervision. It is still too soon to assess whether the potential for payoff has been realized on this specific issue.

6.21 **Some valuable programs that were funded under a project approach will inevitably undergo changes when the MOH is free to define priorities independently – and this is to be expected.** The Family Group Practice Association and Accreditation Commission, for example, now receive reduced funding under the SWAp and are more dependent on USAID funds (training is now provided at state per diem rates, for example, rather than the higher rates available from the Bank and other donors). This decision would probably not have been made under a Bank-financed third project, but the MOH has determined that these associations should further develop as self-financing and independent entities. The shift in priorities and procedures from the project to the SWAp approach, however, can lead to dissent and misunderstandings among those whose situations change. The FGPA and Hospital Association, for example, are concerned about what they see as a lack of transparency under the SWAp compared to what they observed under the Bank-sponsored projects. One observer uses a horse-race metaphor: continuing education for family doctors was started rapidly, but then ground to a halt before it got to the "home stretch." Family physicians did not get the needed follow-up through traditional methods of training, and other possible models – distance learning, for example – have not yet matured.

6.22 **Stability remains a challenge; with frequent changes in MOH personnel, up to the ministerial level, it is important that this volatility not impact the capacity to harness the lessons of prior experience and the development of institutional memory.** The structure of the SWAp in some ways enhances the human resources challenge; with a traditional project format, the Bank can pay higher salaries to staff of the PIU in order to retain them as their increased skills make them more marketable. Under the SWAp, MOH personnel are state employees governed by civil service pay structures, and the temptation is great for these people – accountants, procurement officers – to leave for the private sector as their skills are enhanced. The Bank continues to engage government officials in discussions about exceptions to civil service compensation rules, but this remains a difficult issue.

6.23 **Process and results can be sustained as dual, rather than competing, priorities.** This is largely achieved through the intensive supervision and strong donor coordination already discussed (process), as well as the thorough, comprehensive monitoring and evaluation arrangements in place (results).

6.24 **Coordination of such a large number of active donors, with Government and with one another, is a labor intensive process, and in the Kyrgyz Republic only the Bank has the capacity to play that role.** While the Government continues to develop its considerable capacity to coordinate donor activity, the Bank has been the key facilitator of the genesis and implementation of the SWAp. Because of that "first among equals" role, there is little risk that the Bank's impact will be diluted as all the players act in unison.

7. SUPPORT FOR COMMUNICABLE-DISEASE PROGRAMS

7.1 Over the ten years of Health I and II, the Bank has supported both subcomponents within health projects, and more recently free-standing projects, supporting communicable disease control (Table 7.1). Many of the supervision missions for Health I and II also focused on communicable disease programs, particularly the Central Asia AIDS Project and the National Strategy on TB/HIV/AIDS in prisons. One early 2002 mission resulted in the production of a discussion paper, co-authored by Health II's TTL and other Bank staff, titled "Tuberculosis and HIV/AIDS in the Prisons of the Republic of Kyrgyzstan: Tackling the Growing Public Health Problems." This mission resulted in a letter to the Minister of Health expressing concern about the situation of TB/AIDS in prisons and the release of TB-infected prisoners, fueling the epidemic, and the inadequate follow-up by the TB control system at large. Subsequent Bank missions continued to work with MOH on the development of an action plan to prepare for 2003 Global Fund grant funding to control the country's HIV/AIDS and TB epidemics.

Table 7.1: Bank Support for Communicable Disease Control in Kyrgyz Republic

Project	Date	Amount
Health I, subcomponent on TB control: reduction of risk of TB transmission; reduction of TB morbidity and mortality; institution of policy reforms and improved program management to achieve greater efficiency and effectiveness of TB activities.	June 1996 – September 2002	US$1.5 million of total project cost
Health I, subcomponent on strengthening women's reproductive health management: new methods and protocols of treatment to permit expanded ambulatory care of STIs and to reduce complications of STIs among pregnant women (subcomponent included other activities not related to communicable disease).	June 1996 – September 2002	US$1.8 million of total project cost
Central Asia AIDS Control Project (CAAP): regional capacity building and grants to civil society, with an emphasis on prevention among vulnerable populations. Explicitly designed to complement current public sector activity, working with non-traditional groups to fill gaps in government programs. Also includes Kazakhstan, Tajikistan, and Uzbekistan.	March 2005 – December 2010	US$25 million
Avian Influenza Control and Human Pandemic Preparedness and Response project, with a component on human health intended to implement Highly Pathogenic Avian Influenza (HPIA) prevention, preparedness and planning, response, and containment activities in the human health sector specific to the needs of the Kyrgyz Republic.	February 2006 – December 2010	US$4.24 million

7.2 **The rationale for targeting these communicable diseases in the Kyrgyz Republic was not that their absolute levels were considered to be high, but that their levels were increasing at a rate that was perceived to be a potential threat.** This was particularly true for HIV/AIDS, where there are just 4,000 people estimated to be living with HIV and fewer than 100 recorded deaths due to AIDS, but a high perceived prevalence of risk behavior.

7.3 **Alternative project designs (free-standing projects versus components of larger health reform projects) were considered for some of the interventions on communicable diseases, but not for others.** The TB and STI interventions were always envisioned as a component of Health I, with no consideration of other models. Health I took a deliberately systemic approach aiming to change clinical protocols and the regulatory, payment, and management structures underlying inefficient resource use, rather than a vertical approach targeting specific clinical programs alone. This choice was driven by institutional analysis and observation of international experience suggesting poor sustainability of improvements to specific programs in the absence of accompanying changes in the system-wide incentives that resulted in inefficient resource allocation in the first place.

7.4 For the CAAP, which covers four countries, project designers considered individual national free-standing projects, but rejected this option on the assumption that national actions are strengthened by a coordinated regional response that, acknowledging the global public goods nature of prevention and control of HIV/AIDS and the indivisibility of benefits, shares best practices and increases solidarity among countries to stop the epidemic. Embedding HIV/AIDS control in a larger health reform project was not considered. For avian influenza control, the restructuring of one or more ongoing projects and injection of additional financing for influenza was considered; this alternative was rejected based on the importance of the issue and the need to scale up the

response at the country level, requiring a clear focus, preparation of a multi-sectoral national plan, and impetus to facilitate the implementation of the necessary priority activities. It was decided that this could not be effectively achieved under the umbrella of a restructured ongoing project. There were also concerns that restructuring ongoing projects and diverting funds to other uses might endanger the achievement of those projects' original development objectives.

7.5 **HIV/AIDS and avian influenza support are parallel to the ongoing HSPP, not pooled with it.** The overlap between the HIV/AIDS project and the HSPP lies primarily in epidemiological surveillance. In order to minimize overlap and maximize appropriate use of resources, a Memorandum of Understanding defines activities and facilitates efficient allocation of resources. It is recognized that the system remains fragmented. For HIV/AIDS, for example, the funding from the Global Fund and other donors on infectious disease flows directly into the Ministry of Finance, rather than being integrated with MOH efforts. Coordination between health reform programs and vertical disease programs is perceived to be better in the Kyrgyz Republic than in most other countries, however, largely because of overlapping institutions and personnel: the PMU for the HSPP is supporting the CAAP, and the current manager for the CAAP is a former Kyrgyz minister of health, one of the original champions of the Manas reform program, with a strong network of connections in the health sector and continued respect throughout.

7.6 **The Manas Taalimi strategy, and therefore the HSPP, includes a central focus on five priority programs, two of which involve communicable disease**: maternal and child health, tuberculosis, HIV/AIDS, cardiovascular disease, and micronutrient deficiency prevention and control. Importantly, emphasis is placed not only on strengthening these communicable disease programs, but also on integrating them with the individual health care delivery system. Explicit plans in this regard have included expansion of the functional responsibilities of family doctors and nurses, provision of health organizations and personnel with appropriate equipment and drugs, modules on reproductive health in the training programs for family doctors and nurses, coordination of preventive activities between family medicine centers and units of the SES, further involvement of the population, communities, local self-governance authorities, and NGOs in order to improve the health culture, and the integration of priority program monitoring indicators into the existing medical statistical reporting system. Health Summits have applauded efforts to integrate priority programs into the mainstream health care system, with no new single-profile structures or institutions having been developed, and integration of many activities into primary health care.

7.7 **Other than TB, it is still too early to assess the efficacy and efficiency of the Bank's interventions on communicable disease.** The Bank's interventions on TB appear to have helped reduce incidence, stabilize mortality, and improve treatment outcomes (as discussed earlier); no specific analysis has been conducted to assess impact on TB among the poor. The institutional arrangement, with TB control consistently integrated with the primary health care delivery system, is seen to be appropriate and efficient.

7.8 **Coordination with other donors on HIV/AIDS control presents a significant risk to the CAAP.** A large number of other donors are involved in HIV/AIDS control in the Kyrgyz Republic and the other three countries, including co-financing (US$1.9 million) from DfID for the CAAP. While the project is intended to further development of a regional partnership between Governments, NGOs, the private sector, and international partner organizations, it is recognized that these stakeholders have interests that do not always coincide. This risk is mitigated through a deliberate effort to unify different coordination mechanisms, including in the context of the UN Theme Group, and through the Technical Groups that prepared and are implementing the project.

8. VALUE ADDED OF THE WORLD BANK

8.1 It is universally acknowledged among the donors active in the health sector that the World Bank plays the lead role among them, and that this arrangement has been quite satisfactory to all involved and quite successful.[14] It was initially planned that donors would rotate responsibility for playing the lead role, but fairly quickly it was realized that the Bank was the only agency with the local capacity to do so effectively[15] – although it is also acknowledged that the Bank frequently accedes leadership responsibility to other donors in specific situations, when appropriate. The Bank has been key in mediating conflicts among donors, particularly those related to donors' varying institutional cultures and differing tolerance of risk.

8.2 The Bank was also instrumental in keeping reform not merely afloat, but squarely on the political agenda, in the face of strong opposition at many key decision points. The Bank was the only donor with the credibility and leverage to do so. It not only lent crucial general political support to the Kyrgyz "champions" of reform; it also intervened in key specific instances to ensure that squabbles over implementation details did not derail the entire reform process. For example, the Bank's efforts to prevent the efficiency gains accrued from health sector reform to be allocated to other sectors, rather than reinvested in the health sector, established an important priority and principle of public expenditure management.

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[14] It is telling that two separate interview respondents representing other donors, when asked about Bank activities, answered questions consistently in the first person plural. This verbiage reveals the extent to which there is genuine teamwork among donors in this environment.

[15] One limitation frequently mentioned is the fact that the TTL for the HSPP is based not in Bishkek, the Kyrgyz capital, but instead in Almaty, Kazakhstan. Some donors speculate that this TTL is not able to exchange information and plan day-to-day operations in collaboration with other donors as effectively as he might, were he based in Bishkek. The Bank strategically and deliberately located the TTL several hours' drive away, however, in order to facilitate the development of capacity within the MOH; if the TTL is not physically present to solve each and every immediate challenge, then the MOH by definition will adapt to the situation and grow this capacity on its own. It is also important to note that the Bank has an extremely capable and experienced local health specialist stationed in Bishkek; this specialist provides day-to-day support to MOH, MOF, donors, and other stakeholders, mitigating the impact of having a more distant TTL.

8.3 Although the Manas and Manas Taalimi programs were conceived and shaped largely by the Government itself, the Bank (together with WHO and other donors) played a critical role in working out key implementation details and, most importantly, the correct sequencing of reform. The incentive structures and resulting efficiency gains established in Health I were an essential prerequisite to the benefits packages and purchasing arrangements under Health II.

8.4 Perhaps most significantly for sustainability of the project's benefits and outcomes, the Bank has played a key role in developing institutional capacity at the MOH. Through the joint implementation of project activities and Bank-sponsored technical assistance, there has been a steady learning curve traceable from Health I through the SWAp, during which the MOH has made the transition from a Soviet-era relic to the most modern MOH in the post-Soviet environment. This remarkable evolution is directly attributable to the Bank's consistent and effective supervision across the spectrum of health sector reform, public sector management, and fiduciary management. Furthermore, the Bank continues to offer critical support to the MOH and health sector as its fiduciary and other management practices establish new benchmarks of performance for the public sector as a whole.

8.5 In the absence of the Bank, it is likely that the Kyrgyz Republic would have moved forward with health sector reforms, given the Government's commitment and the support from other donors. Without Bank resources, convening power, and technical assistance, however, there would have been more geographically and institutionally limited progress in restructuring of the health sector; with less efficient use of available resources, there would have been even less progress in improvements in access to health care for the entire population, including the poor. Thus, it is likely that health outcomes would have been worse minus Bank support. Further, health reform efforts would have had a substantially lower probability of surviving multiple political assaults. The MOH would not have undergone such a substantial institutional transformation, making it unlikely that the sector-wide approach would have been adopted.

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Annex A. Basic Data Sheet

HEALTH SECTOR REFORM (CREDIT 2860-KG)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	20.1	17.04	84.7
Loan amount	18.5	15.89	85.8
Cofinancing[a]	1.6	1.15	93.7
Cancellation		1.37	

a. Government's contributions

Cumulative Estimated and Actual Disbursements

	FY97	*FY98*	*FY99*	*FY00*	*FY01*	*FY02*
Appraisal estimate (US$M)	1.0	5.0	11.0	16.0	18.5	
Actual (US$M)	1.03	9.48	12.34	15.4	15.88	15.9
Actual as % of appraisal	103	189.6	112.1	96.2	85.8	

Project Dates

	Original	*Actual*
Initiating memorandum	04/15/1994	04/15/1994
Negotiations	03/21/1996	03/21/1996
Board approval	05/14/1996	05/14/1996
Signing	06/13/1996	06/13/1996
Effectiveness	06/01/1996	06/01/1996
Closing date	06/01/2002	09/01/2002

Staff Inputs[a] (staff weeks)

	FY95	*FY96*	*FY97*	*FY98*	*FY99*	*FY00*	*FY01*	*FY02*	*Total*
Preappraisal	NA								
Appraisal		NA							
Negotiations		NA							
Supervision			NA	NA	NA	31.83	23.05	5.97	60.85
Total						31.83	23.05	5.97	60.85

a. Data prior to FY 2000 used to be retrieved from FACT (which was replaced by SAP); FACT was phased out two years ago. Unfortunately, data were not downloaded into SAP.

Mission Data

	Date (month/year)	*No. of persons*	*Staff days in field*	*Specializations represented*	*Performance rating*	*Rating trend*
Identification/ Preparation	04/94 – 06/95	5		Training Expert, TM, Prim. Health Expert, Proc. & Impl. Spec., Pharmaceutical Expert		
Appraisal	10/95 – 03/96	5		Training Expert, TM, Prim. Health Expert, Proc. & Impl. Spec, Pharmaceutical Expert		
Supervision	07/96	5		Training Expert, TM, Prim. Health Expert, Proc. & Impl. Spec, Pharmaceutical Expert		
	10/96	4		TM, Proc. & Impl. Spec., Project Assistant, Op. Officer		
Supervision	4/97	5		Training Expert, TM, Primary Health Expert, Proc. & Impl. Spec., Op. Officer		
	10/1997	4		Training Expert, TM, Proc. & Impl. Spec., Op. Officer,		
	04/1998	5		Training Expert, TM, Proc. & Impl. Spec., Op. Officers (2)		
	11/1998 (MTR)	6		Training Expert, TM, Proc. & Impl. Spec., Op. Officers (2), Pharmaceutical Expert		
	7/99	6		Training Expert, TM, Proc. & Impl. Spec, Op. Officers (2), Public Health Spec.		
	01/00	6		Training Expert, TM, Proc. & Impl. Spec. Op. Officer, Public Health Spec., Pharmaceutical Expert		
	7/2000	5		Training Expert, Proc. & Impl. Spec., Op. Officer, Public Health Spec., Pharmaceutical Expert		
	1/2001	2		Public Health Spec., Proc. & Impl. Spec.,		
	06/2001			Public Health Spec., Proc. & Impl. Spec., Op. Officer,		

Other Project Data

FOLLOW-ON OPERATIONS

Operation	*Credit no.*	*Amount (US$ million)*	*Board date*
Second Health Sector Reform Project	3506	11.7	05/08/2001

SECOND HEALTH SECTOR REFORM (CREDIT 3506-KG)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	19.5		
Loan amount	15.0	13.94	92.9
Cofinancing[a]	4.5	0.65[b]	14.4
Cancellation		2.9	

a. Government's contributions and Cofinancier (British Department for International Development)
b. There is no information on Cofinancier disbursement

Cumulative Estimated and Actual Disbursements

	FY02	*FY03*	*FY04*	*FY05*	*FY06*	*FY07*
Appraisal estimate (US$M)	3.0	8.2	12.2	14.4	15.0	
Actual (US$M)	1.41	5.19	7.97	11.14	13.89	13.92
Actual as % of appraisal	47	63.29	65.32	77.36	92.6	

Project Dates

	Original	*Actual*
Initiating memorandum	05/25/2000	05/25/2000
Negotiations	03/26/2001	03/26/2001
Board approval	05/08/2001	05/08/2001
Signing		07/17/2001
Effectiveness	10/01/2001	10/01/2001
Closing date	12/31/2005	06/30/2006

Staff Inputs (staff weeks)

	FY00	*FY01*	*FY02*	*FY03*	*FY04*	*FY05*	*FY06*	*FY07*	*Total*
Preappraisal	43.88								43.88
Appraisal/Negotiations		44.24							44.24
Supervision			28.08	42.76	38.25	33.58	34.10	12.41	189.18
Other									
Total	43.88	44.24	28.08	42.76	38.25	33.58	34.10	12.41	277.3

Names	Title	Unit	Responsibility/ Specialty
Lending (from Task Team in PAD Data Sheet)			
Jan Bultman	Lead Health Specialist	ECSHD	Program Team Leader
Veerle C. Sterling	Consultant	ECSHD	Pharmaceuticals
Strasimir Cucic	Consultant		Health Quality Assurance
Dinara Djoldosheva	Senior Country Officer	ECCKG	Operations Officer
Maria Gracheva	Operations Officer	ECSHD	PAD
Dominic S. Haazen	Sr Health Spec	ECSHD	HIMS
Spencer Hagard	Consultant	ECSHD	Public Health
Carol A. Hoppy	Sr Operations Off	ECAVP	Operations
Simo Kokko	Consultant	ECSHD	Public Health
Joseph D. Kutzin	Consultant	HDNVP	Health Finance& Evaluation
Kees Schaapveld	Consultant	ECSHD	Health Finance
Yves J. Tencalla	Consultant	AFTH1	Education Specialist
Supervision (from Task Team Members in all archived ISRs)			
Roque A. Ardon	Sr Auditor	IADDR	Financial Management
Anne M Bakilana	Economist	ECSHD	ICR Author
Jan Bultman	Lead Health Spec.	ECSHD	Program Team Leader
Sarbani Chakraborty	Sr Health Spec	ECSHD	Team Leader
David A Cochrane	Consultant	ECSHD	Human Resources
Almazbek Djanaliev	Procurement Analyst	ECCKG	Procurement
Dinara Djoldosheva	Sr Country Officer	ECCKG	Operations Officer
Gabriel C. Francis	Program Assistant	ECSHD	Team Assistant
Paolo Giribona	Consultant	ECSHD	Medical Equipment Special
Joana Godinho	Sr Health Spec.	LCSHH	Public Health
Tamar Gotsadze	Health Specialist	ECSHD	ICR Author
Spencer Hagard	Consultant	ECSHD	Public Health
Naushad A.Khan	Lead Procur. Spec	CMERI	Procurement
Simo Kokko	Consultant	ECSHD	Public Health
Nurbek Kurmanaliev	Procurement Officer	ECSPS	Procurement
Joseph Kutzin	Consultant	HDNVP	Health Finance, M&E
Akiko Maeda	Sector Manager, HNP	MNSHD	Health Specialist
Elina Manjieva J	PA	ECSHD	Health Financing
John Otieno Ogallo	Sr FM Specialist	ECSPS	FMS
George Purvis	Consultant	ECSHD	Facility Restructuring

Asel Sargaldakova	Health Specialist	ECSHD	Operations Officer
Dennis Streveler	Consultant	MNSHD	Human Resources
Ronald F. Venezia	Proc & Impl. Spec	ECSHD	Procurement
Yingwei Wu	Sr Procurement Spec	ECSPS	Procurement

Other Project Data

FOLLOW-ON OPERATIONS

Operation	*Credit no.*	*Amount (US$ million)*	*Board date*
Health and Social Protection Project	H1970	15.0	12/15/2005

Annex B. Persons Interviewed

Washington, D.C.

World Bank
Anne Bakilana, author of the ICR for Health II
Sarbani Chakraborty, TTL, Health II
Dennis de Tray, former Country Director, Central Asia Country Unit
Armin Fidler, former Manager, ECA Human Development Sector Unit
Maria Gracheva, Operations Office, ECA Region
Charles Griffin, former Director, ECA Human Development Sector Unit
Christopher Lovelace, former Director, ECA Human Development Sector Unit and former Country Manager for Kyrgyz Republic
Patricio Marquez, TTL, Central Asia AIDS Project

Kyrgyz Republic

World Bank
Dinara Djoldosheva, Senior Country Officer, World Bank
Peyvand Khalegian, TTL, Health II and SWAp
Roger Robinson, Country Manager
Asel Sargaldakova, Health Specialist, World Bank

Ministry of Health
Bolot Elebesov, Head, Economy and Finance Department
Ainura Ibraimova, General Director, Mandatory Health Insurance Fund, and Deputy Minister of Health
Toktogazy Kutukeev, Head of Department of Treatment and Prevention

World Bank HIV/AIDS funded projects
Tilek Meimanliev, Project Director, World Bank Central Asia AIDS Project, former Minister of Health
Chinara Seitalieva, Component Coordinator, World Bank Central Asia AIDS Project, former Director, Technical Coordination Unit, Health II

Other Ministries and Agencies
Sultan Ahmatov, Head of Assistance Strategy, Development Department, Ministry of Economic Development and Trade
Gulmira Bazarkulova, Director, Chui Oblast Mandatory Health Insurance Fund
Mirlan K. Baigonchokov, Head, External Financial Assistance Department, Ministry of Finance
Kubanychbek Jymuratov, Head, Hospital Association
Suyumjan Kukeeva, Administrative Director, Family Group Practice Association (FGPA)
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Annex C: Inputs and outputs

Table C 1. Planned versus actual financing by component, Health I

Component	Planned (US$ millions)	Actual (US$ millions)	Actual as a percent of planned
Primary Health Care	3.5	2.76	79
Facilities Management	2.2	2.16	98
Pharmaceuticals Management	7.3	6.69	92
Provider Payment Reform	3.9	4.5	115
Project Administration	0.6	0.53	88
Project Baseline Cost	**17.50**	**16.64**	**92**
Physical Contingencies	1.70	1.70	
Price Contingencies	0.90.	0.90	
Total Project Costs	**20.10**	**19.24**	**96**

Source: Health I SAR, p. 37; Health I ICR, p. 18

Table C 2. Planned versus actual financing by component, Health II

Component	Planned (US$ millions)	Actual (US$ millions)	Actual as a % of planned
Health Services Delivery Restructuring	7.54	6.24	83
Health Financing	2.67	1.91	72
Quality Improvement	3.52	3.05	87
Public Health	2.01	2.67	132
Project Administration and Evaluation	1.74	0.71	41
Project Baseline Cost	**17.48**	**14.58**	**83**
Physical Contingencies	1.35	0.0	
Price Contingencies	0.67	0.0	
Total Project Costs	19.50	14.58	75

Source: Health II ICR, p. 35

Table C 3. Output targets and achievements, Health I

Indicator	Baseline (1994)	Target (2000)	End of project (2001)
Primary Health Care Component			
Percentage of CRH trainers supplied with ARI/CCC trainers' manuals	0	100	100
Percentage of model polyclinics receiving allocation of drugs from PHC shipment	0	100	60
Percentage of rayon physicians who have attended a "hands-on" training course	0	60	ARI: 81.8% of rayon pediatricians; Diarrheal diseases: 91.7% of rayon pediatricians
Percentage of caretakers of children under 5 years with diarrhea at home who know how to make and administer ORS	20[a]	50	95

Indicator	Baseline (1994)	Target (2000)	End of project (2001)
Percentage of children under 5 years with ARI seen at a FAP who receive correct treatment	10[a]	50	95
Percentage of FAPs providing iron supplements regularly to all pregnant women	0	40	12
Percentage of model polyclinics receiving WRH drugs from PHC shipment	0	100	100
Percentage of workshops conducted as compared to target	0	100	100
Facilities Rehabilitation Component			
Number of MOH officials trained in estates management	0	Not available	3
Number of rural hospitals/polyclinics rehabilitated	0	30 (15 in 1998, 15 in 1999)	114
Number of health centers/FAPs rehabilitated	0	30 (15 in 1998, 15 in 1999)	16
Number of polyclinics provided with equipment kits	0	30 (15 in 1998, 15 in 1999)	76
Number of health canters/FAPs provided with equipment kits	0	30 (15 in 1998, 15 in 1999)	Not available
Provider Payments Component			
Number of people trained in payment systems, cost accounting, clinical information systems, management, accreditation, and quality improvement	0	2,260 (1118 in 1997, 673 in 1998, 457 in 1999, 12 in 2000)	2,240
Number of local experts trained and hired by three associations	0	61 (51 in 1997, 5 in 1998, 5 in 1999)	27
Locations determined and equipment provided for FGPs	0	300 (150 in 1997, 100 in 1998, 50 in 1999)	Not available
Number of FGPs formed and operating with practice managers	0	300 (150 in 1997, 100 in 1998, 50 in 1999)	803
Percentage of population enrolled in FGPs	0	100	89% in Issyk-Kul, Chui, and Bishkek
Percentage of budget funds pooled to fiscal intermediary, and providers reimbursed by new payment system	0	90	15
Percentage of facilities with new cost accounting, clinical information, management, and quality improvement systems	0	100	38
Pharmaceutical Rehabilitation Component			
Number of registration applications processed annually by National Drug Registration Organization	432	550	386 applications in 2001, of which 362 approved and 21 disapproved
Number of licensing applications processed annually by NDRO	96	120	166 applications in 2001, of which 162 approved and 4 disapproved
Number of quality tests performed on each drug sample by NDRO	3	8	Not available
Percentage of drugs tested for quality by	50	57	Not available

Indicator	Baseline (1994)	Target (2000)	End of project (2001)
NDRO			
Percentage of pharmacies/health care facilities in possession of current Essential Drugs List	0	100	100
Percentage of physicians aware/supportive of EDP	0	75	Not available
Non-branded (off-patent) drugs as percentage of all drugs on EDL	0	95	Not available

Source: Health I PAD, pp. 245-252; Health I ICR, pp. 15-16; origin of data in ICR unknown.

a. Baseline data confirmed by UNICEF Household Survey, 1995

Table C 4. Output targets and achievements, Health II

Indicator	Baseline (2000)		Target (2004)(a)	End of project (2005)	
Health Services Delivery Restructuring Component					
Percentage of total government health spending devoted to primary health care and public health	10.2 (PHC) 5.2 (public health)		20% for PHC by 2004[b,c]	25.1 (PHC)[d] 7.1 (public health)[d]	
Budgetary (national and local combined), insurance, and out-of-pocket expenditures on ambulatory care plus population-based health, as percentage of total health spending	Budget: 42.0 MHIF: 4.9 Private: 53.2		Not set; percentage from MHIF should increase, and percentage from budget and private sources should decrease	Budget: 34.8[d] MHIF: 6.2[d] Private: 59.0[d]	
Increased equity in distribution of national budget funds for MOH tertiary level institutions (soms per capita)	Naryn	4.3	Not set; goal is to reach similar per capita spending in each region	Naryn[e]	4.1
	Issyk-Kul	22.3		Issyk-Kul	34.0
	Batken	4.6		Batken	7.9
	Jalal-Abad	19.2		Jalal-Abad	16.6
	Talas	0.5		Talas	1.2
	Osh	3.0		Osh	3.0
	Chui	32.6		Chui	30.0
	Bishkek	425.1		Bishkek	604.3
Percent of population enrolled with accredited FGPs out of total number of enrolled population	In 2002:		Not set; should increase	Kyrgyz Republic[d]	37.6
	Kyrgyz Republic	24.5		Batken	30.6
	Jalal-Abad	10.4		Jalal-Abad	77.3
	Issyk-Kul	99.9		Chui	56.4
	Chui	42.9		Bishkek	44.6
	Bishkek	51.2		Osh City	100
Population per primary health care doctor (FMCs plus FGPs)	5.8 doctors/10,000 population		Not set; should increase	8.2 doctors per 10,000 population[f]	
Ratio of occupied positions to actual persons	Doctors: 1.4 Nurses: 1.3 Total: 1.3		Not set; should decrease	Doctors: 1.3[f] Nurses: 1.2 Other staff: 1.3 Total: 1.2	
Health Financing					
Number of purchasing pools, regions and nationally	62		Not set; should decrease	2 (MOH and Central MHIF)	
Percent of population included in the MHIF enrollment database	0		100[b]	78% for Bishkek. Databases were started in Chui, Issyk-Kul, and Jalal-Abad.	
Percent of FGP capitation payments made on the basis of the MHIF enrollment database	0		100[b]	61.4% in Bishkek	
Percent of rayon health departments adequately equipped to launch the MOH network system	0		Not set; should increase	64[d]	

Indicator	Baseline (2000)	Target (2004)(a)	End of project (2005)
Quality Improvement Component			
Number of FM residents trained per year	59	Not set; should increase	59 trained in 2002; 30 trained in final year of project[e]
Number of FM residents graduating per year	0	Not set; should increase	42 graduated in 2002; 18 graduated in final year of project[e]
FM residents as percentage of total number of residents	0	Not set; should increase	13% in 2002; 5.1% in final year of project[e]
Percent of in-patient and primary care health facilities that are accredited	11[d]	Not set; should increase	20[d]
Number of new clinical guidelines approved annually by MOH	22	Not set; should increase	27[d]
Number of physicians that are dues-paying members of FGPA	1,221	Not set; should increase	4,819[e]
Number of health facilities that are dues-paying members of the HA	3	Not set; should increase	30[e]
Number of pharmacies that have contracts with MHIF for the ADP	0	Not set; should increase	167[d]
Number of retail outlets associated with pharmacies that have contracts with MHIF for the ADP	0	Not set; should increase	633[d]
Number of insured persons with FGPs participating in the ADP program	0	Not set; should increase	4.52 million[d]
Public Health Component			
Total number of people trained in courses organized by the Health Promotion Center	20[c]	Not set; should increase	1316[e]
Number of informational-educational materials on health promotion and prevention of diseases issued annually by the Republican Health Promotion Center	193,064	Not set; should remain constant or increase	78,000[d]

Source: Health II ICR, pp. 21-33, and:

a. The PAD did not specify baseline data or targets for specific indicators. Indicators were specified during the first year of the project.
b. Health II PAD, p. 54.
c. Health II Mid-Term Review.
d. Health Policy Analysis Project, Annual Package of Monitoring Indicators, 2005.
e. Source not specified in ICR.
f. WHO/DfID 2005a.
g. Additional specified indicators for which baseline and/or endpoint data are not available: Percentage of all patients who received consultative-diagnostic services in hospital Ambulatory Diagnostic Departments without hospitalization; Hospital admissions per hospital doctor per year; Beds occupied per hospital nurse; Ratio of PHC doctor to PHC nurse; Number of users per month of the MOH Central Information Portal; Number of trained and re-trained FGP physicians and nurses per 10,000 population (nationally and by region) and their share to the total number of physicians and nurses working in the health system; Ratio of licensed specialists by

category and specialization to the total number of specialists employed in the health sector (on national level and by region, and by level of health care provided); Number of users of evidence-based medicine literature, electronic databases, and the internet.

Annex D. Outcomes by objective

Table D 1. Health I

Objective/Indicator	Baseline (1996)	Target (2000)	End of project (2001)(a)
Improving the health status of the population			
Under 5 mortality rate	7.7/1,000 (1994)[b]	9/1,000[d]	22.6/1,000[c]
Maternal mortality rate	80.1/100,000 (1994)[b]	75/100,000	46.5/100,000[c]
Perinatal mortality rate	12.1/1,000 (1994) [b]	11.1/1,000	12.3/1,000[a]
Improving the clinical effectiveness of the health service delivery system			
Percentage of infant deaths due to ARI	48 (1994)[b]	Not available	5.1% reduction[c]; Health I ICR also states that IMR due to ARI declined by 41%[c]
Percentage of infant deaths due to diarrhea	11 (1994)[b]	40	Not available
Percentage of maternal mortality due to eclampsia	23 (1994)[b]	20	2% reduction[c]
Percentage of neonatal deaths due to asphyxia	23.8 (1994)[b]	22	21.7[c]; Health I ICR also states that IMR due to asphyxia declined by 9%[c]
Improving the economic efficiency of the health service delivery system AND assuring the long-term financial viability of the system			
Increase in utilization of facilities rehabilitated	No acceptable baseline provided	5% increase	20-25% increase[c]
Reduction in hospital admission rates	16.4/100[e,f]	20% decrease	12.7/100 (2002) (22.6% decrease)[e,f]
Reduction in hospital ALOS (days)	14.9 [b,e]	16% decrease	13 (12.8% decrease) [b, e]
Increase in proportion of resources allocated to primary care sector	10.6[f,g]	16% increase	18.4 (73.6% increase)[f,g]
Reduction in number of beds and facilities	38,000 hospital beds[d,e]	20% decrease	27,500 hospital beds[d,e] (27.6% decrease)
Extension of access of appropriate care			
No indicators apply exclusively; several listed under other objectives are relevant to access			
Intermediate outcome indicators			
Average speed of registration decisions by NDRO (time between presentation of full required information and decision)	90 days	70 days	3-4 months[c]
Average speed of licensing of proprietors by NDRO (time between presentation of full required information and decision)	30 days	14 days	15-30 days[c]
EDL drugs prescribed/dispensed as percentage of all drugs prescribed/dispensed at each level of the pharmacy system	20	60	100
EDL drugs dispensed free of charge or at subsidized prices to entitled patient group as percentage of all drugs dispensed free of charge or at subsidized rates to entitled groups	20	100	100

Source: Health I ICR, pp. 16-17; Health I SAR, pp. 245-252, and:

a. Health II PAD, pp. 99-112.

b. Kyrgyz Ministry of Health data.

c.Source unknown.

d. Jakab and Manjieva, 2007.

e. Kyrgyz Ministry of Health/HPAP data.
f. WHO/DfID, 2003.
g. Meimanaliev et al., 2005.
h. Additional indicators for which baseline and/or endpoint data are not available: Reduction in use of energy at facilities that have been rehabilitated; Reduction in referral rate of primary care physicians; Percentage of sampled medicines at pharmacies satisfying minimum quality requirements (content and stability); Percentage of pharmaceuticals samples proprietors satisfying licensing requirements; Change in availability and price of those drugs procured under the Credit at community pharmacies and rayon hospital pharmacies; Change in availability and price of drugs on the EDL at each level of the pharmacy system.

Table D 2. Health II

Objective/Indicator	Baseline (2000)		Target (2004)	End of project (2005)	
Adjust the delivery system to available means					
Closed hospital buildings and hospitals	0		Not set; should be reduction in number of hospitals and hospital buildings	Square footage of hospital sector reduced by 39.6%; number of buildings reduced by 46.5%[b]	
Total number of hospital beds	34,412		Not set; should decrease	26,040[a]	
Hospital beds per 10,000 population	70.4		Not set; should decrease	52.8[a]	
Total number and mix of hospitals	58 specialized hospitals 194 general hospitals		Not set; should decrease	45 specialized hospitals[b] 110 general hospitals	
Medical staff per 10,000 population	Doctors: 18.5 Nurses: 60		Not set; should decrease	Doctors: 20.3[a] Nurses: 47.8	
Focus on important health risks and diseases					
Percentage of treated cases of asthma for which clinical practice is considered to be appropriate and in accord with MOH guidelines	27.2		Not set; should increase	27.4[a]	
Percentage of treated cases of hypertension for which clinical practice is considered to be appropriate and in accord with MOH guidelines	48.6		Not set; should increase	68.4[a]	
Percentage of treated cases of peptic ulcer disease for which clinical practice is considered to be appropriate and in accord with MOH guidelines	27.7		Not set; should increase	57.0[a]	
Percentage of treated cases of acute upper respiratory infection in children for which clinical practice is considered to be appropriate and in accord with MOH guidelines	66.9		Not set; should increase	57.1[a]	
Incidence of TB per 100,000 population	Kyrgyz Republic	121.8	Not set; should decrease (although observed trend could increase due to better case detection)	Kyrgyz Republic[c]	166.7
	Batken	102.2		Batken	155
	Jalal-Abad	135		Jalal-Abad	138.1
	Issyk-Kul	91.4		Issyk-Kul	93.9
	Naryn	86.5		Naryn	119.4
	Osh	142.9		Osh	110.1

Objective/Indicator	Baseline (2000)		Target (2004)	End of project (2005)	
	Talas	109.5		Talas	210.8
	Chui	130.6		Chui	175
	Bishkek	104.7		Bishkek	167.5
Incidence of brucellosis per 100,000 population	Kyrgyz Republic	24.9	Not set; should decrease (although observed trend could increase due to better case detection)	Kyrgyz Republic[c]	69.5
	Batken	14.3		Batken	200.4
	Jalal-Abad	25.2		Jalal-Abad	88
	Issyk-Kul	55.9		Issyk-Kul	84.6
	Naryn	80.1		Naryn	136
	Osh	7.4		Osh	32.3
	Talas	33.1		Talas	153.7
	Chui	32.3		Chui	58.6
	Bishkek	13.2		Bishkek	11.8
Improve access through better distribution of services					
Equity in per capita distribution of public health funds (soms per capita)	Naryn[d]	257.1	Not set; goal is to reach similar levels in each region	Naryn[d]	341.2
	Issyk-Kul	219.6		Issyk-Kul	322.4
	Batken	164.2		Batken	273.2
	Jalal-Abad	198.7		Jalal-Abad	273.4
	Talas	232.4		Talas	310.1
	Osh	179.8		Osh	313.9
	Chui	260.3		Chui	346.5
	Bishkek	658.2		Bishkek	973.1
Improve access through offering financial protection for the population against potentially impoverishing levels of out-of-pocket health spending					
Health spending as a percentage of total household and per capita consumption	4.5 (poorest quintile)[e] 4.8 (richest quintile)		Not set; should decrease	6.8 (poorest quintile) (2003)[f] 4.3 (richest quintile)	
Out-of-pocket spending as percentage of total health spending	51.7		Not set; should decrease	59[f]	
Improve the responsiveness of the health system to the expectations of the population					
Percentage of patients rating the cleanliness of hospitals to be "good" or "very good"	Bishkek	78.1	Not set; should increase	Bishkek[g]	86.2
	Jalal-Abad	84.7		Jalal-Abad	85.1
	Issyk-Kul	78		Issyk-Kul	85.1
	Naryn	83.3		Naryn	83.2
	Osh	88.7		Osh	97
	Talas	91.2		Talas	85
	Chui	72.1		Chui	52.8
	Batken	85.2		Batken	58.1
Percent of total payments from primary care from pooled resources steered by consumer choice of FGP	Bishkek	31	Not set; should increase	Bishkek[g]	35
	Chui	19.5		Chui	31
	Osh	10.4		Osh	25.5
	Batken	10.3		Batken	28.6
	Jalal-Abad	10.4		Jalal-Abad	32.4
	Issyk-Kul	15.7		Issyk-Kul	25.3
	Naryn	13.1		Naryn	32.3
	Talas	17.5		Talas	35
Percent of drugs tested at the two quality control laboratories that are rejected/faulty	Bishkek: 5.24 Osh: 10.55		Not set; should decrease	Bishkek: 1.94[a] Osh: 2.03	

Source: Health II ICR, pp. 21-33, and:

a. Health Policy Analysis Project, Annual Package of Monitoring Indicators, 2005.

b. WHO/DfID 2005.

c. Republican Medical Information Center database.
d. Source not specified in ICR.
e. WHO/DfID 2001.
f. WHO/DfID 2005b.
g. Mandatory Health Insurance Fund data

Annex E. Additional health projects supported by the World Bank and other donors

Project	Sector Issue	Amount	Status
World Bank			
Governance Structural Adjust. Credit	IDA credit in three tranches. Public administration reform: reforms in public expenditure management, internal control, procurement systems, and financing/delivery of health and education services.	US$20 million	2003-ongoing
Central Asia Regional HIV/AIDS Project	Reduction of the growth rate of HIV/AIDS in Central Asia. Establishes a Central Asia Regional AIDS Fund as a vehicle for financing HIV/AIDS prevention and control activities in the region; contributes to better regional cooperation in Central Asia and better intersectoral cooperation between the public sector, NGOs, and the private sector on HIV/AIDS control.	US$25 million plus US$1.9 million DfID grant	2005-ongoing
Avian Influenza Control & Human Pandemic Preparedness & Response Project	Minimization of the threat to humans and to the poultry industry by Highly Pathogenic Avian Influenza, and preparation, control, and response to an influenza pandemic. Supports prevention, preparedness/planning, and response/containment.	US$6.4 million	2006-ongoing
Other Donors, Active			
Asian Development Bank	Community-Based Early Childhood Development Project. Targets children less than eight years of age to improve <5 mortality rate, nutritional status, and immunization through community-based efforts to improve early childhood development.	US$10.5 million credit	2003-onging
Asian Development Bank	Improvement of Nutrition of Mothers and Children from Poor Households. Focus on BCC/IEC for population on anemia and IDD prevention.	US$0.7 million grant	2001-ongoing
DfID	Strengthening the Health Policy Response to Poverty. Finances the Health Policy Analysis Project and its activities: performance indicators, curriculum development for health management, evaluation of health reforms	£2.9 million grant	2000-ongoing
DfID	Hygiene, Water, and Sanitation Project. Works in Naryn, Talas, and Issyk-Kul in conjunction with World Bank Rural Water Supply Project.	£3.3 million grant	2002-ongoing
GFATM	HIV/AIDS and TB prevention. Provides national ARV treatment, blood safety interventions, and political, legal, and social support for PLWHA; supports expansion of DOTS strategy (integration in general facilities and community), improved detection and quality of diagnosis (clinical and lab), and better cure and treatment of MDR TB. Also harm reduction grants for NGOs and public sector.	US$6.2 million grant: US$5 million AIDS and US$1.2 million TB	2004-ongoing
JICA	Project for Improvement of Child Health Care in Rural Areas. Medical technology for pediatrics departments of oblast hospitals in Osh, Issyk-Kul, Naryn, and Talas plus three institutions in Bishkek.	US$3.7 million grant	2004-ongoing.
KfW	MCH Program III. Supports procurement and delivery of medical equipment for obstetric and neonatal department of oblast and rayon hospitals in Chui, Talas, Naryn, and Issyk-Kul	€5.6 million grant and €0.3 million	2004-ongoing.

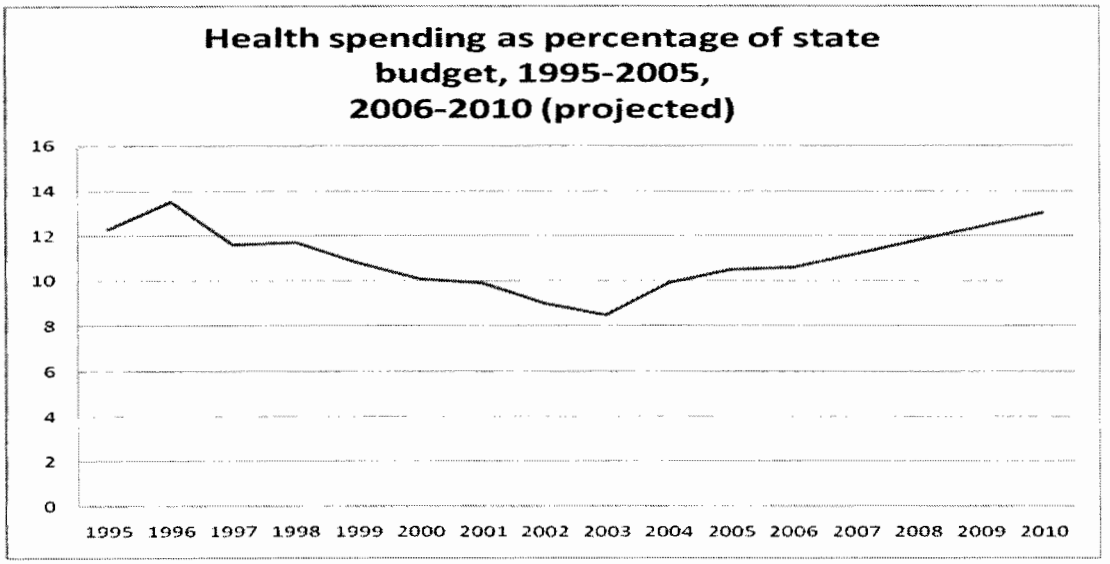
Project	Sector Issue	Amount	Status
	plus Bishkek Perinatal Center and Obstetric Hospital # 1, including training in use and maintenance.	TA grant	
KfW	TB Control Program III. Restructuring and reconstruction of TB hospitals, national TB lab in Bishkek and procurement of medical equipment, including training in use and maintenance.	€3 million grant	2006-ongoing.
KfW	Improvement of medical emergency system. Procurement of medical equipment, vehicles, communication technology, and training for medical staff in emergency care.	€3 million credit, €2.3 million grant, and €1 million TA grant	2006-ongoing.
KfW	TB Control Program II. Medical equipment for rayon TB facilities in Southern oblasts and Bishkek to support TB control program.	€2.6 million grant	2000-ongoing.
KfW	HIV/AIDS Prevention. Equipment supply plus TA.	US$4.3 million grant	2004-ongoing.
SDC	Health Reform Support Program. Three-phases. Phase I (1999-2001) focused on rehabilitation of two territorial hospitals; Phase II and III include increasing emphasis on primary care. Phase III strongly emphasizes community-based health promotion in pilot areas in Naryn and Talas oblasts, as well as quality of care, hospital hygiene, and basic infrastructure.	Total grant US$8 million; current phase, US$3.7 million	1999-ongoing.
SDC	STD Prevention Program. Initially focused on STIs in Southern oblasts, including drug distribution in IEC for sex workers; now expanded to include HIV/AIDS and STIs and for BCC to youth population as a whole, focusing on Jalal-Abad and Osh.	US$0.65 million grant	1997-ongoing.
UNDP/UNAIDS	Support to Kyrgyz Government's Response to HIV/AIDS. Builds capacity among national-level leaders in responding to HIV/AIDS threat by interaction with civil society, PLWHAs, and others.	US$2.1 million TA grant	2005-ongoing.
UNFPA	Improved supply and distribution of reproductive health commodities to poor and vulnerable persons. Supports introduction and implementation of an appropriate logistics management information system (LMIS) to better monitor contraceptive management.	US$0.074 million TA	2005-ongoing.
UNFPA	Implementation of national policies to prevent mother-to-child and sexual transmission of HIV/AIDS, including sex education and support to youth-friendly centers. Supports Youth Friendly Centers; KAP survey on HIV; advocacy campaign for youth and high-risk groups; training in BCC and counseling; education programs for schools; awareness-raising in law enforcement agencies; integration of VCT into health care system; and supply of condoms to Youth Friendly Centers.	US$0.11 million grant	2005-ongoing.
UNFPA	Trust Fund Project "Quality of Care/Stronger Voices for Reproductive Health: Improving Quality of Sexual and Reproductive Health Care."	US$0.3 million grant	2004-ongoing.
UNFPA and UN Trust Fund for Human Security supported by the Government	Improvement of Community Health Services in the Northern Regions of Kyrgyzstan. Training and IEC on HIV/AIDS, STIs, and modern RH/FP/STI technologies; procurement of contraceptives and medical equipment for Family Planning Centers; establishment of HIV/AIDS/STI crisis centers; and roundtable for religious and community leaders on RH/FP in Islam.	US$0.5 million grant	2003-ongoing.

Project	Sector Issue	Amount	Status
of Japan			
USAID	Primary Health Care Project/ZdravPlus II project. Support for payment and information system reforms and quality improvement in primary health care through incentives for FGP staff and development/use of CPGs. Also supports strengthening of disease surveillance, prevention and control functions according to modern public health standards. Implemented by Abt Associates in collaboration with John Snow Inc., CitiHope International, STLI, and Socium Consult.	US$10.7 million TA grant	2005-ongoing.
USAID	CAPACITY: Central Asia Program on AIDS Control and Intervention Targeting Youth and High Risk Groups. Support for launching of large-scale responses to HIV/AIDS and for development of local institutions to manage comprehensive HIV/AIDS programs. Implemented by JSI Research & Training Institute, Abt Associates, International HIV/AIDS Alliance, PSI, Boston University, and Howard University.	US$2.8 million TA grant	2004-ongoing.
USAID	Health Partnership Program between US universities, Kyrgyz State Medical Academy, and Osh State University Medical Faculty. Increases capacity of medical institutions in Kyrgyz Republic to train high-quality health professionals. Implemented by American International Health Alliance.	US$0.8 million TA grant	2003-ongoing.
USAID	Drug Demand Reduction Project. Support for drug treatment, social rehabilitation and prevention education for health professionals, prisoners, CSWs, homeless youth, and other high-risk groups.	US$1.2 million TA grant	2002-ongoing.
USAID	New Participating Agency Services Agreement (PASA). HIV/AIDS surveillance; TB laboratory diagnosis and electronic surveillance; blood safety; definition of live births and infant mortality prevention; epidemiology network creation; and applied epidemiology and training program introduction. Provides training and monitoring of implementation of international standards in nine maternity hospitals in Bishkek and Chui Oblast. Implemented by U.S. Centers for Disease Control and Prevention.	US$2.4 million TA grant	2004-ongoing.
USAID	Health Families. Child mortality and morbidity in Batken Oblast. Implemented by Project HOPE.	US$0.7 million TA grant	2004-ongoing.
Closed projects			
ADB/OPEC Fund	Financing of Social Services. Rehabilitation of 495 medical facilities in Jalal-Abad and Osh oblasts.	US$5.8 million from ADB plus US$1.8 million from OPEC Fund	1999-2004
DfID	Human Resources for Health. Functional analysis of HR in PHC and specific attention to restructuring in Bishkek and Osh.	£0.1 million grant	2004-2005
JICA	Upgrading Medical Equipment to Obstetric Facilities. Equipping obstetric departments in Issyk-Kul, Naryn, Talas oblast hospitals and the Kyrgyz Center of Reproductive Health.	US$6.1 million grant	1998-2003
KfW	MCH Program II. Medical equipment for obstetric and neonatal departments of hospitals in Osh and Jalal-Abad Oblasts and Bishkek.	US$3.1 million grant plus US$4.9 million credit	2000-2004

Project	Sector Issue	Amount	Status
KfW	TB Control Program I. TB drugs for all TB facilities in the country as well as delivery of medical diagnostic equipment, laboratory equipment, consumables for TB facilities in Osh Oblast, Jalal-Abad Oblast, Batken Oblast, and Bishkek.	US$3.2 million grant	1998-2003

Sources: Health and Social Protection Project PAD, pp. 45-51; www.donors.kg

Annex F. Trends in Public Expenditure on Health



Source: Ibraimova (2007)

Annex G. Timeline on Kyrgyz health sector reform and Bank-sponsored projects

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
1991	--Kyrgyzstan declares independence from the Soviet Union. (August 13) --Askar Akayev elected president of the Kyrgyz Republic. (October) --Kyrgyz Republic joins the Commonwealth of Independent States. (December)		
1992	The Kyrgyz Republic joins the United Nations and the Committee on Security and Cooperation in Europe.	Government passes Health Protection Act, shifting priority toward health promotion and disease prevention, with an emphasis on primary and family-based care. (July)	
1993		National drug regulatory organization, the Administration for Standardization and Oversight of the Quality of Medicines and Medical Technology, established within the Ministry of Health.	
1994	Government establishes the Social Fund, a quasi-governmental authority with responsibility to collect all social and health insurance payments, amounting to 39% of the payroll tax.	Government approves State Program for a Healthy Nation, the first comprehensive national health policy in the country, defining as priority areas family health, maternal and child health, protection of the environment, safe drinking water, and healthy lifestyles.	--Government requests technical assistance from USAID to implement experimental health care financing and service delivery reform in Issyk-Kul Oblast. (Spring) --WHO Regional Office for Europe and Kyrgyz Ministry of Health sign Memorandum of Understanding to undertake the Manas National Health Care Reform Program. (March) --WHO completes analytic work: analysis of the tuberculosis situation. (March) --World Bank begins identification and

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
			preparation missions for Health Sector Reform Project. (April) --World Bank completes analytic work "Assessment of the Sexually Transmitted Disease Program in the Kyrgyz Republic." (October)
1995		National Tuberculosis Program for 1996-2000 approved by Government. (December)	--World Bank completes analytic work "Maternal and Perinatal Health in the Kyrgyz Republic," and also an assessment of health facility sites in Chui oblast. (June) --World Bank completes analytic work "Evaluation of the Status of ARI/CDD Program in Kyrgyzstan." (July) --Appraisal of Health Sector Reform Project. (October 2) --World Bank completes analytic work on health spending in Kyrgyz Republic.
1996		--Manas National Health Care Reform Program approved. (November) --Family Group Practice enrollment campaign begins in Issyk-Kul Oblast. --Law on Drugs and first Essential Drugs Lists are adopted. --Law on AIDS Prevention passed. (December)	--Health Sector Reform Project approved. (May 14) --Health Sector Reform Project becomes effective. (June 1)
1997		--Mandatory Health Insurance Fund created. (January) --Case-based payments to hospitals from insurance funds begin, and primary health reforms are extended to the city of Bishkek and three additional oblasts. (July) --Medical Accreditation Commission (MAC) established as an independent agency responsible for accreditation of	

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
		health facilities; licensing and accreditation process begins. (Spring) --New drug policy adopted permitting the privatization of pharmacies.	
1998	Kyrgyz Republic joins the World Trade Organization. (December)	Family group practice enrollment begins in Chui Oblast and City of Bishkek. (November)	Mid-Term Review mission for Health Sector Reform Project. (November)
1999		--Medical Insurance Law passed, providing the basis for financing the health care system through compulsory and voluntary health insurance. (October 18) --Mandatory Health Insurance Fund becomes part of the Ministry of Health.	First identification mission for Second Health Sector Reform Project. (September 3)
2000	Laws on self-government and the budget are passed that lay the foundation for the single-payer system of financing health care. (December)	--Oblast Health Departments abolished, transferring budget financing of oblast-level health facilities to Oblast MHIF Departments. (January) --Out-patient Drug Benefit Program introduced.	--Task Manager changed on Health Sector Reform Project. (July 1) --World Bank completes analytic work on informal health payments in Eastern Europe and Central Asia, and on social/health expenditures in the Kyrgyz Republic. --MOH/World Bank hold formal conference to discuss design of Health II. (August 11-12)
2001		--Government decree passed on a new health care financing mechanism for health facilities, transferring funding responsibility from the rayon/city level to the oblast level. (January) --Program of State Guarantees introduced in Issyk-Kul and Chui Oblasts. --Out-patient Drug Benefits package piloted in Bishkek. --Output-based health financing mechanisms and co-payments	--Appraisal of Second Health Sector Reform Project. (January 8) --World Bank completes analytic work "Review of Sanitary Epidemiological Services (SES) in Kyrgyz Republic." (January) --Second Health Sector Reform Project approved. (May 8) --Second Health Sector Reform Project becomes effective. (October 1)

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
		introduced in Issyk-Kul and Chui Oblasts.	
2002		--State Guaranteed Benefit Package passed, defining clearly the rights and obligations of patients and the state with regard to the provision of health services. (February 25) --Naryn and Talas Oblasts join the single payer system and introduce co-payments. (March) --Government creates the High Technology Fund, in recognition of the need to create sustainable, transparent, and equitable mechanisms for providing medical care requiring the use of advanced and expensive technology. (May 7) --Change in Health Minister; previous health minister had been key architect of the health reforms. (July)	Health Sector Reform Project closes. (September 1)
2003	Roundtable on health sector reform takes place, with participation of the President and donor organizations, reaffirming commitment to continue and enhance health reforms. (February)	--Batken, Jalal-Abad, and Osh Oblasts join the single payer system and introduce co-payments. (March) --Out-patient Drug Benefits package rolled out nation-wide. (April) --Law on Single Payer System In Financing Healthcare System passed. (July 30) --Republic-level facilities join the single-payer system. (November) --Government passes law On Health Insurance of the Population, stipulating	--Mid-Term Review Mission, Second Health Sector Reform Project. (November) --Change in Team Leader of Second Health Sector Reform Project.

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
		payment of insurance premiums from the national budget for mandatory health insurance of pensioners.	
2004	--Kyrgyz Republic passes public procurement legislation consistent with international standards and World Bank guidelines. (May)	--Kyrgyz Republic introduces new live birth criteria, bringing infant mortality reporting in line with international standards. --Single-payer reforms and co-payments introduced in City of Bishkek. --State Guaranteed Benefits Package completes nation-wide rollout. (February) --Law on Health Care Organizations passed, giving state health facilities significant financial autonomy. (August 13) --Core team for development of what will become Manas Taalimi health sector strategy established. (December)	
2005	--Parliamentary elections are held. Widely perceived as fraudulent, they result in demonstrations eventually forcing President Akayev to flee the country (the "Tulip Revolution") and resulting in the formation of a new Government. (February-March) --Akayev resigns the presidency. (April 4) --New Government formed under President Kurmanbek Bakiyev. (July)	--Law on Health Protection passed, establishing a general legal framework and setting roles and responsibilities of state bodies involved in health care service provision. (January 9) --First roundtable discussion on Manas Taalimi health sector strategy. (January 17) --First draft of Manas Taalimi health sector strategy shared with donors for technical comments. (Feb. 10)	--Joint Fiduciary Assessment for sector-wide approach (SWAp). (Late May) --SWAp pre-appraisal mission. (September 5-16)

Year	Kyrgyz Political and Economic Developments	Kyrgyz Health Sector	World Bank and Other Donors
		--Second roundtable discussion on Manas Taalimi health sector strategy. (May) --Third and final roundtable discussion on Manas Taalimi health sector strategy. (October 6)	
2006	--First of repeated rallies and demonstrations in which protesters have demanded implementation of promised reforms and expressed resentment against ineffective policy and corruption. (April) --Implementation of delayed constitutional reforms, including transfer of some presidential powers to Parliament. (November) --Amendments restoring many presidential powers passed by Parliament. (December)	--Oblast-level MHIF purchasing pools centralized into one national purchasing pool. --"Health Summit" held as part of implementation of Manas Taalimi program. (September)	Second Health Sector Reform project closes. (June)
2007	--Government decides not to seek assistance under the Heavily Indebted Poor Countries (HIPC) debt relief initiative. (February) --Large demonstrations demanding return to constitutional reforms of November 2006. (April) Government's new Country Development Strategy launched. (May 16)	-- "Health Summit" held as part of implementation of Manas Taalimi program. (May) -- Government approved decree "Financing the Health Sector on a Program Basis," establishing the procedures for formation and execution of the health sector on a program basis beginning later in 2007. (May 21)	